



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 25, 2025

Administrator
Heritage Manor
321 NORTHEAST SIXTH STREET
CHISHOLM, MN 55719

RE: CCN: 245245

Cycle Start Date: June 26, 2025

Dear Administrator:

On July 21, 2025, we notified you a remedy was imposed. On September 24, 2025, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of 09/24/2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective 08/05/2025, be discontinued as of 09/24/2025. (42 CFR 488.417 (b))

In our letter of July 21, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from 08/05/2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 16, 2025

Administrator
Heritage Manor
321 NORTHEAST SIXTH STREET
CHISHOLM, MN 55719

RE: CCN: 245245

Cycle Start Date: June 26, 2025

Dear Administrator:

On 07/21/2025, we informed you of imposed enforcement remedies.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective 08/05/2025.
- Civil money penalty. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 26, 2025. (42 CFR 488.417 (b))

On June 26, 2025, the Minnesota Department of Health completed a revisit, and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F755 - Pharmacy Srvcs/Procedures/Pharmacist/Records
F880 -Infection Prevention & Control

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions
(42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R.

498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

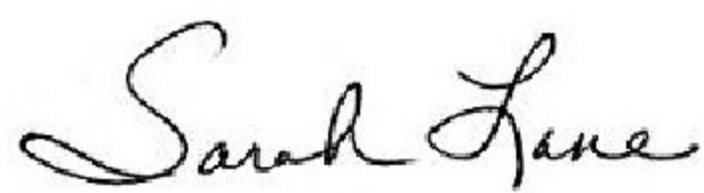
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/04/2025	
NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments		E0000			09/25/2025	
F0000	NO deficiencies were cited for Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, CFR §483.73, at the time of the standard recertification survey, exited on 6/25/25.		F0000			09/25/2025	
	INITIAL COMMENTS						
	On 9/2/25-9/4/25, an onsite revisit was conducted to follow up on deficiencies related to a standard recertification survey exited on 6/25/25. The facility was found to be NOT in compliance with the requirements of §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.						
	The following tags were recited: F755 and F880.						
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.						
	Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.						
F0755 SS = F	Pharmacy Srvcs/Procedures/Pharmacist/Records		F0755	F755:		08/20/2025	
	CFR(s): 483.45(a)(b)(1)-(3)			DON and/or Designee will implement corrective action for resident affected by this practice (R262):			
	§483.45 Pharmacy Services			R262 PRN Ativan administrations were compared between the electronic health record and narcotic book with no errors in administration. Ativan liquid amount will be corrected in the narcotic book by two licensed nurses to reflect the accurate amount of liquid in the Ativan bottle.			
	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			All residents who receive liquid controlled substances have the potential to be impacted by this deficient practice.			
	§483.45(a) Procedures. A facility must provide						

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0755 SS = F	Continued from page 1 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to maintain accurate controlled substance medication accounting for 1 of 1 resident (R262) who received a scheduled controlled substance in liquid form. R232's quarterly Minimum Data Set (MDS) dated 6/24/25 indicated R262 was significantly cognitively impaired with the diagnoses of conversion disorder with seizures, depression, hemiplegia and hemiparesis post stroke, and anxiety. R232's Active Orders As of 9/4/25, included the order: Ativan 1 MG/0.5 ML Give 0.5 ML by mouth two times a day related to conversion disorder with seizures or convulsions. During a medication room review on 9/3/25 at 3:55 p.m., with licensed practical nurse (LPN-A) the locked fridge medications included a 30 milliliter (ML) bottle of Ativan. The manufacture label indicating the strength was 2 milligram (MG)/ML. The pharmacy label read, take 0.5 ML by mouth twice a day. LPN-A confirmed they had done narcotic count with the off going nurse and explained they counted all the narcotics in the medication cart against the narcotic book. For the liquid Ativan, they had gone by the number in the	F0755	Continued from page 1 DON and/or Designee will implement measures to ensure this practice does not reoccur including: The Controlled Medication policy was reviewed with no changes. The Medication Administration policy was reviewed and updated to include: verify the controlled substance medication amount in the dispensing container matches the documented amount in the narcotic book. If the liquid in the medication bottle does not match the count in the narcotic book (is more than what is documented on the narcotic book), two licensed nurses will compare the narcotic book administration record to the electronic medical record to ensure all administrations are documented correctly. If all administrations were documented correctly, then the two licensed nurses are to correct the accurate amount in the narcotic book and sign off on the correction. If unable to verify that all administrations are accurate, please follow Controlled Medication policy. If the amount is less in the bottle compared to the narcotic book, please refer to Controlled Medication policy. All licensed nurses will be educated on the Controlled Medication policy and Medication Administration policy. All current residents who have orders for liquid controlled substances will be audited to ensure the amount in the bottle matches the amount on the narcotic book. Any discrepancies will be followed-up on per policy. Random audits will be completed by DON and/or designee verifying that the amount of liquid in the bottle of controlled substances matches the amount documented in the narcotic book and that licensed nurses are completing controlled substance count at shift change based on policy 3x/week x 2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning 9/16/2025. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	

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F0755 SS = F	Continued from page 2 narcotic count book for the total in the bottle. LPN-A confirmed they had not looked at the Ativan bottle during count. Instead, together they reviewed the doses subtracted from the total amount for accuracy. LPN-A opened the narcotic book to page 79 and stated the Ativan count showed the bottle contained 11 ML. LPN-A then looked at the bottle and stated it was between 13 and 14 ML, but the bottle design made it hard to be exact. LPN-A confirmed there was a discrepancy between the count book and amount in the bottle. If the discrepancy had been less than what was recorded in the book then they would have been concerned and reported it, but since it was over it was not really a concern. They would continue to use the ML recorded in the book and would not adjust the book to match the bottle total. The facility narcotic book showed R262's Ativan had been logged in the book on page 41 and 79. Entries on page 79 for the dates of 9/3/25, and 9/4/25, were as follows: 9/3/25 at 9:10 a.m.: 0.5 ML administered/amount remaining 11 ML, 9/3/25 at 8:00 p.m.: 0.5 administered/ amount remaining 10.5 ML, and 9/4/25 at 9:00 a.m.: 0.5 ML administered/amount remaining 10 ML. During an interview on 9/4/25 at 9:43 a.m., LPN-B stated liquid medication was tricky to count because it was hard to read the exact amount in the bottle. If the order was for one ML of medication, then during count staff would expect one ML doses to be subtracted correctly from the count total with each administration. During count staff looked at the amount in the bottle to make sure it was pretty close to the recorded total in the book. The bottle amount could be off by about 4 ML from the book total. LPN-B confirmed when there was a discrepancy between the amount of ML in the bottle and what was recorded in the count book, they did not adjust the book to reflect the current amount in the bottle. Staff just knew the two could be off by a few ML and to use the amount recorded in the book as the correct count number. During an interview on 9/4/25 at 11:21 a.m., registered nurse RN-B stated they expected liquid medications to be counted at the beginning and end of each shift. Staff should compare the amount in the bottle against the narcotic count in the book to make sure both volumes match. If they do not match, then a report should be completed so the discrepancy can be reviewed and corrected. During an interview on 9/4/25 at 11:00 a.m., RN-A removed R262's Ativan from the fridge and stated it		F0755				

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F0755 SS = F	Continued from page 3 looked like the bottle contained a little less than 14 ML. RN-A explained because the bottle ML were so hard to read, when they did count, they went off doses subtracted in the book from last recorded total for the count. RN-A confirmed they and a coworker had done count this morning. Together they had reviewed the dose subtractions in the book for correctness, but they had not physically pulled the bottle and looked at the total ML in the bottle. R262's Ativan was entered on page 79 in the book. RN-A stated the total in the book was 10 ML. RN-A stated they felt that 4 ML was a big discrepancy. It could mean that doses were missed, or the resident had refused doses, there could be many different reasons however not knowing how off the bottle was before the difference became 4 ML makes it harder to figure out the difference now. RN-A stated they would report a four ML difference. During an interview on 9/4/25 at 11:27 a.m., RN-C explained when narcotic count was done on liquids, the staff reviewed the entries in the book to make sure the last volume recorded in the book accurately reflected the volume of doses that had been administered. Staff also looked at the bottle to see how many MLs were in the bottle, but it did not always match the count book because new 30 ML bottles often contained an extra two to four ML so staff knew the book and bottle volumes may not always match. During count if the bottle volume was found to be different from the count volume, they did not adjust the count volume to match the bottle volume, instead they continued to make sure each dose was correctly subtracted from the total recorded volume. When the count volume in the book reached zero, if the bottle had remaining medication in it, then two staff would destroy it. When they personally did count, they always made sure the bottle volume was at least the recorded count volume and if it was under that, they would report it. RN-C stated staff did not document known volume differences between the count volume and the bottle anywhere at present. RN-C agreed not recording and being able to know the total volume overage at any given time would make it difficult to identify potential medication errors and or if diversion had occurred. During an interview on 9/4/25 at 12:19 p.m., the director of nursing (DON) stated narcotic count should be performed by the off going and on-coming nurse. The liquid medication bottles should be viewed for total ML and then compared against the narcotic count ML balance. If there is a discrepancy during count, they should be checking in with the charge nurse for further review and then a note should be made in the book to identify the discrepancy.		F0755				

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F0755 SS = F	Continued from page 4 During an interview on 9/5/25 at 2:34 p.m., the consulting pharmacist (CP) stated liquid medications are often over filled by the manufacture to account for evaporation or small spillage. The manufacture does not list the total amount of overage, the bottles come as 30 ML dispensed. After a few does are given, and nurses are able to identify a discrepancy in the count book and the total amount in the bottle, the discrepancy should be addressed. The total bottle ML really needs to match the book ML. Accurate narcotic count is needed to prevent diversion and to be able to determine if a medication over or under dosing may have occurred when the numbers don't match. The right thing is to bring it to attention and for two nurses to adjust the book to the total ML in the bottle and sign off on it. The discrepancy would also get reviewed. The facility policy Controlled Medication dated 2/27/24, section F. Auditing Usage instructed controlled medication count audit must be completed at each shift change with the oncoming and off-going Trained Medication Aide (TMA) or nurse. A licensed nurse must be included in the count. The off going TMA or nurse counts the controlled substance and the on-coming nurse is to verify the on-hand count matches the recorded balance in the bound count book. If a discrepancy is identified it must be resolved before shift personnel leave the nursing area. If the error cannot be located, the DON or Director on call must be notified. The form Notification of Controlled Mediation Error should be completed, and an investigation should begin immediately. Suspected drug diversion would be reported to appropriate agencies by the DON and/or administrator.		F0755				
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:		F0880	F880: Infection Prevention and Control DON or designee will implement corrective action for residents affected by this practice (R376): R376 has the appropriate Enhanced Barrier Precautions signage and PPE in place. Staff will utilize Enhanced Barrier Precautions per policy when caring for R376. All residents who are on Enhanced Barrier Precautions have the potential to be impacted by this deficient practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: Enhanced Barrier Precautions policy was reviewed, no updates needed. All nursing staff will be educated on the Enhanced		08/20/2025	

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F0880 SS = D	Continued from page 5 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.		F0880	Continued from page 5 Barrier Precautions policy, including when PPE is to be worn. Random audits will be completed by the DON and/or designee to ensure staff are in compliance with wearing PPE as required per Enhanced Barrier Precautions policy 3x/week x 2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning 9/16/2025. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/04/2025	
NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0880 SS = D	Continued from page 6 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to implement enhanced barrier precautions (EBP) for 1 of 2 residents (R376) reviewed for catheters. Findings include: R376's significant change minimum data set (MDS) dated 5/20/25, identified R376 had moderate cognition. R376's diagnoses included multiple sclerosis and history of urinary tract infection (UTI) and had an indwelling catheter. R376's Care plan reviewed 8/18/25, identified R376 was on enhanced barrier precautions related to a history of methicillin-resistant staph aureus (MRSA) and had an indwelling catheter. Staff were instructed to wear personal protective equipment (PPE) with resident. The plan failed to identify when the staff should wear PPE or the type of PPE to wear. On 9/3/25 at 10:52 a.m., observed a sign on R376's door and a three-drawer plastic bin outside the resident's room. The sign on the door identified the resident was on EBP and staff were to wear PPE including a gown and gloves when providing direct cares. The sign identified examples of when staff should wear PPE, including toileting cares. On 9/3/25 at 10:57 a.m., observed R376 in the bathroom, standing in front of the toilet with a wheelchair placed in front of the resident. R376 was leaning her forearms on the armrests of the wheelchair and had her brief and pants around her knee's. NA-A was standing next to the resident, wearing gloves and was using wipes to cleanse R376's buttocks. NA-A was not wearing a gown. On 9/3/25 at 11:12 a.m., NA-A stated staff wore PPE including gown and gloves when completing catheter cares for R376. AN-A stated she had not worn a gown when providing toileting cares because she was not required to. Further, RN-D stated she had recently		F0880				

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F0880 SS = D	Continued from page 7 received education regarding PPE, although had not remembered what was included in the education. The facility Enhanced Barrier Precautions policy reviewed 8/20/24, identified EBP was used to prevent the spread of multidrug-resistant organisms (MDRO's). EBP should be used for residents with chronic wounds and/or indwelling medical devices (e.g., urinary catheters, feeding tubes, central line, tracheostomy) during high-contact resident care activities including toileting/peri care.		F0880				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 21, 2025

Administrator
Heritage Manor
321 NORTHEAST SIXTH STREET
CHISHOLM, MN 55719

RE: CCN: 245245

Cycle Start Date: June 26, 2025

Dear Administrator:

On June 26, 2025, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), August 5, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 5, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 5, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 5, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Heritage Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 5, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePoC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePoC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePoC must include the following:

- *How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- *How the facility will identify other residents having the potential to be affected by the same deficient practice.
- *What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- *How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- *The date that each deficiency will be corrected.
- *An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Office: 218-302-6186 Mobile: 651-279-5375

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver

along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an

explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

**Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189**

Feel free to contact me if you have questions.

Sincerely,



Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2025	
NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 6/23/25 to 6/26/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/20/2025	
F0000	INITIAL COMMENTS On 6/23/25 to 6/26/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was Not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H#: 52457628C MN#: 00108545 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000			08/20/2025	
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,		F0550	F550- Resident Rights/Exercise of Rights DON and/or designee will implement corrective action for residents affected by this practice (R36) Resident R36 will be assisted out of bed when requested.		08/20/2025	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025
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F0550 SS = D	Continued from page 1 self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to get 1 of 2 residents (R36) out of bed when requested. Findings include: R36's quarterly Minimum Data Set (MDS) dated 6/3/25, identified R36 had diagnoses which included quadriplegia, fracture of surgical neck of left humerus with routine healing, anxiety, and depression. R36's	F0550	Continued from page 1 All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The review of the Combined Federal and State Bill of Rights , with no updates needed. All nursing staff will be educated on the Combined Federal and State Bill of Rights, including assisting all residents out of bed when requested. Random audits on the right to get out of bed when requested beginning on 08-18-25 will be completed by DON and/or designee three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2025	
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F0550 SS = D	Continued from page 2 MDS identified R36 was moderately cognitively intact, had no rejections of care, and was dependent on staff for bed to wheelchair transfers. R36's care plan dated 5/21/25, identified R36 had the potential for calling 911 if her call light was not answered fast enough or if she dropped something on the floor. Interventions included to try to answer the call light as soon as possible if not able to answer call light immediately to let R36 know when would be back (to give a length of time). In addition, R36's care plan dated 2/1/25, identified R36 had an activity of daily living (adl) self-care performance and required a mechanical lift with substantial maximal assistance of one staff for transfers. On 6/24/25 at 2:52 p.m., R36 waved writer in and said "can you help me?" She said she wanted to get up out of bed, she was asked if she had pushed her call button, which she then did. The room number showed on the call light scroll bar in the hallway. -at 2:55 p.m., nursing assistant (NA)-A entered R36's room with linens, the call light was shut off and NA-A exited the room and went to the next room. -at 3:05 p.m., the call light was back on, NA-A entered the room and could be heard asking what she could get for R36. The call light was shut off and NA-A exited the room. R36 was not assisted out of bed. During an interview on 6/24/25 at 3:24 p.m., R36 said NA-A told her that her partner didn't show up so she couldn't get her up. During an interview on 6/24/25 at 3:30 p.m., NA-A stated she told R36 twice that she couldn't get her up because she couldn't find her partner. NA-A offered that R36 "gets up on days." Then stated, "oh there's my partner." NA-A did not approach NA-B to ask for help in getting R36 up. During an interview on 6/24/25 at 3:48 p.m., licensed practical nurse (LPN)-B verified they had not been approached by any NAs for help in getting R36 up.		F0550				

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F0550 SS = D	Continued from page 3 During an interview on 6/24/25 at 3:49 p.m., NA-B stated they were not informed by NA-A that R36 wanted to get up. During an interview on 6/26/25 at 11:18 a.m., registered nurse (RN)-B verified R36 had been wanting to get up in her chair more often. RN-B verified she would expect staff to get her out of bed even if she didn't want to stay up for very long. RN-B stated not getting R36 up could have been related to staffing, said "too much" work to do, offered that the unit used to have three nursing assistants but has gone down to two even though the census hadn't changed, the unit remained full, so there were two NAs to care for 25 residents. During an interview on 6/26/25 at 12:50 p.m., the director of nursing (DON) verified she would expect staff to help a resident out of bed as requested. The DON offered if they couldn't find their partner they should find another staff. The Combined Federal and State Bill of Rights dated 2/1/17, identified under Self-Determination, "The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident."	F0550		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed ensure residents were comprehensively assessed for self-administration of medications for 1 of 2 residents (R20) reviewed for self-administration of medication. Findings include: R20's significant change Minimum Data Set (MDS) dated	F0554	F554 Resident Self- Admin Meds- Clinically Appropriate. DON and/or designee will implement corrective action for residents affected by this practice (R20): R20 will have a new self-administration assessment completed and care plan will be updated, as needed. All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Self-Administration of Medication by Residents policy was reviewed, with no updates needed. All licensed nursing staff will be educated on the Self-Administration of Medication by Residents policy, including only residents who have been assessed to safely self-administer medications are allowed to	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Heritage Manor			STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719	
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F0554 SS = D	Continued from page 4 5/14/25, identified R20 had intact cognition with diagnoses that included heart disease, hypertension, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following nontraumatic subarachnoid hemorrhage (bleeding in the space between the brain and the protective layers covering the brain), Parkinson's disease, chronic atrial fibrillation, type 2 diabetes, congestive heart failure, chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), anxiety, osteoarthritis, and dysphagia (difficulty swallowing). R20's provider orders reviewed on 6/25/25, included the following orders: -Advair Diskus inhalation aerosol powder breath activated 250-20 micrograms per actuation (mcg/act), inhale one puff orally two times a day related to COPD, rinse mouth after use, ok to self admin after nurse set up -Ipratropium-albuterol inhalation solution 0.5-2.5 (3) milligrams per 3 milliliters (mg/3mL) inhale one vial orally via nebulizer two times a day for shortness of breath (SOB) related to COPD, ok to self admin after nurse set up -Ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3mL inhale one vial orally via nebulizer every 4 hours as needed (PRN) for SOB related to COPD, ok to self admin after nurse set up -Proventil HFA inhalation aerosol solution 108 (90 Base) mcg/act inhale 2 puffs orally every 4 hours PRN for SOB related to COPD, ok to self admin after nurse set up R20's Medication Self Administration assessment dated 5/23/24, indicated R20 being able to self-administer inhalant medications and nebulizer medications. Review of R20's medical record showed no other medication self-administration assessments from 5/23/24 to 6/25/25. During interview on 6/26/25 at 12:28 p.m., licensed practical nurse (LPN)-A verified R20's provider orders as listed. LPN-A stated for residents that can self-administer medications the nurse would bring the medication to the resident, fill the nebulizer if	F0554	Continued from page 4 self-administer medications and to complete Self-Administration of Medications assessment on admission and with any significant changes. All current residents will be reviewed to ensure a self-administration of medications assessment has been completed per policy and care plan will be updated, as needed. Random audits on appropriate administering of medications per residents self-administration assessment will be completed by DON and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Heritage Manor			STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719	
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F0554 SS = D	Continued from page 5 needed, and give to the resident. LPN-A identified R20 as being cognitively able to self-administer medications, and was able to turn off nebulizer when the treatment was complete. During interview on 6/26/25 at 12:33 p.m., registered nurse (RN)-A verified R20's provider orders as listed. RN-A stated in order for a resident to self-administer medications an assessment would be done to make sure resident understood how to self-administer safely. RN-A stated these assessments were completed quarterly and if there was a change in the resident's condition. RN-A confirmed R20 had an assessment done on 5/23/24 and had not been assessed since that time. During interview on 6/26/25 at 12:37 p.m., director of nursing (DON) verified R20's provider orders as listed. DON explained residents had to be assessed for ability to safely self-administer medications and needed to be reassessed periodically and if the resident's condition had changed. DON confirmed R20 had assessment done on 5/23/24 and had not been reassessed since that time. Self-Administration of Medication by Residents policy reviewed on 2/27/24, indicated "If the resident wishes to self-administer medications, they will be assessed for their ability to safely self-administer their medications. The assessment will include cognitive status, physical status, which medications are appropriate." Policy continued to say "A periodic re-assessment by the IDT of the continued appropriateness of the self-administration will be completed, and the decision to continue the self-administration of medications will be based on changes in the resident's medical and decision-making status"	F0554		
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F0561	F561 Self Determination DON and/or designee will implement corrective action for residents affected by this practice (R10) Resident R10 will be interviewed and care plan will be updated with bathing preferences. All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including:	08/20/2025

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F0561 SS = D	Continued from page 6 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure bathing preferences were honored for 1 of 1 resident (R10) reviewed for choices. Findings include: R10's significant change Minimum Data Set (MDS) dated 5/2/25, indicated R10 was cognitively intact with the diagnoses of congestive heart failure, diabetes and end stage renal disease. Section GG. indicated R10 required partial/moderate assistance with shower/bathing. R10's Care Plan Report last revised 5/7/25, identified R10 required partial/moderate assistance of one with bathing/showering. R10's care plan lacked identification of R10's preferences for personal hygiene and bathing. During an interview on 6/23/25 at 4:41 p.m., R10 stated they would like to have a shower two times a week. They didn't feel very clean by mid-week and felt like they were smelling a little. They really wished it could be two times a week, but nobody would do it. During an observation on 6/25/25 at 9:03 a.m., R10 was at the nurse station asking when they would get their bath. R10 was told they were behind. R10 propelled	F0561	Continued from page 6 The review of the Person Centered Care Planning policy, with no updates needed. All nursing staff will be educated on the Person Centered Care Planning policy. Interviewed all cognitive residents and update care plans with bathing preferences as needed. Random audits to ensure resident bathing preferences are honored beginning on 08-12-25 will be completed by DON and/or designee three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	

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F0561 SS = D	Continued from page 7 themselves to their room. During an interview on 6/25/25 at 9:05 a.m., R10 stated they were supposed to get their shower this a.m., but they had been told staff were running late. R10 stated when they were at home, they took a shower every day and now they only got a shower once a week, every Wednesday. When they arrived, they had not been asked about bathing preferences, they were just told their day was Wednesdays. R10 stated they wished they could get a shower more frequently because after a couple days they started to feel dirty. They had told a few different nurses, how they felt and asked for a second shower, but nobody had listened or helped them. They really looked forward to Wednesdays because their body just didn't feel good when they felt like they smelled bad. During an interview on 6/26/25 at 11:34 a.m., RN-A stated if a resident had expressed, they wanted a shower two times a week, then their request should be honored. During an interview with on 6/26/25 at 2:04 p.m., the director of nursing (DON) stated the facility tried to honor resident bathing preferences and if a resident requested a shower two times a week, they would do their best to honor that. They would expect staff to bring forward resident requests and preferences for bathing frequency so that the team could address them in the care plan. The facility policy Person Centered Care Planning dated 12/18/23, listed the care partner team will work to replicate resident's preferences for daily routine and incorporate person centered language into the plan of care. The self-determination section included resident/family representative should be involved, informed and have input in decisions about their care.		F0561				
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . .		F0605	F605 Right to be free from Chemical Restraints DON and/or designee will implement corrective action for residents affected by this practice (R20): Medical records will be reviewed for residents R20 to ensure all PRN psychotropic medications have a clearly documented end date. Will request end date orders from the Provider for R20 Gabapentin. All residents who receive psychotropic medications have		08/20/2025	

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F0605 SS = D	Continued from page 8 chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F0605	Continued from page 8 the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Psychotropic Medication policy was reviewed, with no updates needed. All licensed nurses will be educated on the Psychotropic Medication policy, including end date requirements for PRN psychotropic medications. All PRN psychotropic medications will be reviewed to ensure there is an end date. If there is no end date, the Provider will be contacted to obtain end date orders. Discuss with Pharmacy consultant monthly to ensure all medications requiring stop dates are present. Random audits that PRN psychotropic medications have a clearly documented end date will be completed by DON and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	

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F0605 SS = D	Continued from page 9 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F0605					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F0605 SS = D	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the us of as-needed (PRN) psychotropic medication was limited to 14 days or extended to a certain date with supporting rationale provided by the medical provider for 1 of 5 residents (R20) reviewed for unnecessary medication use. Findings include: R20's significant change Minimum Data Set (MDS) dated 5/14/25, identified R20 had intact cognition with diagnoses that included heart disease, hypertension, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following nontraumatic subarachnoid hemorrhage (bleeding in the space between the brain and the protective layers covering the brain), Parkinson's disease, chronic atrial fibrillation, type 2 diabetes, congestive heart failure, chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), anxiety, osteoarthritis, and dysphagia (difficulty swallowing). R20's provider order sheet reviewed on 6/25/25, identified order for gabapentin oral tablet 100 milligram (mg) to be given by mouth PRN for anxiety. This order started on 5/9/25 and did not have an end date. During interview on 6/26/25 at 12:28 p.m., registered nurse (RN)-C verified R20 had an order for gabapentin PRN and the order did not have an end date. During interview on 6/26/25 at 12:33 p.m., RN-A verified R20 had an order for gabapentin PRN and the order did not have an end date. RN-A stated the order needed an end date as it was a PRN psychotropic medication. During interview on 6/26/25 at 12:37 p.m., director of nursing (DON) verified R20 had an order for PRN gabapentin and the order did not have an end date. DON stated the order should have an end date due to it being PRN psychotropic medication.	F0605		

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F0605 SS = D	Continued from page 11 Psychotropic Medications policy last issued 5/21/25, indicated "PRN psychotropic medications ordered will be limited to 14 days. The prescribing practitioner will evaluate and document the medications necessity, benefits, and improvement (expressions, indications of distress). If the physician deems it appropriate to extend beyond the 14-day limit, supporting rationale must be documented."	F0605		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F0655	F655: Baseline Care Plan DON and/or designee will implement corrective action for residents affected by this practice (R110): R110 care plan will be reviewed and revised to ensure care plans are current, comprehensive, and reflect the residents' needs and preferences. All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The review of the Person Centered Care Planning policy, including baseline care plan include all important resident information and available for all staff until the comprehensive care plan is in place in PCC, with no updates needed. All nursing staff will be educated on the Person Centered Care Planning policy. Random audits on new admission and admissions since July 1st to ensure complete baseline care plan is completed and available and comprehensive care plans are complete in PCC to ensure all required information is contained beginning on 08-12-25 will be completed by DON and/or designee three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	08/20/2025

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F0655 SS = D	Continued from page 12 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the baseline care plan did not cover the required elements for 1 of 2 residents (R110) reviewed for care plans. Findings include: R110's admission Minimum Data Set (MDS) dated 6/18/25, was in progress. R110 was admitted 6/11/25. R110's provider orders dated 6/26/25, identified R110 had diagnoses which included acquired absence of right leg below knee, diabetes mellitus, lymphedema (swelling, most often in an arm or leg, caused by a lymphatic system blockage), and reduced mobility. R110's orders included the following: -Consistency CHO (carbohydrate) diet Regular texture, Thin consistency, limit of potassium to 2000 mg (milligram) dated 6/11/25 -Apply Sequential Compression Device to left leg QD (every day) for 1 hour one time a day related to LYMPHEDEMA dated 6/12/25 -Observe closely for side effects of Diuretic medication including decreased PO (oral) intake, acute confusion, agitation, delusions, aggression, lethargy, decreased sweating, tachycardia, hypotension, orthostasis, generalized weakness, sunken eyes every shift dated 6/11/25 -Observe for s/s (signs and symptoms) of Hypoglycemia,		F0655				

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F0655 SS = D	Continued from page 13 cold clammy skin, fainting, irritability, shaking, change in LOC (level of consciousness), confusion, trembling, headache, hunger, rapid pulse, nausea. Hyperglycemia increased thirst, confusion, agitation, weight loss, increase urination, drowsiness, every shift dated 6/11/25 R110's care plan dated 6/16/25, identified R110 had the potential for significant change in medical condition and addressed advance directive preferences. Limited mobility dated 6/19/25, identified R110 was wheel chair dependent, did not include how R110 transferred (however physical therapy had a transfer care plan inside the closet door). Discharge plans dated 6/16/25, plan was return to home. Skin impairment dated 6/11/25, interventions included to follow facility protocols for treatment of injury, and pressure reducing cushion in wheel chair and pressure reducing mattress. Trauma related to loss of leg dated 6/18/25, was addressed. Vulnerable adult was also addressed dated 6/16/25. R110's care plan did not include activities of daily living (ADLs), diabetes mellitus, consistent carbohydrate diet, side effect monitoring for diuretic, hypoglycemia, and use of sequential compression device. During an interview on 6/25/25 at 11:34 a.m., registered nurse (RN)-B verified the care plan in the computer was missing information on diabetes mellitus, ADLs, diet, and medication. RN-B verified the care plan in the computer flowed to the Kardex, which the nursing assistants would have access to. During an interview on 6/26/25 at 1:11 p.m., the director of nursing (DON) verified the care plan in the computer was missing information on diabetes mellitus, ADLs, diet, and medication which would flow to the Kardex, which the nursing assistants had access to. During an interview on 6/26/25 at 1:45 p.m., the DON stated the 48 hour care plan was paper and there were all kinds of those care plans on the nursing unit. The DON verified the 48 hour care plan was located at the central nursing unit in the hard chart (not on the resident's nursing unit). The DON stated the charge nurse would have one and the nursing assistants would have the paper care plan as well. A review of R110's nursing unit with the DON was unable to find any paper 48 hour care plans. The DON verified the NAs would only have access to the Kardex which was generated from the		F0655				

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F0655 SS = D	Continued from page 14 computer care plan not the 48 hour care plan. The policy Person Centered Care Planning dated 4/20/23, identified the care plan would include the minimum healthcare information necessary to properly care of the resident to include: physician orders, dietary orders, activities of daily living (ADLs). In addition, "If the goals and interventions change from the baseline care plan, due to a change in the resident's goals or physical, mental or psychosocial functioning, those changes must be incorporated into an updated summary and provided to the resident and his or her representative, (if applicable), until the comprehensive care plan is developed." The policy identified "Care plans are available to staff using the electronic medical record (EMR) system."	F0655		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)-	F0656	F656: Develop Implement Comprehensive Care Plan DON and/or designee will implement corrective action for residents affected by this practice (R13,R33): R13 and R33 care plan and all other residents care plans will be reviewed and revised to ensure that all care plans are current, comprehensive, and reflect the residents' needs and preferences. All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The review of the Person Centered Care Planning policy, with no updates needed. All RN, SS Director, and Dietary Manager will be educated on the Person Centered Care Planning policy, ensuring the care plans are comprehensive and current. Random audits on Resident care plans to ensure all required information is contained beginning on 08-12-25 will be completed by DON and/or designee three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	08/20/2025

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NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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F0656 SS = D	Continued from page 15 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure to develop a comprehensive care plan for 2 of 6 residents (R13, R33) reviewed for care planning. Findings include: R13: R13's admission Minimum Data Set (MDS) dated 5/16/25, indicated R13 was cognitively intact with the medical condition of fractures and other multiple traumas with the diagnoses of hip fracture and lymphedema. MDS Section N. indicated R13 received opioid pain medication and a diuretic. Section GG. indicated R13 was dependent for showering, toileting, transfers, and required maximal assistance for dressing. R13's care plan date last revised 6/2/25, included the following: ADL self-care performance focus identified R13 required assistance of one with for dressing, oral care, and one to two staff for bed mobility. Personal hygiene and toilet use read I require (specify assistance) by (x) staff for both areas. R13's care plan did not identify nor include focus areas and interventions for hip fracture/weight bearing status, pain management/opioid use, diuretic medication, anticoagulant medication, self-administration, or lymphedema management.		F0656				

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F0656 SS = D	Continued from page 16 R13's Order Summary Report as of 6/26/25, included: ---Morphine sulfate and hydromorphone for pain as needed (opioid medication) ---Eliquis 2.5 mg two times a day (anticoagulant) and ---Lasix 40 mg daily for lymphedema (diuretic) ---Observation for anticoagulant side effects R13's orders did not include observation for side effects from opioid pain medications and/or diuretic medication. R13's N Adv-Clinical Admission dated with effective date 6/24/25 at 9:22 p.m., section AS_8. Cardiovascular assessment was documented as: Skin warm and pink with brisk capillary refill (< 3 seconds). No edema present. No Edema issues. Sequential N Adv-Skilled Evaluation assessments documented under AS_8. Cardiovascular were documented as: Skin warm and pink with brisk capillary refill (< 3 seconds). No edema present, No Edema issues on the following dates: 5/29/25, 5/30/25, 6/1/25-6/7/25, 6/9/25-6/14/25, 6/16/25-6/18/25, and 6/21/25-6/24/25. Admission and ongoing assessments lacked evidence to show R13's chronic lower extremity edema had been identified on admission and assessed for worsening on an ongoing basis. During an interview on 6/23/25 at 5:31 p.m., R13 was in bed wearing a hospital gown, legs and feet were uncovered and edematous from the thigh down. A catheter bag was attached at the foot of the bed. R13 stated they were taking a water pill (diuretic) that had just been increased for the swelling in their legs and indicated they had the catheter because the water pill made it so they couldn't make it to the bathroom. R13 stated they were getting therapy in their room for a broken leg. It was noted R13 had two inhalers located on their bedside table. During an observation on 6/24/25 at 12:57 p.m., R13 was in bed with legs directly on bed, no compression or elevation of legs. Extremities were edematous from the thigh down. R13 stated they had mostly been doing strengthening exercises because they couldn't bear weight on their leg yet. During an interview on 6/25/25 at 2:17 p.m., PT-A		F0656				

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F0656 SS = D	Continued from page 17 stated they were familiar with R13. R13 had chronic lymphedema and was toe touch weight bearing on the left leg due to fractures. PT-A reviewed OT notes and stated OT had been doing strengthening and bed mobility with R13. PT-A indicated the main focus for R13 had been to get R13 moving, but that had been difficult due to R13's pain and limited ability to bear weight on their left leg. PT-A stated they did not see any lymphedema treatments. During an interview on 6/25/25 at 3:47 p.m., RN-A stated R13 had an order entered on 6/10/25, that stated R13 could have inhalers at bedside. A Self med-assessment was completed on 6/24/25, which indicated R13 was safe to have their inhalers kept at the bedside. RN-A confirmed self-medication administration was not on the care plan. During an interview on 6/26/25 at 12:34 p.m., OT-A stated they had worked with R13 today and had wrapped R13's left leg and elevated it on a pillow because the left leg edema had been getting worse. R13's legs should be elevated on pillows to help with the edema. OT-A stated compression was also good for lymphedema and indicated OT-B had fitted R13 for tubi-grips on 5/31/25, but usually an order had to be obtained for the resident to wear them. During an interview on 6/26/25 at 11:25 a.m., RN-A stated OT primarily managed care for lymphedema however nurses were to assess for edema, skin issues, and pain related to lymphedema. RN-A stated nursing had gotten R13's diuretic increased on 5/28/25, due to increased edema. RN-A opened R13's electronic medical record (EMR) and stated R13's skilled assessments documented "no edema issues". The assessments should have identified edema issues and indicated the severity of the edema. The use of diuretics and lymphedema should have been incorporated into R13's care plan. RN-A confirmed their care plan process also included planning for fractures/weight bearing, therapy, and/or other special precautions staff would need to know to care for the resident. During an observation on 6/26/25 at 12:18 p.m., R13's left leg was ace wrapped and elevated on a pillow. R13's right leg was edematous and directly on the bed. During an interview on 6/26/25 at 12:55 p.m., OT-B stated there had not been orders placed for them to see R13 for lymphedema, they had only been seeing R13 for ordered occupational therapy. Therapy goals had been slow moving due to R13's non-weight bearing status and	F0656		

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F0656 SS = D	Continued from page 18 pain levels. OT-B stated R13 had managed their lymphedema at home with ace wraps before admit. OT-B had not yet recommended OT orders for lymphedema manual treatments, but they had shown R13 some exercises R13 could do to help with their leg edema. OT-B stated they had also fitted R13 for tubi-grips but had not notified nursing because at the time R13 had gotten them on independently. OT-B was aware R13 had not been wearing the tubi-grips though. OT-B thought it may be because it was too difficult for R13 to put them on when in pain. During an interview on 6/26/25 at 2:13 p.m., the director of nursing (DON) stated lymphedema should be addressed on R13's care plan and if R13 had been fitted for tubi-grips that information should be communicated to nursing so it could be incorporated into the nursing plan of care. The care plan should also include medical diagnoses, pain management, and medications like anticoagulants and diuretic use. The DON confirmed these items were not included in R13's care plan and stated the reason for admission, therapy, and weight bearing status should also be on the care plan. The DON indicated they would expect nurses to measure the level of edema as plus one, plus two etc. when they completed assessments so clinical changes in edema could be identified and followed up on. R33: R33's significant change MDS dated 4/29/25, indicated R33 was cognitively intact with the diagnoses of hypertension, thyroid disorder, stroke, and seizure disorder. R33's Care Plan Report last updated on 6/2/25, lacked evidence to show a plan of care with goals and interventions had been developed for R33's seizure disorder. R33's undated Order Summary included the following orders: ---Observe closely for significant side effects of Anticonvulsant medication including drowsiness, ataxia, nystagmus, dizziness, blurred vision, nausea, rash, gum enlargement, ---Keppra Oral Solution 100 MG/ML (Levetiracetam) Give 5 ml by mouth two times a day related to OTHER seizures During an interview on 6/26/25 at 11:24 a.m., RN-A, stated nursing had a standard guide they followed for care planning which identified certain medications and		F0656				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0656 SS = D	Continued from page 19 side effect monitoring that should be included in the care plan. RN-A indicated pain was a standard part of the care plan and identified seizure medication and monitoring should also be included in the care plan. During an interview on 6/26/25 at 1:49 p.m., the DON stated a seizure disorder would be important to include on the care plan. The DON identified R33 was on Keppra and stated they expected medication monitoring for Keppra and seizure disorder to be part of the care plan. The policy Person Centered Care Plan dated 4/20/23, instructed for each resident to have a comprehensive person-centered care plan developed with resident/representative input consist with resident rights that was to include measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs identified through comprehensive assessment.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657	F657: Care Plan Timing and Revision DON and/or designee will implement corrective action for residents affected by this practice (R37, R52): R52 care plan will be reviewed and include refusals of care, and reflect the residents' needs and preferences. R37 will have a hospice care plan created. All residents on hospice and have refusal of care have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The review of the Person Centered Care Planning policy, with no updates needed. All RN staff will be educated on the Person Centered Care Planning policy, Hospice services and the refusal of care. Random audits on all residents on hospice and who refuse cares care plans to ensure all required information is contained beginning on 08-12-25 will be completed by DON and/or designee three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The	08/20/2025

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F0657 SS = D	Continued from page 20 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plans to reflect current care needs for 2 of 6 residents (R37, R52) reviewed for care planning. Findings include: R37: R37's significant change Minimum Data Set (MDS) dated 5/15/25, identified intact cognition and hospice care. Diagnoses for R37 included hemiplegia and hemiparesis following a cerebral hemorrhage affecting the right side, diabetes mellitus, pneumonia, chronic kidney disease stage three, and chronic gout. R37's care plan didn't indicate a hospice status or contain coordination of care with St. Croix Hospice. During an interview on 6/26/25 at 8:47 a.m., the HUC stated she didn't keep hospice paperwork for St. Croix, any documents they had should be in the hard chart. During an interview on 6/26/25 at 10:20 a.m., the DON would expect there to be a hospice care plan for R37. R52: R52's quarterly MDS dated 4/22/25, identified limited range of motion (ROM) in both lower extremities. Was dependent on assist of two for toilet hygiene, personal hygiene, lower body dressing, and transfers. R52 needed maximum assistance of two for showers and bed mobility. Section H identified R52 was always incontinent of bowel and bladder. Diagnoses included a current urinary tract infection (UTI), psoriasis, delusional disorder, hallucinations, severe major depressive disorder with psychotic symptoms, depression, and adult failure to thrive. R52's care plan dated 2/2/25, identified an activities of daily living (ADL) self-care deficit with a goal to maintain her current level of function with an intervention to provide an assist of two staff to transfer R52 in and out of the bath or shower, and an assist of one to complete bathing tasks. The care plan didn't address refusal of care or planned follow-up		F0657	Continued from page 20 Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25			

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F0657 SS = D	Continued from page 21 approaches. Review of R52's electronic medical record (EMR) on 6/26/25, identified in the month of June bathing was charted as completed for R52 on 6/11 and 6/18/25. Review of R52's progress notes didn't reveal refusals of care in June 2025. During an observation on 6/23/25 at 6:17 p.m., R52 was sitting on her bed, her hair appeared wet and stringy, white facial hair was noted on her chin, and there was a red rash around her mouth and chin. During an observation on 6/25/25 at 8:25 a.m., R52 was sitting on her bed eating breakfast, her hair appeared wet and hung in clumps. During an interview on 6/25/25 at 2:19 p.m., nursing assistant (NA)-E stated R52 just got a bed bath because she didn't like to get out of bed. During an interview on 6/25/25 at 2:56 p.m., NA-F stated R52 had mostly bed baths because she didn't like getting out of bed, she really hated it. They try and take it day by day with R52. NA-F stated there were shampoo caps for washing hair when doing a bed bath, and they only shaved her face when it wasn't broke out from her psoriasis but she refused her cream (treatment for psoriasis) all the time too. During an interview the week of 6/23 to 6/26/25, an unidentified employee (UE)-A stated they can't get their work done, checks and changes (for incontinent care) didn't get done on time, and they are expected to get one bath done on a shift, but typically wasn't possible. UE-A stated they were able to chart about 75% of the time. UE-A added they used to have a restorative aid, but because of staffing issues that person had to go back to NA work, and sometimes they have a bath aid. UE-A provided an example for a unit having seven two-person transfers while there were two NAs and one nurse during a day shift. UE-A confirmed R52 did refuse cares, they would give her some time and then re-approach. During an interview on 6/26/25 at 7:38 a.m., licensed practical nurse (LPN)-D confirmed she was familiar with R52, and she often refused bathing, hair washing, and the prescription cream for her face and then would refuse to shave because her face would be broken out. LPN-D explained you had to take it day to day with R52 because some days she was delusional, you had to try get things done for her on days she was willing.		F0657				

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F0657 SS = D	Continued from page 22 During an interview on 6/26/25 at 10:14 a.m., the DON stated they just keep trying when R52 refused care, try a different staff, or call her husband and he may be able to get her to do it. The DON's expectation would be for the refusal of care to be on the care plan. A policy, Person Centered Care Planning dated 4/20/23, identified its purpose was to provide guidance to care center staff on developing/establishing the resident's person-centered care plan. The policy indicated care plan development will include an assessment of needs to identify and support what is important to the person as well as including preferences for when how, and by whom direct are partner support is provided, and the interdisciplinary team will review the care plan quarterly, with significant changes and as needed to determine if the care plan reflects current resident needs and choices. An undated Hospice Respite Care Agreement between Chisholm Heritage Manor and St. Croix Hospice, identified the facility shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Respite Care. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day.	F0657		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to track and report lack of bowel movements to provider for 2 of 2 residents (R16, R52) reviewed for bowel tracking. This resulted in actual harm when R16 was hospitalized for constipation and subsequently taken to the operating room for disimpaction. In addition, the facility failed to monitor vital signs	F0684	684: Quality of Care DON or designee will implement corrective action for residents affected by this practice (R16, R52, R37): R16 and R52 Bowel movement tracking will be initiated and reviewed and an assessment of bowel movements will be completed. Interventions will be implemented as clinically indicated. R52 will have vitals and weights completed as ordered. R37 will have Blood glucose and Insulin monitored as ordered. All residents have potential to be impacted by this deficient practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: BM policy was created.	08/20/2025

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F0684 SS = G	Continued from page 23 and complete weights as ordered for 1 of 1 resident (R52) and follow orders for blood glucose monitoring and insulin administration for 1 of 1 resident (R37). Findings include: R16's significant change Minimum Data Set (MDS) dated 4/8/25, identified R16 had diagnoses which included osteoarthritis of knee, postconcussional syndrome (a set of symptoms that can persist for weeks, months, or years after a concussion or traumatic brain injury), depression, muscle weakness, trigeminal neuralgia (a chronic pain condition affecting the trigeminal nerve in the face), constipation, and diabetes. R16's MDS identified R16 was cognitively intact, had impaired vision, had no rejections of care and required substantial to maximal assistance with activities of daily living (ADLs). In addition, R16's MDS identified R16 was occasionally continent of bowel and was dependent for toileting. R16's Order Summary Report identified the following orders: -daily during each shift monitor for side effects of opioids (lethargy, sedation, constipation, dizziness, nausea, vomiting), dated 1/25/25 -ok for standing house orders unless noted otherwise dated 1/16/25 -Magnesium Citrate Oral Solution (Magnesium Citrate) give 1 dose by mouth one time a day every 3 day(s) for constipation, dated 6/10/25 -MiraLax Oral Powder 17 GM (gram)/SCOOP (Polyethylene Glycol 3350) give 17 gram by mouth one time a day for constipation, dated 5/29/25 -Morphine Sulfate (Concentrate) Solution 20 MG (milligram)/ML (milliliter) give 0.5 ml by mouth every 4 hours as needed for Pain 10 mg =(0.5 ml), dated 6/23/25 -Senna Plus Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) give 2 tablets by mouth two times a day related to CONSTIPATION, dated 5/29/25 -Ultram Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth four times a day for pain, dated 6/23/25 R16's care plan identified the following: - constipation related to decreased mobility,	F0684	Continued from page 23 Weight Monitoring policy reviewed, with no changes needed. Medication Administration policy and House Standing Orders reviewed, with no changes needed All nursing staff will be educated on Bowel Management policy and House Standing Order Bowel Management protocol including documented bowel movements and bowel movement tracking and implementing bowel movement interventions. All licensed nurses will be educated on Medication Administration policy and Weight Monitoring policy, including monitoring and documenting weights and vital signs weekly and following and documenting all diabetic medication orders. All current residents will be audited to ensure if no BM in 3 days that bowel interventions were implemented, and care plans address bowels. All current residents who have Insulin will be audited to ensure Insulin administration orders are followed All current residents will be audited to ensure vitals are documented as ordered and bowel movement within last the last 7 days. Random audits on bowel movement tracking, care plan addressing bowels, charting of weights and vital signs per orders, and blood glucose monitoring will be completed by DON and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2025	
NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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F0684 SS = G	Continued from page 24 interventions included to encourage to sit on the toilet for bowel evacuation, to follow the bowel management program, to record bowel movement (BM) daily. A review of R16's bowel report 5/1/25-6/26/25, identified the following: 5/1/25-5/10/25, documentation identified no BMs (10 days) 5/12/25-5/17/25, documentation identified no BMs (5 days) 5/19/25-5/27/26, documentation identified no BMs (9 days) out of the facility from 5/27/25-5/29/25 5/30/25-6/4/25, documentation identified no BMs (6 days) A review of R16's electronic medical record medication administration (eMAR) revealed the following: 5/1/25-5/10/25: refused senna plus twice on 5/1/25 refused senna plus once on 5/3/25, 5/4/25, 5/5/25, 5/6/25, 5/7/25, 5/8/25, 5/10/25 milk of magnesia 30 milliliters given on 5/2/25 5/12/25-5/17/25: refused senna plus twice on 5/17/25 refused senna plus once on 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25 5/19/25-5/27/25: refused senna plus once on 5/19/25, 5/20/25, 5/21/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25 5/30/25-6/4/25: refused senna plus once on 6/2/25, 6/4/25 A review of R16's progress notes dated 5/1/25-6/26/25, identified the following: 5/7/25 9:37 p.m., "0 BM for multiple days. Bowel sounds			F0684			

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F0684 SS = G	Continued from page 25 active x4. Abdomen soft and non-distended at this time. Has been receiving laxatives per protocol." This was not documented in R16's eMAR. 5/8/25 3:28 p.m., "residents' abdomen is soft, non-distended, when palpated, resident denies any discomfort, bowel sounds are present in all 4 quadrants let resident know that charting says she has not had a BM for 2 weeks around, residents stated that that could not be, she said I for sure had one lately." No indication that a provider was notified. 5/21/25 2:35 p.m., "MOM (Milk of magnesia) 30ml given PO for no BM multiple days." No indication that a provider was notified. 5/26/26 at 3:08 a.m., "Unable to determine last bowel movement however resident did receive MOM on evening shift." No indication that a provider was notified. 5/26/25 9:29 p.m., "CNAs stated res had an emesis that looked like bm. CNAs did not save it. Res told this writer and the charge nurse that it was "bile". No indication that a provider was notified. 5/27/25 12:09 p.m., note identified the wound clinic called and informed them the resident was sent to the emergency room for altered mental status. 5/27/25 2:10 p.m., Resident was admitted to the hospital with "colitis"(Inflammation of the colon) A review of the Bowel Regulation/Protocol - Constipation per the standing orders did not indicate dietary interventions were taken, milk of magnesia given daily, Dulcolax suppository given, fleets enema given, Miralax given, or provider notified for bowel regimen need or refusals of bowel medication. In addition, R16's eMAR did not reflect medications given per "Bowel Regulation/Protocol - Constipation". A review of R16's hospitalization from 5/27/25-5/29/25, revealed the following: R16 was admitted from the wound clinic with altered mental status, nausea and vomiting, stercoral colitis (a rare sore that develops in the colon due to prolonged and severe constipation), and a primary diagnosis of fecal impaction in the rectum. According to R16's hospital notes general surgery was consulted and made a recommendation for enemas three times daily which was ordered. Subsequently she did go to the operating room for manual disimpaction by a physician.		F0684				

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F0684 SS = G	Continued from page 26 During an interview on 6/25/25 at 9:45 a.m., registered nurses (RN)-A and RN-B stated they had not run a report to identify which residents had not had BM in the last three days. RN-A stated the night shift should have run a report for the day shift. Licensed practical nurse (LPN)-C stated they would run the report around 12:30 p.m. or 1:00 p.m.. LPN-C showed an alert on her electronic screen medication screen, and said it would show alerts for example vital signs out of range and no BM for longer than three days. Both RN-A and RN-B were unable to run the BM report on the computer. During an interview on 6/25/25 at 10:20 a.m., both RN-A and RN-B confirmed they currently had no way of knowing when the last BM report had been run or which residents had not had a BM in the past three days. When asked if the process for monitoring BMs was working, LPN-C stated emphatically "no". A three-day BM report was run which identified 16 residents who had not had a BM in the last 3 days. This was one third of the residents. During an interview on 6/25/25 at 11:18 a.m., LPN-C ran a seven-day report which showed different information. The 16 residents on the three-day report were showing they'd had a BM on the 22nd, yesterday or today. LPN-C could not explain why the two reports were different. LPN-C stated she had no idea if any other staff ran the seven day report. LPN-C said the night shift was supposed to run a BM report and highlight the residents who would need bowel medication per the house standing orders bowel regulation/protocol - constipation. LPN-C could not confirm when the report was last run. During an interview on 6/26/25 at 9:30 a.m., RN-D stated nights had not run a bowel list. RN-D stated they had no idea which residents had not had a BM in the past three days. RN-D stated they did not know how to run the report and would have to ask the charge nurse to run the report. RN-D stated R16 was one of the residents who typically had trouble with constipation and that she had recently been hospitalized with a "bowel problem". RN-D stated magnesium citrate was a new medication since she returned. R16 was supposed to take the medication every three days if she hadn't had a BM but offered, "she always refuses". RN-D stated she would mark it as refused and tell the charge nurse. She stated she was not sure when R16's last BM was. A review of R16's eMAR and corresponding progress note revealed the following: -Magnesium citrate oral, give one time a day every three days for constipation.	F0684		

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F0684 SS = G	Continued from page 27 -Refused on 6/17/25, omitted on 6/20/25, refused on 6/23/25, and not given 6/26/25, see progress note. -6/26/25 10:10 a.m., "res would take 3 sips, ref the rest. states it tastes "too horrible"". No indication the provider had been notified. On 6/26/25 at 10:27 a.m., RN-A stated she was asked to run a bowel report for R16 but not for the entire unit. During an interview on 6/26/25 at 11:22 a.m., RN-B stated the bowel report should be run for the entire unit, stated it was important to know which residents had not had a BM in the past three days to prevent impaction and bowel obstruction. RN-B stated when R16 returned from the hospital magnesium citrate was a new order, she thought R16 had been going "regular". She was not aware R16 was refusing the magnesium citrate. RN-B verified the facility system for monitoring bowel movements was not working. RN-B stated they worked short a lot (nursing assistants and nurses) get pulled to work on the medication cart, help on the floor. Stated when working short can't look into other concerns. During an interview on 6/26/25 at 12:42 p.m., the medical director (MD) verified when R16 had a report of an emesis that looked like BM, the staff on duty should have consulted with the charge nurse and called the provider. MD stated it might have indicated a bowel obstruction and R16 may have needed to go to the emergency room that night. During an interview on 6/26/25 at 12:53 p.m., the director of nursing (DON) verified she would expect staff to utilize the house standing orders for bowel protocol, involve the charge nurse and call the provider. The DON verified it was important for residents to have BMs every three days, "don't want residents to become impacted or have a bowel rupture". The DON stated, in a perfect world the nurse on every shift would run a bowel report and stated it was an "old idea" to have the night shift RN the bowel report. House Standing Orders dated 7/17/23, identified the following: Bowel Regulation/Protocol - Constipation 1. If the resident has not had a BM in the last 24 hours may receive dietary interventions, such as prune juice of fiber	F0684		

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F0684 SS = G	Continued from page 28 2. Milk of magnesia or equivalent 30 milliliters orally every day as needed for constipation 3. Dulcolax suppository or equivalent one rectally every day as needed for constipation 4. Fleets enema or equivalent one rectally every day as needed for constipation. If no results within two hours after enema, notify the medical doctor or nurse practitioner. 5. Miralax 17 grams oral as needed per package instructions 6. If as needed bowel meds are used more than twice in one week, assess for routine bowel regimen need. 7. Senna two tablets orally every day at bedtime as needed for three days. R52: R52's quarterly MDS dated 4/22/25, identified limited range of motion (ROM) in both lower extremities. Was dependent on assist of two for toilet hygiene, personal hygiene, lower body dressing, and transfers. R52 needed maximum assistance of two for showers and bed mobility. Section H identified R52 was always incontinent of bowel and bladder. Diagnoses included a current urinary tract infection (UTI), psoriasis, delusional disorder, hallucinations, severe major depressive disorder with psychotic symptoms, depression, and adult failure to thrive. R52's care plan dated 2/2/25, identified an activity of daily living (ADL) self-care deficit with a goal to maintain her current level of function with an intervention to provide an assist of two staff to transfer R52 in and out of the bath or shower, and an assist of one to complete bathing tasks. The care plan didn't address refusal of care or planned follow-up approaches. R52's provider orders dated 2/7/25, identified an order to obtain vital signs and weights on bath day on Wednesdays. On 1/30/25, an order for glycolax powder 17 grams daily for constipation, an order for senna-docusate 8.6-50 milligrams (MG), give two tablets two times a day for constipation, and an order for house standing orders unless otherwise noted. Review of R52's electronic medical record (EMR) revealed the following:		F0684				

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F0684 SS = G	Continued from page 29 -from February to June 2025, R52's weight was recorded on 2/10, 2/21, 4/4, 4/22, 5/5, 5/27, and 6/11. -from 6/20 to 6/26/25, R52 had no documented BM. During an interview on 6/26/25 at 9:53 a.m., licensed practical nurse (LPN)-D stated if a resident hadn't had a bowel movement (BM) there was an alert at the top of the dashboard (in the electronic medical record, EMR) or she could run a report and see which residents hadn't had a BM. LPN-D navigated to R52's EMR and stated it didn't show an alert bell on the dashboard. LPN-D confirmed the last charted BM for R52 was 6/19/25 and stated she didn't ever pull any reports, so she wasn't sure how. During an interview on 6/26/25 at 10:01 the director of nursing (DON) stated if a resident had no BM in three days it should show under alerts, and then once it was cleared it went away for everyone. The DON further stated nurses should be running a report when they got to work, and aids also reported when a resident hadn't voided or had a BM in their shift. The DON added all nurses were trained on pulling the reports and on every desktop, there was a folder with workflows to pull reports and different things. The DON would expect for refusals to be charted and to be on the care plan. During an interview the week of 6/23 to 6/26/25, an unidentified employee (UE)-A stated they can't get their work done, checks and changes (for incontinent care) didn't get done on time, and they are expected to get one bath done on a shift but typically wasn't possible. UE-A stated they were able to chart about 75% of the time. UE-A added they used to have a restorative aid, but because of staffing issues that person had to go back to NA work, and sometimes they have a bath aid. UE-A provided an example for a unit having seven two-person transfers while there were two NAs and one nurse during a day shift. A document, St. Francis Health Services of Morris House Standing Orders (HSO) dated 7/17/23, under the bowel regulation protocol – constipation, instructed: If the resident has not had a BM in the past 24 hours may receive dietary interventions, such as prune juice or fiber Milk of Magnesia or equivalent, 30 milliliters (mL) daily as needed for constipation		F0684				

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F0684 SS = G	Continued from page 30 Dulcolax suppository or equivalent, 1 rectally daily as needed for constipation Fleets enema or equivalent, 1 rectally daily as needed for constipation. If no results in 2 hours, notify provider. Miralax 17 grams oral as needed per package instructions If PRN (as needed) bowel meds are used more than twice in one week, assess for routine bowel regimen need. Senna 2 tablets daily at bedtime as needed for three days. R37: R37's significant change Minimum Data Set (MDS) dated 5/15/25 identified intact cognition and hospice care. Diagnoses for R37 included hemiplegia and hemiparesis following a cerebral hemorrhage affecting the right side, diabetes mellitus (DM), pneumonia, chronic kidney disease stage three, and chronic gout. R37's care plan dated 1/31/25, identified a problem statement for diabetes mellitus and included an intervention to give diabetes medication as ordered by doctor. Monitor and document side effects and effectiveness. Labs as ordered, update provider with abnormal values. Review of R37's May and June 2025 medication administration records (MAR)s identified the following orders not provided to R37: -an order dated 2/3/25, if R37's blood sugar was 200 or less at 8 p.m., please ensure resident has a bedtime snack related to diabetes. Order was not signed off 5/2, 5/3, 5/4, 5/8, 5/9, 5/17, 6/2, 6/5, 6/13, 6/14, 6/15, 6/23. -an order dated 5/20/25, blood sugar checks 2 hours after meals scheduled three times a day at 10 a.m., 2 p.m., and 7 p.m. Order was not signed off for the 9 p.m. check on 5/25, and the 2 p.m. check on 6/4, 6/8, and 6/18. -an order dated 6/9/25, Humalog pen-injector 100 units/mL, inject 8 units subcutaneously two times a day related to DM at 11:15 a.m. and 4:15 p.m. Order was not signed off for the 4:15 p.m. administration on 6/20/25, R37's blood sugar was 80.		F0684				

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F0684 SS = G	Continued from page 31 -an order dated 5/19/25, Humalog pen-injector 100 units/mL, inject as per sliding scale: if blood sugar 201 - 230 = 6 units; 231 - 260 = 8 units; 261 - 290 = 10 units; 291 - 320 = 12 units; 321 - 360 = 14 units; 361+ = 15 units over 360 give 15 units subcutaneously three times per day two hours after meals, at 10 a.m., 2 p.m., 7 p.m. Order for the 2 p.m. blood sugar and insulin sliding scale was not signed off on 5/23, 5/29, 6/4, 6/8, and 6/18. -an order dated 5/28/25, Lantus solution 100 units/mL, inject 30 units subcutaneously one time a day at 7 p.m. The order was not signed off on 5/25/25. R37's blood sugar was 153. During an interview on 6/24/25 at 8:51 a.m., R37's spouse stated there was a nurse who would not give his insulin if his blood sugar was 70-80, they would hold the insulin. Spouse reported she had talked with the DON, and the DON had talked with this nurse and has told them not to do that, but he continued to do it as recently as a week and a half ago. The spouse stated R37 end up with blood sugar in the 300s mornings after this had happened. During an interview on 6/26/25 at 10:20 a.m., the DON would expect a nurse to hold insulin if the resident's blood sugar was under 72. A document, St. Francis Health Services of Morris House Standing Orders (HSO) dated 7/17/23, identified within the diabetic monitoring and treatment section that a blood sugar of 70 was hypoglycemic	F0684		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure oxygen tubing and supplies were properly managed for 1 of 1 resident (R211) who	F0695	F695: Respiratory/Tracheostomy Care and Suctioning DON and/or designee will implement corrective action for residents affected by this practice (R211): R211 oxygen tubing and bubbler were changed and dated. All residents on oxygen have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Oxygen policy was reviewed, with no updates needed. All licensed nursing staff will be educated on the oxygen policy, to include changing and dating the tubing and bubbler.	08/20/2025

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F0695 SS = D	Continued from page 32 was reviewed for oxygen use. Findings include: R 211's admit Minimum Data Set (MDS) dated 6/11/25, indicated R211 was mildly cognitively impaired with the diagnoses of emphysema and congestive heart failure. R211's Care Plan Report last revised 6/8/25, included R211's use of humidified oxygen of 1 to 4 liters related to diagnoses of congestive heart failure and emphysema. R211's Treatment and Medication Administration Record dated between 6/1/25 and 6/24/25, did not include documented oxygen tubing and/or bubbler changes. During an observation on 6/23/25 at 6:48 p.m., R211 was wearing oxygen tubing that was connected to an oxygen concentrator with bubbler (container with water to add moisture to received oxygen). Neither the oxygen tubing or bubbler were dated. R211 stated they were not sure when their oxygen tubing had last been changed. During an observation on 6/24/25 at 11:59 a.m., R211 was seated in their wheelchair with oxygen tubing on. Neither the tubing or the bubbler were dated. During an observation on 6/25/25 at 8:57 a.m., R211 was seated on their bed with their oxygen on. Neither the tubing or the bubbler were dated. During an interview on 6/25/25 at 3:49 p.m., registered nurse (RN-A) reviewed R211's electronic medical record (EMR) and confirmed there was not any documentation to show when R211's oxygen tubing had last been changed, nor did R211 have an order for oxygen tubing to be changed. RN-A went into R211's room and confirmed R211's tubing was not dated. RN-A stated they could not determine when R211's tubing had last been changed because it was not labeled, nor was there documentation in R211's EMR. RN-A stated it was policy to date tubing when it was changed, their normal process was to have an order for oxygen tubing changes. Nurses were expected to sign off on the order and date the tubing when changed so that others could tell it had been changed.	F0695	Continued from page 32 All current residents on oxygen will be reviewed to ensure the tubing and bubbler area changed and dated, as needed. Random audits on oxygen tubing and bubbler changing and dating will be completed by DON and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Heritage Manor			STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719	
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F0695 SS = D	Continued from page 33 During an interview on 6/26/25 at 1:52 p.m., the director of nursing stated all residents at the facility should have an order to have their oxygen tubing changed every Sunday. The tubing should be dated when it is changed. The tubing should be changed for infection preventions reasons. The facility Oxygen Policy dated 4/14/21, directed oxygen tubing and cannula or mask should be labeled with the date and changed every week.	F0695		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to follow dialysis orders for 1 of 1 resident (R111) reviewed for dialysis care. Findings include: R111's admission Minimum Data Set (MDS) dated 6/16/25, identified R111 had diagnoses which included dissection of thoracoabdominal aorta, anxiety, dependence on renal dialysis, and seizures. In addition, R111's MDS identified she was moderately cognitively intact, had no rejections of care and was receiving dialysis. R111's Order Summary report identified the following: Daily weights, update medical doctor for weight gain more than two pounds per day or five pounds per week. Dated 6/9/25. Ensure the dressing on the double lumen right internal jugular tunneled-site is intact. If comes loose re-secure, or replace dressing with a Tegaderm. Keep dressing clean and dry and lumens covered. Two times a day. Dated 6/9/25. R111's electronic treatment administration record	F0698	F698: Dialysis DON and/or designee will implement corrective action for residents affected by this practice (R111): R111 dialysis orders will be followed and assessments will be completed when returning from dialysis. All residents receiving dialysis have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Dialysis policy was created. All licensed nursing staff will be educated on the dialysis policy. All current residents on dialysis will be reviewed and have monitoring orders post dialysis. Random audits on dialysis orders will be completed by DON and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	08/20/2025

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F0698 SS = D	Continued from page 34 (eTAR) identified the following: Daily weights missing on 6/13/25, 6/16/25, 6/18/25, 6/20/25, 6/25/25 Dressing check twice daily missing morning check on 6/13/25, 6/19/25, 6/20/25, 6/25/25 R111's care plan dated 6/9/25, identified R111 needed dialysis related to renal failure. Interventions included to check dressing daily at access site, to document, to re-secure or change dressing if it became loose or fell off. To ensure lumens were covered. On 6/26/25 at 3:12 p.m., R111 returned from dialysis, she was using a wheeled walker and walked to the kitchenette and drank two glasses of juice. R111 said she felt "shaky" so she had some orange juice. She said the nurses never do anything when she would get back and said she still had her paperwork from the morning, said she had forgotten to give it to them at the dialysis center. R111 said her family picked her up and took her to dialysis and brought her back. During an interview on 6/26/25 at 11:00 a.m., registered nurse (RN)-B reviewed the documentation and verified the missing documentation for weights and dressing checks. RN-B stated she would expect staff to follow orders as written, said she was not sure if "they were short" on those days. RN-B verified it was important to weigh R111 daily and to report the changes in weight to the MD as medication may have need to be changed. RN-B verified the dressing on R111's access site needed to be checked twice daily and said missing documentation was related to staffing, had often been told by staff they don't have time to document cares. During an interview on 6/26/25 at 2:19 p.m., the director of nursing (DON) verified she would expect staff to follow and document orders as written. Said concern with missing weights could mean fluid overload and the need to diurese (remove fluid) the resident. During an interview on 6/26/25 at 3:20 p.m., RN-E stated R111 stopped at the nurses station and asked for a glass and nothing more, she was not aware R111 was feeling "shaky". RN-E said she would check R111's dialysis site/dressing at bedtime and check a blood sugar at 4:00 p.m.. RN-E stated she had not had any training on taking care of residents who were on dialysis and stated she was supposed to be in training, but there was a "call in" so she was pulled from training to work on the cart. RN-E stated communication from dialysis center went to the charge nurse.		F0698				

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F0698 SS = D	Continued from page 35 During an interview on 6/26/25 at 3:26 p.m., RN-A stated the paperwork from the dialysis center would be faxed around supper time and stated if there were concerns or problems the dialysis center would call them directly. During an interview on 6/26/25 at 3:39 p.m., the DON stated she would expect a resident returning from dialysis to have the nurse perform an assessment to include checking the dialysis site, review the paperwork and check a set of vitals. During an interview on 6/26/25 at 3:48 p.m., RN-F stated she was not sure if they received dialysis education in the annual training. The policy Dialysis Management dated 2/19/18, identified the purpose of the policy was to provide guidance to care center staff for residents requiring dialysis services. The policy identified the dialysis center and the facility would exchange information on medical, nursing issues, dietary concerns, psychosocial concerns, and any lab values. The policy did not address what steps the facility staff would take when the resident returned from their dialysis appointment or care of the dialysis site if it was not a graft or fistula. The training for RNs caring for dialysis residents was requested but not provided.	F0698		
F0725 SS = F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff.	F0725	F725 Sufficient Nursing Staff DON and/or designee will implement corrective action for residents affected by this practice (R36, R16, R111): Facility Assessment will be updated to reflect current staffing levels. All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Facility Assessment will be updated to reflect current staffing levels. SFHS community support specialists will be contacted for additional recruitment ideas for filling open positions.	08/20/2025

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F0725 SS = F	Continued from page 36 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure there were sufficient numbers of staff to ensure all resident cares including getting residents out of bed when requested for 1 of 2 resident (R36) reviewed for choices, monitoring for and treating constipation for 1 of 2 (R16) and monitoring residents receiving dialysis for 1 of 1 resident (R111) reviewed for dialysis care. This had the potential to affect all residents residing in the facility. Findings include: Staff and Resident Interviews/Observations: On 6/23/25 at 2:53 p.m., R110 stated she had taken herself to the bathroom (said she had already waited 40 minutes) and was fearful of "soiling" self. R110 was tearful during the interview and further stated she had put on her artificial leg on to complete the transfer (even though she had not been cleared by therapy to do so). On 6/24/24 at 8:30 a.m., family member (FM)-F stated therapy had told them at the beginning of May there were only two nursing assistants for the entire building. FM-F stated they had a camera in their family member's room and on 5/4/25, between 2:00 p.m., and 3:00 p.m., one staff used the mechanical lift to put R35 into bed. At 8:00 p.m., two staff lifted R35 under the arms and pivot transferred her to bed (no lift was used). During an interview on 6/24/25 at 11:33 a.m., the medical director (MD) was asked about the concerns brought forward by family and residents (long waits, transferring themselves to the bathroom, not using the	F0725	Continued from page 36 DON/Designee will review upcoming needs to provide additional options or changes for current staff to pick up shift openings. The facility scheduler will review staffing with the DON/Designee weekly to discuss future needs. Random audits will be completed by DON and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	

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F0725 SS = F	Continued from page 37 mechanical lift for transfers or one staff using the mechanical lift instead of two staff, cold food) the MD stated the root cause of the concerns listed would be related to not having enough staff. The MD stated he did not know what the "number" would be where the facility can't or shouldn't take any admissions. The MD stated the corporation thinks the facility should fill all the beds even though it might not have enough staff to take care of the residents. On 6/25/25 at 12:56 p.m., during the resident council interview, R20, R33, and R41 stated it "sometimes" took a long time to get their call light answered, they stated when there was a long wait, they assumed staff were busy and stated waits could be up to 40 minutes long. R20 stated when asked how long it took to get their call light answered, "as long as it takes". During an interview 6/25/25 at 3:20 p.m., scheduler (S)-H explained the assignment sheets and stated the second nurse on the night shift hadn't been being filled for a couple of years. The assignment sheets identified one nurse and three nursing assistants for the entire building for nights. During an interview on 6/26/25 at 8:41 a.m., NA-C stated they worked on call so worked to fill in for call ins. NA-C stated sometimes had a bath aide, but not always, sometimes showers "have to be skipped", and would be left for the next shift. During an interview on 6/26/25 at 8:43 a.m., NA-D stated would sometimes need to skip showers if it was "very busy" and would tell the next shift the showers weren't done. During an interview on 6/26/25 at 10:31 a.m., anonymous staff (AS)-G stated some days were "really rough" because of call ins, sometimes the staff for the shift would be one licensed person and two nursing assistance with new admits, falls, and hospice residents who would need medications every two hours. AS-G stated it was a big building with residents spread out. AS-G stated during the COVID-19 outbreak the second staff for nights was taken away (said this was supposed to be a temporary solution to lack of staff). AS-G stated their concerns have been brought to the director of nursing (DON) several times. Stated about six weeks ago started having an RN on call. AS-G stated with residents in the facility for short term rehabilitation after surgery they often need two staff to transfer them and require a lot of as needed pain medication. AS-G stated when working would "try to run the bowel list" but often no time to do it. AS-G stated two-hour turns are often	F0725		

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F0725 SS = F	Continued from page 38 late, many times the staffing was not safe when only three staff in the building. AS-G stated they would not mandate a third nursing assistant to stay for night call ins, leaving two NAs and a nurse. During an interview on 6/26/25 at 11:46 a.m., S-H verified on nights they would not mandate a nursing assistant to stay if one of the three NAs called in, leaving two NAs for the building. During an interview that occurred between the dates of 6/23/25, to 6/26/25, AS-O stated they were passing medications for 18 to 20 residents which was manageable. However, when scheduled with just one nursing assistant it was difficult to get medications passed on time. On those days, in addition to medication pass, they also had to work the floor helping to get people up, passing meal trays, answering call lights, toileting, and completing check and changes. AS-O stated they probably worked a quarter of their shifts short one nursing assistant. Residents did not get the same level of care when short staffed. Medications get delayed for cares, and residents wait longer for things like call lights, toileting, and repositioning. AS-O didn't think residents were neglected or any had had a seriously bad outcome while short staffed, but they did feel like they couldn't give the residents the quality of care they would like to. Between the dates of 6/23/25, and 6/26/25, an anonymous resident's (AR)-R family member (FM)-S asked to share information about their family member's care. They stated staffing was a real issue at the facility. There were many times staff worked short and when that happened the quality of care suffered. FM-S shared notes that showed AR-R had frequently gone 10 days between bath and one time 20 days had lapsed between bath days. FM-S stated they assisted AR-R with things like shaving, brushing teeth etc. when they were visiting but when they were not there, these things did not get done for AR-R. On several occasions they have found AR-R dressed in the same shirt as the day before. When gone for a weekend, when they got back, they would see AR -R had not been shaved. At a care conference a routine for AR-R had been developed, but staff were not following it. AR-R also has a medication that needs to be taken at the same time every day to be effective per AR-R's doctor and neurologist, but the medication is not being given as ordered and has been given as much as 2 hours later than ordered. The nurses are great, and they try, but they get pulled to do cares and then the medication gets late. FM-S stated they had brought their concerns to the director of nursing and the		F0725				

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F0725 SS = F	Continued from page 39 administrator. The administrator had said they were working on filling vacant positions but did not give any indication if they thought staffing was or wasn't good. Staff here are good people, they want to do good, they work really hard, and things are not getting done for lack of trying they don't have enough time to get everything done for resident because of staff levels. During an interview that occurred between the dates of 6/23/25, to 6/26/25, AS-N stated they were very concerned about staffing at the facility. The area they were working had residents that required two staff for transfers, however they only had one nursing assistant assigned. When this happened, they had to wait for another staff to be freed up to assist, or the nurse would have to help when there wasn't an NA. AS-N stated they would not transfer a resident by themselves if it was unsafe, so often when they worked short and family or residents would get mad because they ended up having to wait longer to get up or transfer to the bathroom. Check and changes suffered when they were short staffed as well. AS-N stated they worked short staffed more than they worked with full staff, at least 4 to 5 times in a pay period. This made it very challenging to do safe care because they were spread thin, and many residents needed assistance of two for some of their care. During an interview that occurred between the dates of 6/23/25, to 6/26/25, AS-Q stated some days staffing was not very good. Last weekend they had had only four nursing assistants for the whole building until 6:30 p.m., and then only three for the rest of the afternoon shift. AS-Q stated they felt rushed to get their work done, but they didn't feel like residents were neglected, they just couldn't do as much as they would like for residents. Sometimes they had bath aides, but bath aides often got pulled to the floor, so that made it really hard to get everyone's bath in, and baths often got bumped to another day. AS-Q stated most residents just got shaved on bath days, but if a resident asked to be shaved on another day, they would do their best to get that done. Rights: see also F550 R36's quarterly Minimum Data Set (MDS) dated 6/3/25, identified R36 had diagnoses which included quadriplegia, fracture of surgical neck of left humerus with routine healing, anxiety, and depression. R36's MDS identified R36 was moderately cognitively intact, had no rejections of care, and was dependent on staff		F0725				

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F0725 SS = F	Continued from page 40 for bed to wheelchair transfers. R36's care plan dated 5/21/25, identified R36 had the potential for calling 911 if her call light was not answered fast enough or if she dropped something on the floor. Interventions included to try to answer the call light as soon as possible if not able to answer call light immediately to let R36 know when would be back (to give a length of time). In addition, R36's care plan dated 2/1/25, identified R36 had an activity of daily living (ADL) self-care performance and required a mechanical lift with substantial maximal assistance of one staff for transfers. On 6/24/25 at 2:52 p.m., R36 waved writer in and said "can you help me?" She said she wanted to get up out of bed, she was asked if she had pushed her call button, which she then did. The room number showed on the call light scroll bar in the hallway. -at 2:55 p.m., nursing assistant (NA)-A entered R36's room with linens, the call light was shut off and NA-A exited the room and went to the next room. -at 3:05 p.m., the call light was back on, NA-A entered the room and could be heard asking what she could get for R36. The call light was shut off and NA-A exited the room. R36 was not assisted out of bed. During an interview on 6/24/25 at 3:24 p.m., R36 said NA-A told her that her partner didn't show up so she couldn't get her up. During an interview on 6/24/25 at 3:30 p.m., NA-A stated she told R36 twice that she couldn't get her up because she couldn't find her partner. NA-A offered that R36 "gets up on days." Then stated, "oh there's my partner." NA-A did not approach NA-B to ask for help in getting R36 up. During an interview on 6/24/25 at 3:48 p.m., licensed practical nurse (LPN)-B verified they had not been approached by any NAs for help in getting R36 up. During an interview on 6/24/25 at 3:49 p.m., NA-B stated they were not informed by NA-A that R36 wanted to get up. During an interview on 6/26/25 at 11:18 a.m., registered nurse (RN)-B verified R36 had been wanting to get up in her chair more often. RN-B stated she would expect staff to get her out of bed even if she didn't want to stay up for very long. RN-B stated not getting R36 up could have been related to staffing,		F0725				

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F0725 SS = F	Continued from page 41 said "too much" work to do, and stated that the unit used to have three nursing assistants but has gone down to two even though the census hadn't changed, the unit remained full, so there were two NAs to care for 25 residents. During an interview on 6/26/25 at 12:50 p.m., the director of nursing (DON) verified she would expect staff to help a resident out of bed as requested. The DON offered if they couldn't find their partner they should find another staff. The Combined Federal and State Bill of Rights dated 2/1/17, identified under Self-Determination, "The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident." Constipation: see also F684 R16's significant change MDS dated 4/8/25, identified R16 had diagnoses which included osteoarthritis of knee, postconcussional syndrome (a set of symptoms that can persist for weeks, months, or years after a concussion or traumatic brain injury), depression, muscle weakness, trigeminal neuralgia (a chronic pain condition affecting the trigeminal nerve in the face), constipation, and diabetes. R16's MDS identified R16 was cognitively intact, had impaired vision, had no rejections of care and required substantial to maximal assistance with activities of daily living (adls). In addition, R16's MDS identified R16 was always continent of bowel. R16's Order Summary Report identified the following orders: -daily during each shift monitor for side effects of opioids (lethargy, sedation, constipation, dizziness, nausea, vomiting) dated 1/25/25 -ok for standing house orders unless noted otherwise dated 1/16/25 -Magnesium Citrate Oral Solution (Magnesium Citrate) give 1 dose by mouth one time a day every 3 day(s) for constipation dated 6/10/25 -MiraLax Oral Powder 17 GM (gram)/SCOOP (Polyethylene Glycol 3350) give 17 gram by mouth one time a day for constipation dated 5/29/25		F0725				

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NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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F0725 SS = F	Continued from page 42 -Morphine Sulfate (Concentrate) Solution 20 MG (milligram)/ML (milliliter) give 0.5 ml by mouth every 4 hours as needed for Pain 10 mg =(0.5 ml) dated 6/23/25 -Senna Plus Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) give 2 tablets by mouth two times a day related to CONSTIPATION dated 5/29/25 -Ultram Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth four times a day for pain dated 6/23/25 R16's care plan identified the following: - constipation related to decreased mobility, interventions included to encourage to sit on the toilet for bowel evacuation, to follow the bowel management program, to record bowel movement (BM) daily. A review of R16's bowel report 5/1/25-6/26/25, identified the following: 5/1/25-5/10/25, no BM documented (10 days) 5/12/25-5/17/25, no BM documented (5 days) 5/19/25-5/27/26, no BM documented (9 days) out of the facility from 5/27/25-5/29/25 5/30/25-6/4/25, no BM documented (6 days) A review of R16's electronic medical record medication administration (eMAR) revealed the following: 5/1/25-5/10/25: refused senna plus twice on 5/1/25 refused senna plus once on 5/3/25, 5/4/25, 5/5/25, 5/6/25, 5/7/25, 5/8/25, 5/10/25 milk of magnesia 30 milliliters given on 5/2/25 5/12/25-5/17/25: refused senna plus twice on 5/17/25 refused senna plus once on 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25 5/19/25-5/27/25:		F0725				

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F0725 SS = F	Continued from page 43 refused senna plus once on 5/19/25, 5/20/25, 5/21/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25 5/30/25-6/4/25: refused senna plus once on 6/2/25, 6/4/25 A review of R16's progress notes dated 5/1/25-6/26/25, identified the following: 5/7/25 9:37 p.m., "0 BM for multiple days. Bowel sounds active x4. Abdomen soft and none-distended at this time. Has been receiving laxatives per protocol." This was not documented in R16's eMAR. 5/8/25 3:28 p.m., "residents' abdomen is soft, non-distended, when palpated, resident denies any discomfort, bowel sounds are present in all 4 quadrants let resident know that charting says she has not had a bm for 2 weeks around, residents stated that that could not be, she said I for sure had one lately." No indication that a provider was notified. 5/21/25 2:35 p.m., "MOM 30ml given PSO for no BM multiple days." No indication that a provider was notified. 5/26/26 at 3:08 a.m., "Unable to determine last bowel movement however resident did receive mom on evening shift." No indication that a provider was notified. 5/26/25 9:29 p.m., "CNAs stated res had an emesis that looked like bm. CNAs did not save it. Res told this writer and the charge nurse that it was "bile". No indication that a provider was notified. 5/27/25 12:09 p.m., note identified the wound clinic called and informed them the resident was sent to the emergency room for altered mental status. 5/27/25 2:10 p.m., Resident was admitted to the hospital with "colitis". A review of the Bowel Regulation/Protocol - Constipation per the standing orders did not indicate dietary interventions were taken, milk of magnesia	F0725					

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F0725 SS = F	Continued from page 44 given daily, Dulcolax suppository given, fleets enema given, Miralax given, or provider notified for bowel regimen need or refusals of bowel medication. In addition, R16's eMAR did not reflect medications given per "Bowel Regulation/Protocol - Constipation". A review of R16's hospitalization from 5/27/25-5/29/25, revealed the following: R16 was admitted from the wound clinic with altered mental status, nausea and vomiting, stercoral colitis (a rare sore that develops in the colon due to prolonged and severe constipation), and a primary diagnosis of fecal impaction in the rectum. According to R16's hospital notes general surgery was consulted and made a recommendation for enemas three times daily which was ordered. Subsequently she did go to the operating room for manual disimpaction by a physician. During an interview on 6/25/25 at 9:45 a.m., registered nurses (RN)-A and RN-B stated they had not run a report to identify which residents had not had BM in the last three days. RN-A stated the night shift should have run a report for the day shift. Licensed practical nurse (LPN)-C stated they would run the report around 12:30 p.m. or 1:00 p.m.. LPN-C showed an alert on her electronic screen medication screen, and said it would show alerts for example vital signs out of range and no BM for longer than three days. Both RN-A and RN-B were unable to run the BM report on the computer. During an interview on 6/25/25 at 10:20 a.m., both RN-A and RN-B confirmed they currently had no way of knowing when the last BM report had been run or which residents had not had a BM in the past three days. When asked if the process for monitoring BMs was working, LPN-C stated emphatically "no". A three day BM report was run which identified 16 residents who had not had a BM in the last 3 days, one third of the residents. During an interview on 6/25/25 at 11:18 a.m., LPN-C ran a seven day report which showed different information. The 16 residents on the three day report were showing they'd had a BM on the 22nd, yesterday or today. LPN-C could not explain why the two reports were different. LPN-C stated she had no idea if any other staff ran the seven day report. LPN-C said the night shift was supposed to run a BM report and highlight the residents who would need bowel medication per the house standing orders bowel regulation/protocol - constipation. LPN-C could not confirm when the report was last run. During an interview on 6/26/25 at 9:30 a.m., RN-D stated nights had not run a bowel list. RN-D stated		F0725				

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F0725 SS = F	Continued from page 45 they had no idea which residents had not had a BM in the past three days. RN-D stated they did not know how to run the report and would have to ask the charge nurse to run the report. RN-D stated R16 was one of the residents who typically had trouble with constipation and that she had recently been hospitalized with a "bowel problem". RN-D stated magnesium citrate was a new medication since she returned. R16 was supposed to take the medication every three days if she hadn't had a BM but offered, "she always refuses". RN-D stated she would mark it as refused and tell the charge nurse. She stated she was not sure when R16's last BM was. A review of R16's eMAR and corresponding progress note revealed the following: -Magnesium citrate oral, give one time a day every three days for constipation. -refused on 6/17/25, omitted on 6/20/25, refused on 6/23/25, and not given 6/26/25, see progress note. -6/26/25 10:10 a.m., "res would take 3 sips, ref the rest. states it tastes "too horrible"". -No indication the provider had been notified. On 6/26/25 at 10:27 a.m., RN-A stated she was asked to run a bowel report for R16 but not for the entire unit. During an interview on 6/26/25 at 11:22 a.m., RN-B stated the bowel report should be run for the entire unit, stated it was important to know which residents had not had a BM in the past three days to prevent impaction and bowel obstruction. RN-B stated when R16 returned from the hospital magnesium citrate was a new order, she thought R16 had been going "regular". She was not aware R16 was refusing the magnesium citrate. RN-B verified the facility system for monitoring bowel movements was not working. RN-B stated they worked short a lot (nursing assistants and nurses) get pulled to work on the medication cart, help on the floor. Stated when working short can't look into other concerns. During an interview on 6/26/25 at 12:42 p.m., MD verified when R16 had a report of an emesis that looked like BM, the staff on duty should have consulted with the charge nurse and called the provider. MD stated it might have indicated a bowel obstruction and R16 may have needed to go to the emergency room that night. During an interview on 6/26/25 at 12:53 p.m., the DON verified she would expect staff to utilize the house		F0725				

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F0725 SS = F	Continued from page 46 standing orders for bowel protocol, involve the charge nurse and call the provider. The DON verified it was important for residents to have BMs every three days, "don't want residents to become impacted or have a bowel rupture". The DON stated "in a perfect world" the nurse on every shift would run a bowel report and stated it was an "old idea" to have the night shift RN the bowel report. House Standing Orders dated 7/17/23, identified the following: Bowel Regulation/Protocol - Constipation 1. If the resident has not had a BM in the last 24 hours may receive dietary interventions, such as prune juice of fiber 2. Milk of magnesia or equivalent 30 milliliters orally every day as needed for constipation 3. Dulcolax suppository or equivalent one rectally every day as needed for constipation 4. Fleets enema or equivalent one rectally every day as needed for constipation. If no results within two hours after enema, notify the medical doctor or nurse practitioner. 5. Miralax 17 grams oral as needed per package instructions 6. If as needed bowel meds are used more than twice in one week, assess for routine bowel regimen need. 7. Senna two tablets orally every day at bedtime as needed for three days. Dialysis care: see also F698 R111's admission Minimum Data Set (MDS) dated 6/16/25, identified R111 had diagnoses which included dissection of thoracoabdominal aorta, anxiety, dependence on renal dialysis, and seizures. In addition, R111's MDS identified she was moderately cognitively intact, had no rejections of care and was receiving dialysis. R111's Order Summary report identified the following: -Daily weights, update medical doctor for weight gain more than two pounds per day or five pounds per week. Dated 6/9/25.			F0725			

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F0725 SS = F	Continued from page 47 -Ensure the dressing on the double lumen right internal jugular tunneled-site is intact. If comes loose re-secure, or replace dressing with a Tegaderm. Keep dressing clean and dry and lumens covered. Two times a day. Dated 6/9/25. R111's electronic treatment administration record (eTAR) identified the following: -Daily weights missing on 6/13/25, 6/16/25, 6/18/25, 6/20/25, 6/25/25 -Dressing check twice daily missing morning check on 6/13/25, 6/19/25, 6/20/25, 6/25/25 R111's care plan dated 6/9/25, identified R111 needed dialysis related to renal failure. Interventions included to check dressing daily at access site, to document, to re-secure or change dressing if it became loose or fell off. To ensure lumens were covered. On 6/26/25 at 3:12 p.m., R111 returned from dialysis, she was using a wheeled walker and walked to the kitchenette and drank two glasses of juice. R111 said she felt "shaky", so she had some orange juice. She said the nurses never do anything when she would get back and said she still had her paperwork from the morning. She had forgotten to give it to them at the dialysis center. R111 said her family picked her up and took her to dialysis and brought her back. During an interview on 6/26/25 at 11:00 a.m., RN-B reviewed the documentation and verified the missing documentation for weights and dressing checks. RN-B stated she would expect staff to follow orders as written, said she was not sure if "they were short" on those days. RN-B verified it was important to weigh R111 daily and to report the changes in weight to the MD as medication may have need to be changed. RN-B verified the dressing on R111's access site needed to be checked twice daily and said missing documentation was related to staffing, had often been told by staff they don't have time to document cares. During an interview on 6/26/25 at 2:19 p.m., the DON verified she would expect staff to follow and document orders as written. Said concern with missing weights could mean fluid overload and the need to diurese (remove fluid) the resident. During an interview on 6/26/25 at 3:20 p.m., RN-E stated R111 stopped at the nurses' station and asked for a glass and nothing more, she was not aware R111	F0725		

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F0725 SS = F	Continued from page 48 was feeling "shaky". RN-E said she would check R111's dialysis site/dressing at bedtime and check a blood sugar at 4:00 p.m. RN-E stated she had not had any training on taking care of residents who were on dialysis and stated she was supposed to be in training, but there was a "call in" so she was pulled from training to work on the cart. RN-E stated communication from dialysis center went to the charge nurse. During an interview on 6/26/25 at 3:26 p.m., RN-A stated the paperwork from the dialysis center would be faxed around supper time and stated if there were concerns or problems the dialysis center would call them directly. During an interview on 6/26/25 at 3:39 p.m., the DON stated she would expect a resident returning from dialysis to have the nurse perform an assessment to include checking the dialysis site, review the paperwork and check a set of vitals. During an interview on 6/26/25 at 3:48 p.m., RN-F stated she was not sure if they received dialysis education in the annual training. The policy Dialysis Management dated 2/19/18, identified the purpose of the policy was to provide guidance to care center staff for residents requiring dialysis services. The policy identified the dialysis center and the facility would exchange information on medical, nursing issues, dietary concerns, psychosocial concerns, and any lab values. The policy did not address what steps the facility staff would take when the resident returned from their dialysis appointment or care of the dialysis site if it was not a graft or fistula. The training for RNs caring for dialysis residents was requested but not provided. Facility Assessment: A review of the Facility Assessment dated 6/16/25, identified the facility mission statement as "Expressing Chris love by providing care that values every human life." The average daily census was listed as 65. The facility assessment identified they would accept residents with renal insufficiency, renal failure, and end state renal disease. In addition, residents with digestive concerns, colitis, inflammatory bowel disease and bowel incontinence. The facility assessment identified they could support and care for those who		F0725				

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F0725 SS = F	Continued from page 49 needed assistance with bathing/showers, mobility support and bowel/bladder toileting programs. Included behavioral support such as dealing with anxiety. The staffing plan identified the following: licensed nurses providing direct care - three on days / evenings and one on nights nursing assistants six on days / evenings and three on nights Weekend were the same A review of the day/afternoon/night assignment sheets and nurse staffing report for the following days revealed the following staffing: 5/1/25, census 59 day - no NA for Windy Hill or Park evening - no NA for Lakeview 5/2/25, census 59 evening - no charge nurse / no NA for Central 5/3/25, census 59 day - no second NA for Windy Hill, no NA for Lakeview, NAs from Park to cover Lakeview at 10:30 a.m. and Park, NA pulled from Lakeview to cover Windy Hill evening - no charge nurse 5/4/25, census 59 day - no NA for Windy Hill evening - no charge nurse 5/5/24, census 59 evening - no charge nurse, no NA for Central or Lake (NAs form Windy Hill and Park had to cover Central and Lake) 5/7/25, census 58 evening - no charge nurse 5/8/25, census 59		F0725				

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F0725 SS = F	Continued from page 50 evening - no second NA for Windy Hill Central to help 5/9/25, census 58 evening - no charge nurse, no NA for Central 5/10/25, census 60 day - no NA for Lakeview evening - no charge nurse 5/11/25, census 59 day - no NA for Lakeview evening - no charge nurse night - no NA for Central/Lakeview 5/14/25, census 58 evening - no charge nurse 5/15/25, census 57 evening - no charge nurse 5/16/25, census 59 evening - no charge nurse, Lakeview had NA from 4:00 p.m.-8:00 p.m. (partial shift) 5/17/25, census 59 evening - no charge nurse/ no LPN after 6:30 p.m., for Windy Hill, no NA for Lakeview until 6:30 p.m. 5/18/25, census 59 evening - no charge nurse / no NA for Lakeview 5/19/25, census 59 day - no NA for Central 5/20/25, census 58 day - no NA for Central 5/21/25, census 58 day - no NA for Lakeview			F0725			

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F0725 SS = F	Continued from page 51 evening - no charge nurse 5/22/25, census 59 day - no NA for Lakeview evening - no charge nurse 5/23/25, census 58 evening - no NA for Central 5/24/25, census 58 evening - no nurse for Central / Lakeview 5/25/25, census 57 day - no NA for Central or Lakeview 5/27/25, census 57 day - no NA for Central 5/28/25, census 57 evening - no charge nurse 5/29/25, census 59 eve - no charge nurse night - no NA for Park 5/30/25, census 59 day - no NA for Lakeview evening - no charge nurse / no NA for Lakeview 5/31/25, census 59 eve - no charge nurse / no second NA until 8:30 p.m. night - no NA for Windy Hill after midnight Administration Interview: During an interview on 6/26/25 at 1:01 p.m., the DON stated the staffing was "adequate" and one nurse and three NAs over night was okay. The DON verified an NA would not be mandated to stay if one of the three NAs for nights called in, leaving one nurse and two NAs for			F0725			

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F0725 SS = F	Continued from page 52 the building. The DON stated, "barring any events it should be manageable".	F0725		
F0755 SS = F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to maintain controlled medication accounting for facility stock medication and for 1 of 1 resident (R262) reviewed for medication side effects. The facility failed to ensure residents were free from medication errors for 1 of 1 resident (R262) who didn't receive their medication as ordered. In addition, the facility failed to remove expired facility stock medication which had to potential to affect any	F0755	F755: Pharmacy Services/Procedures/Pharmacist/Records DON and/or designee will implement corrective action for residents affected by this practice (R262): R262 Medication Eluxadoline was added to Narc count book and locked in controlled bin. Medication error incident was completed. All E kits with controlled substances will have every shift counting process in place. All expired stock medication was removed. All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Medication Administration, Medication Storage and Controlled Substances policies were reviewed, with no updates needed. All licensed nurses will be educated on the Medication Administration and Medication Storage policies, including controlled substances (counting and storage of) and requirements for removing expired stock medications, and reordering medication process. All medications rooms and carts will be audited to ensure there are no expired stock medications. If there is, they will be removed Random audits of medication pass documentation being completed, controlled substances are logged in book, and counts are being completed, all controlled medications are locked appropriately, and medication carts/rooms do not contain any expired medications will be completed by DON and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2025	
NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0755 SS = F	Continued from page 53 resident needing facility stock medication. Findings include: R262's Admission Record dated 6/26/25, identified an admission date of 6/17/25 and a diagnosis of irritable bowel syndrome (IBS-D, a condition characterized by stomach pain, cramping and diarrhea). R262 had a provider order dated 6/17/25, for the medication eluxadoline (trade name Viberzi, a schedule IV-controlled substance used to treat IBS-D) oral tablet 75 milligrams (mg) two time per day. Review of R262's medication administration record (MAR) for June 2025, identified the number "9" appeared on 6/19 and 6/25 for the 7 p.m. dose, and on 6/23 for the 7 a.m. dose for the medication eluxadoline. Progress notes for R262 identified the following entries regarding eluxadoline oral tablet 75 mg: 6/19/25 at 4:54 p.m., cannot locate medication. 6/23/25 at 6:08 a.m., drug not available. 6/25/25 at 10:08 p.m., cannot locate medication. During an interview on 6/24/25 at 12:27 p.m., licensed practical nurse (LPN)-E stated the number nine identified on the MAR meant the medication couldn't be found. LPN-E searched the drawers of the 100s unit medication cart and found the bottle of eluxadoline for R262. LPN-E thought it was a controlled substance because there was a "C" on the bottle. LPN-E was going to notify the charge nurse, add this medication to the narcotic count book and lock it in the narcotic box in the medication cart. At 1 p.m., LPN-E found a second person to count and record the eluxadoline. LPN-E stated they had received 60 tablets on 6/18/25, nine doses were given and LPN-E counted 51 pills remaining. LPN-E further explained the pharmacy usually delivers in the afternoons, and they do give a slip with the medications that the receiving nurse would need to find. LPN-E stated she will be updating the director of nursing (DON). During an interview on 6/25/25 at 1:26 p.m., pharmacist (PH)-T stated controlled medications (those that need to be counted) were on a list separate from the non-controlled medications and both required a signature from the facility on deliver. At 1:48 p.m., PH-T stated he did find the signed list from the facility receiving the eluxadoline on 6/18/25 at about		F0755				

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F0755 SS = F	Continued from page 54 5:30 p.m. However, the pharmacy technician didn't realize it was a controlled substance and grouped it with the other medications. During an interview on 6/26/25 at 10:08 a.m., the DON stated they counted controlled substances schedules two through five. The DON stated it would be a medication error if a medication couldn't be found. During an observation and interview on 6/26/25 at 12:37 p.m., the unit one nurse's station medication refrigerator in the medication room had an unopened 30 mL bottle of lorazepam intensol (an oral liquid concentrate of lorazepam, a benzodiazepine medication used for anxiety). RN-A explained this was for the facility emergency kit, the rest of the kit was in a locked cabinet in the same medication room. The kit was observed to be locked with a numeric-coded tag. There was a clipboard with loose pieces of paper on it for counting the emergency kit controlled substances. RN-A indicated this was where the lorazepam, which was a schedule IV-controlled medication, would be counted but the papers hadn't been filled out for any of the emergency kit items since 6/22/25. RN-A stated the risk of not counting it would be for the whole bottle to go missing. During an observation and interview on 6/26/25 at 12:57 p.m. the medication cart in the 400's unit had an open bottle of facility-stock Tussin (generic cough syrup) with a manufacturer's expiration date of 02/25. Registered nurse (RN)-D stated the night nurse checked for expired medications, but she wasn't sure when that was done. RN-D explained the controlled substances were counted before and after each shift but wasn't sure which nurse (out-going or in-coming) read from the cards or the book. During a follow-up interview on 6/26/25 at 2:20 p.m., RN-D clarified there was no count sheet for the lorazepam intensol, it hadn't been recorded when it was delivered. During an interview on 6/26/25 at 2:32 p.m., the DON stated they usually did a weekly audit for expired medications, the risk of administering expired medication was that it might not be effective anymore. The DON also stated the emergency kit controlled substances were counted on a sheet that needed to be counted and signed-off shift to shift. The DON stated the risk of not counting the controlled substances would be that the whole kit could be lost, and acknowledged doing the count on loose pieces of paper would run the risk of losing those pieces of paper and		F0755				

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F0755 SS = F	Continued from page 55 not having a record. A document, Heritage Manor Health Center Emergency Medication Kit Unit 1 dated 6/21/25, identified the other controlled substances contained in the emergency kit: Lorazepam 1 mg tabs, 2 tabs Oxycodone 5 mg tabs, 6 tabs Ultram 50 mg, 6 tabs Roxanol 10 mg/0.5 mL, 6 oral syrniges Morphine 10 mg/mL, 8 syringes Hydrocodone 5/325 mg, 6 tabs A document, Medication Storage Policy dated 4/11/23, identified nursing staff will conduct weekly audits of the medication storage room and destroy any expired medications and moisturizers. A document, Controlled Medications dated 2/27/24, identified its purpose to provide care center staff direction for providing resident use of controlled substances related to acquisition, storage, disposal, and documentation to prevent the diversion of controlled substances. Controlled Substances are medications categorized into five “schedules” dependent on how dangerous and/or addictive the substances are and to what extent they have accepted medical uses. Schedule I Medications have no accepted medical use in treatment in the United States and is the most addictive with the highest potential for abuse. Schedule II Medications are substances accepted for medical use in treatment in the United States and have a high potential for abuse with the greatest potential for physical and psychological dependence of FDA-approved pharmaceutical controlled substances. For this reason, Schedule II controlled substances are subject to the highest levels of controls among FDA-approved controlled substances. Schedule III-V Medications are substances accepted for medical use in treatment in the United States and have a lower addictive dependency and potential for abuse than Schedule II medications.		F0755				

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F0755 SS = F	Continued from page 56 Receipt of Controlled Medications from the Pharmacy -Upon receipt of controlled medications from the pharmacy, the Charge Nurse or TMA must check them into the Medication Room. -Remove stickers from the substance and apply one to a separate count sheet in the bound book. -If no sticker is available, record information including the resident name, name of medication, form of the substance, number of units or volume in each container, dispensing directions and route and record in the bound book. Recording Usage -All Schedule II-V controlled substances are regulated by using drug administration record sheets. -All Schedule II-V controlled substances will be recorded in the care center's bound book immediately following preparation of each medication. -The following information must be recorded: i. Date and time. ii. Dose administered. iii. Route of administration. iv. Nurse's signature. v. Amount remaining. Auditing Usage. A controlled medication count audit must be completed at each shift change. i. The Nurse or TMA going off the shift counts all controlled substances within the controlled substance lock box with the Nurse or TMA coming on the shift. ii. The controlled substance count must be conducted with a minimum of one licensed personnel. iii. Together with the Nurse or TMA coming on the shift, the Nurse or TMA going off physically counts the controlled substances on hand. The count should match the recorded balance on the individual count sheet in the bound book.		F0755				

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F0755 SS = F	Continued from page 57 1. During the count the oncoming Nurse or TMA will count the controlled substance while the outgoing Nurse or TMA verifies the number/count on the count sheet in the bound book. 2. The outgoing Nurse or TMA will use the ledger in the front of the bound book to tell the oncoming Nurse or TMA the number of the card, cassette, or bottle. 3. The oncoming Nurse or TMA should then count the substance according to pharmacy packaging (dose). 4. The outgoing Nurse or TMA should verify that this is the correct number of substances left using specific page number and verify to the incoming Nurse or TMA verbally with "yes" or "no." -Each Nurse and/or TMA that is counting will sign the count sheet for that date and shift.	F0755		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders for 2 of 4 residents (R37, R48) observed to receive medication. A total of three errors out of 34 opportunities were identified resulting in a facility error rate of 8%. Findings include: R37: R37's significant change Minimum Data Set (MDS) dated 5/15/25 identified intact cognition and hospice care. Diagnoses for R37 included hemiplegia and hemiparesis following a cerebral hemorrhage affecting the right side, diabetes mellitus (DM), pneumonia, chronic kidney disease stage three, and chronic gout.	F0759	F759 : Free of Medication Error rate 5% or More DON and/or designee will implement corrective action for residents affected by this practice (R37,R48): R37 medication error was completed. R48 will receive medications as ordered All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Medication Administration policy was reviewed, with no updates needed. All licensed nurses will be educated on the Medication Administration, the process for re-ordering of medications and if medication is unavailable medication error report must be completed. Medication pass will be audited to ensure medications are received as ordered and documented, otherwise medication error will be filed. Random audits of medication pass will be completed by DON and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance	08/20/2025

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F0759 SS = D	Continued from page 58 R37's medication administration record (MAR) for June 2025, identified an order on 4/2/25 for tart cherry ultra oral capsules 1200 milligrams (mg), give two capsules by mouth two times per day related to gout. During an observation and interview on 6/25/25 at 9:09 a.m., licensed practical nurse (LPN)-E was preparing R37's medications for administration and noted there was only one capsule of the cherry ultra capsules left. LPN-E stated it had been ordered but wasn't here yet, so she documented a partial dose and made a note explaining the medication was on order from the pharmacy. During an interview on 6/25/25 at 2:03 p.m., LPN-E stated the medication had not come in yet, but they might get it with delivery tonight. During an interview on 6/26/25 at 10:10 a.m., the director of nursing (DON) stated LPN-E could have called the pharmacy to see if more of the cherry tabs were coming or notify the provider of a partial dose and have them ok it. The DON stated it would be a medication error. R48: R48's admission MDS dated 4/17/25, identified intact cognition and diagnoses of Parkinson's disease, hypothyroidism and gastro-esophageal reflux disease (GERD). R48's provider orders identified the following orders: -On 4/10/25, omeprazole delayed release capsule 40 mg, give one capsule by mouth one time per day before meal for acid reflux. Do not crush medication. -On 6/24/25, carbidopa-levodopa 25-100 mg, give one-half tablet by mouth two times per day related to Parkinson's. During an observation and interviews on 6/25/25 at 9:34 a.m., LPN-C prepared and administered the above-noted medications to R48. LPN-C stated they had a fall on the unit this morning so they were behind, and typically she wouldn't give omeprazole after a meal because it was important to help prevent GERD. LPN-C further stated it was important to administer carbidopa-levodopa at the same time every day. During an interview on 6/25/25 at 2 p.m., R48 stated he had breakfast about 8:30 a.m. this morning, before he got his morning pills.		F0759	Continued from page 58 Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25			

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F0759 SS = D	Continued from page 59 During an interview on 6/25/25 at 1:26 p.m., pharmacist (PH)-T stated it was best to give medications like carbidopa-levodopa and omeprazole at the same time every day. For the omeprazole, it would be best to give a half-hour before a meal to help avoid the symptoms of GERD. During an interview on 6/26/25 at 2:31 p.m., the director of nursing (DON) stated she expected medications to be given on time and would have expected the nurse to call for help. A policy, Heritage Manor Ordering and Receiving Medications dated 11/2017, identified requests for refills of current medications were either written on a medication re-order form or to pull the sticker from the bottle and place on the re-order form provided by the pharmacy for this purpose. Reorder medications three to five days in advance of the need to assure an adequate supply was on hand.	F0759		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	F812: Food Procurement-Store/Prepare/Serve Sanitary Dietary Services Manager and/or designee will implement corrective action: Freezable storage bins will be utilized for keeping temperature below 41 degrees during service, bins were purchased and are in use. Dishwasher temperature will be checked to ensure dishwasher temperatures are properly monitored and controlled All residents have potential to be impacted by this deficient practice. Dietary Services Manager and/or designee will implement measures to ensure this practice does not reoccur including: The Food storage policy was updated to reflect FDA standards of foods and foods requiring refrigeration should be maintained at or below 41 degrees F to prevent food borne illness. Dishwashing Temperature Monitoring Logs policy was updated. Dietary staff will be educated on the updated Dishwasher Temperature Monitoring Logs policy and updated Food Storage policy regarding juice and milk remaining below 41° F during service to prevent food borne illness Random audits to ensure dishwasher temperatures are properly monitored and controlled and liquid temps	08/20/2025

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F0812 SS = F	Continued from page 60 Based on observation, interview, and document review the facility failed to ensure food was stored in accordance with professional standards for food service safety by failing to maintain safe food storage temperatures. This practice had the potential to affect all residents consuming food at the facility. OR Based on observation, interview, and record review, the facility failed to ensure beverages including milk were maintained and served at a safe temperature of less than 41 degrees Fahrenheit (F). In addition, the facility failed to ensure dishwasher temperatures were maintained for proper sanitization of dishes. These deficient practices had the potential to impact all residents residing at the facility Findings include: The facility form Weekly Temp Logs included at the bottom of the form: Temperature danger zone is 41 to 140 F. All food has to be held above or below this until meal service is complete. The breakfast section of the form did not include a section to record beverage temperatures. The lunch and dinner sections had a place to record dessert and milk temperatures. Temp logs for the month of June 2025, were requested and reviewed. Hot food temperatures were recorded each day, but all spaces for milk and dessert temperature documentation were empty. An invoice from Genesis Refrigeration dated 6/26/25, included the following: -all systems operating normally. Room temperature 36 degrees. Product tested at 38 degrees. -set room temp down two degrees -recommend moving more sensitive items away from the door and removing food from boxes if possible. The undated facility policy Food Handling Section F. included: "Cold foods shall be held at 40 degrees or below until served. Nursing and Dietary Services will establish procedures such that delivery of food to serving areas that accommodate this requirement." The undated facility policy Food Temperature line item three instructed temperatures should be taken periodically to ensure hot foods stay above 135 degree F and cold foods stay below 41 degree F.			F0812	Continued from page 60 remain within safe storage temperature parameters below 41° F during meal service will be completed by DSM and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25		

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F0812 SS = F	Continued from page 61 During an observation on 6/25/25 at 11:35 a.m., milk, assorted juices including prune juice, and almond milk were contained in a two stack of metal bins on a cart parked at the intersection of the 200 and 300 hallways. During beverage temperature checks that started on 6/25/25 at 11:59 a.m., the dietary manager (DM) performed a temperature check of main dining room milk and stated the milk temperature was 49.1 degrees F. The DM identified the milk temperature as being high and rechecked the milk with a second thermometer. The DM confirmed the second thermometer read 50.7 degrees F. The DM removed the milk from the serving area and returned with milk from the back cooler. The milk temperature of new milk read 41.5 degrees F. The DM stated they would need to remove the milk from service and replace it. The DM went into the dining room and collected milk cups from three residents who had been served milk. The DM stated they kept beverages cold during meal service by storing it in double stacked bins with ice between the bins. The DM confirmed they did not regularly check temperatures of beverages before serving them to residents during meal service. -At 12:09 p.m., the DM confirmed beverage temperatures for the following located at the intersection of the 200 and 300 hallways: ---milk: 51.4 degrees F ---almond breeze milk: 59 degrees F ---apple juice: 66.4 degrees F -at 12:12 p.m., the DM asked RN-A to determine who had milk in the 200 and 300s. -at 12:15 p.m., the DM returned with a new gallon jug of milk from the main cooler and reported the milk temperature was 41.5 degrees F. The DM put the milk on the beverage cart and requested a staff bring the cart of beverages to the kitchen and instruct staff not to put any of the beverages away. -At 12:19 p.m., the milk from dining service on the 400s unit had already been returned to the unit fridge. The DM removed the milk from the 400s unit fridge and confirmed the milk temperature was 52.7 degrees F. The refrigerator temperature was confirmed at 36 degrees F. The DM removed the milk from the fridge and stated it would need to be dumped. -At 2:23 p.m., the DM removed two cartons of milk from	F0812		

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F0812 SS = F	Continued from page 62 the 100s unit fridge. The DM confirmed the milk temperatures were 43.2 degrees F and 43.3 degrees F. The unit fridge temperature was confirmed at 38 degrees F. The DM removed both gallon jugs from the fridge. During an interview at 6/25/25 at 12:39 p.m., the administrator stated they had just discussed the milk situation and had decided they would dump and replace the milk that was temping at greater than 41 degrees. On 6/25/25 at 1:34 p.m., The dietary manager reported they had dumped all of teh milk and then provided a resident list for 6/25/25, lunch service which identified: -100s hallway: two residents received milk. -200s hallway: three residents received juice. -300s Unit: two residents received juice. -400s Unit: nine residents had received milk, and one resident had received almond milk. During an interview on 6/26/25 at 8:47 a.m., the assistant director of nursing (ADON) stated it was concerning that beverages, especially milk were reaching temperatures greater than 41 to 51 degrees F during meal service. The ADON explained as milk warmed, bacteria could grow, and this created a risk for food borne illness. The practice of beverages potentially sitting and warming and then returning to refrigeration until another meal service was also a concern for the same reason. The ADON reported the facility had had residents with gastrointestinal illness, but the facility had not found a pattern of illness or an incident where multiple residents had experienced gastrointestinal symptoms at the same time. During an interview on 6/26/25 at 10:15 a.m., the dietary manager (DM) stated milk temperatures should be maintained between 33 to 40 degrees to prevent bacteria growth and food borne illnesses. Safe temperatures should be maintained because the risk for bacteria growth and food borne illness increased the longer milk remained at a temperature of 41 degrees or greater. The DM stated they had modified their milk storage and placed ice around the beverages. Temperatures were done at 7:22 a.m., and milk had been 38 and when it was returned to the fridge it was less than 40 on each unit at 8:37 a.m. During an interview on 6/26/25 at 12:42 p.m., the		F0812				

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F0812 SS = F	Continued from page 63 facility administrator stated it was their expectation that the facility policy was followed and that beverages that required cold storage were not let to sit out longer than 4 hours in the danger zone. The administrator explained 51 degrees was still a cool serving temp for milk however the facility tried to keep it cooler. Milk can be warmer and out for 4 hours at a time, but not beyond that. The administrator confirmed they felt it was okay for the facility to re-refrigerate milk with temperatures of 41 to 51 degrees F as long as it had not been out for more than 4 hours in the danger zone. The administrator stated beverages at the facility were never out for more than a half hour, so the facility milk temperatures were okay and complaint with the FDA (Food and Drug Administration) four-hour rule. Dishwasher During an observation of the dishwashing area on 6/23/25 at 2:00 p.m., dietary aide (DA-A) was running dishes through the dishwasher and DA-B was taking washed dishes and placing them on drying racks. A temperature log in the washing area included temperature recordings and handwritten temperature ranges: wash 140 to 160, final rinse 180. The log instructed staff to notify DM and environmental service manager if out of range. DA-A stated they had forgotten to do a temperature check earlier and proceeded to check wash and rinse temperatures and record them on the log. DA-A verified the final rinse temperature was 140 degrees F and stated that didn't seem right, that they would run check it again in a few minutes. On the next check, DM-A confirmed the wash temperature was 152 degrees F, and the final rinse was 140 degrees F. DA-B continued to put dishes from dishwasher on drying racks. --At 02:07 p.m. DA-A verified the wash temperature was 149 and the final rinse was 158 degrees F. DA-A stated normally the wash was right on 160 degrees and the final rinse was 180 degrees. DA-A stated it had never happened to them to have the final rinse cycle so low, they knew others had had that happen, but they didn't know what to do about it. DA-A stated they were not concerned about the low temperatures, they planned to wash the rest of the dishes. When asked again, DA-A stated they were not concerned but they would ask others. C-A stated they did not work with the dishwasher, so they did not know much about it. NA-B stated they worked the other side of the dishwasher, and the dishes were scalding hot when they came out, so they were not concerned about the temperature readings. NA-A and NA-B stated they felt they could continue to		F0812				

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F0812 SS = F	Continued from page 64 wash dishes. NA-B turned a crank on the dishwasher and stated it might help raise the temperatures of the dishwasher. NA-A continued to prepare silverware for washing. On 6/23/25 at 2:17 p.m., the administrator was notified there was a concern related dish sanitization in the kitchen. On 6/23/25 2:32 p.m., the administrator stated they had just returned from the kitchen and the staff had descaled and cleaned the dishwasher. While there he had seen the final rinse read at 180 degrees F. The administrator stated staff had followed protocol and cleaned the dishwasher and hooked up the chemical wash for low temperature washing because of the low temperatures. All the log entries had looked good except for today's entry which may have been an error. During a follow up interview on 6/23/25 at 2:39 p.m., DA-B stated they had noticed the dishwasher chemical bins were empty, so they had replaced them. DA-B confirmed they had not switched to low temperature washing solution, they had just replaced the high temperature wash solutions as soon as they had noticed they were empty. DA-B stated they used wash and rinse solutions all the time with the dishwasher. -at 2:49 p.m., DA-B confirmed the final rinse temperature was 180 degrees F, and the wash temperature was 145 degrees F. DA-B explained when they drained and cleaned the dishwasher of debris, it often raised wash and rinse temperatures. DA-B stated they had called their supervisor, and they had instructed them to switch to the yellow sanitizer (DA-A had the jug in hand). DA-B stated they would be re-washing all of the dishes they had washed before. During an observation on 6/23/25 at 6:07 p.m., the dishwasher was hooked to the regular rinse and wash solutions. DA-C was in the dishwashing area cleaning off dishes and placing them in a rack. -at 6:10 p.m., DA-C confirmed the wash temperature was reading 149 and the rinse temperature was 150 degrees F. The DM came over to the dishwashing area and stated the dishwasher final rinse gauge needed to be read as the dishes were actually going through the final rinse not after the gauge had been sitting. --at 6:13 p.m., the DM read the final rinse cycle as 170 and instructed DM-C to re-wash 3 racks of dishes on the clean side of the dishwasher.		F0812				

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F0812 SS = F	Continued from page 65 --at 6:16 p.m., the DM confirmed the final rinse cycle was 180 and the wash cycle was 160 degrees F. DA-C then proceeded to wash dishes. DM stated the wash cycle needed to be 140 or greater and the final rinse needed to be at least 180 degrees F. During an observation on 6/26/25 at 9:04 a.m., the dishwasher sanitizing solutions were not empty. The final rinse was verified to be at 180 degrees F and the wash at 160 degrees F. During an interview on 6/26/25 at 10:15 a.m., the DM stated they had always used the 140 to 160 degrees F for the dishwasher wash temperature and indicated it was in their policy. The DM reviewed the manufacture instructions and stated the high temperature ranges were listed as 150 F to 160 F for the wash, and 180 F to 195 F for the final rinse cycle. DA then went to the dishwasher and confirmed the placard on the dishwasher read wash 150 F and final rinse 180 F. The DM stated they must have missed updating the wash cycle temperatures on the temperature log and policy when they switched for a low heat to a high heat dishwasher. The DM explained staff could not just check and record dishwasher temperatures once, they were expected to perform ongoing temperature monitoring while washing dishes because temperatures could fluctuate out of range. It was important for wash and final rinse cycles were to be maintained so that were dishes were properly sanitized to prevent the risk or food borne illness. The dishwasher was serviced on 6/24/25, and it was in working order. Dishes being washed at too low of temperatures on 6/23/25, was operator error. Past staff education has included how to run the dishwasher, monitor the gauges, and actions to be taken when out of range, but there will need to be re-education done. During an interview on 6/26/25 at 12:42 p.m., the administrator stated it was their expectation that staff monitored dishwasher temperatures and notified someone if temperatures remained out of range. The CMA Dish Machine EST-44 High Temperature Low Temperature Conveyor Dish Machine manufacturer instructions dated 2020, listed the high dish wash temperature ranges as 150 F to 160 F for the wash, and 180 F to 195 F for the final rinse cycle. The facility form Dishwasher Temperature Log had instruction at the top: please record temperature of wash and rinse cycle when washing dishes. The log included a place to document wash and rinse temperatures each day for breakfast, lunch and supper and actions taken. The bottom of the log instructed		F0812				

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F0812 SS = F	Continued from page 66 staff to notify the dietary manger and environmental director immediately when temperatures were outside of acceptable range. Identified temperature ranges were wash 140-160 and final rinse 180. Logs from 12/2024, to 6/23/25, were reviewed. Temperatures were consistently documented as wash 160 and rinse 180-182. The undated facility policy Dishwasher Temperature Monitoring Logs identified the purpose of the log was to ensure dishwasher temperatures were properly monitored and controlled. The policy instructed temperatures must be maintained at 140F-160F for washing, 165 F at rack level and 180F at final rinse. Temperatures below required levels were to be reported to service director, dietary team leader or maintenance staff immediately for correction of problem before dishwashing was continued.	F0812		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F0842	F842: Resident Records-Identifiable Information DON and/or designee will implement corrective action for residents affected by this practice (R37): R37 will have hospice care plan added and care plan will be reviewed and revised to ensure that care plan is current, comprehensive, and reflect the residents' needs and preferences. All hospice residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The review of the Person Centered Care Planning policy, with no updates needed. All nursing staff will be educated on the Person Centered Care Planning policy, importance of having Hospice information in care plan. Ensure all outside agencies have access to charting in EMR. Random audits on residents on Hospice to ensure all of Hospice information is accurate and in care plan. beginning on 08-12-25 will be completed by DON and/or designee three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations	08/20/2025

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F0842 SS = D	Continued from page 67 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.		F0842	Continued from page 67 for ongoing monitoring. Completion Date: 8/20/25			

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F0842 SS = D	Continued from page 68 This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain the hospice medical record for 1 of 1 resident (R37) reviewed for hospice care. Findings include: R37's significant change Minimum Data Set (MDS) dated 5/15/25 identified intact cognition and hospice care. Diagnoses for R37 included hemiplegia and hemiparesis following a cerebral hemorrhage affecting the right side, diabetes mellitus, pneumonia, chronic kidney disease stage three, and chronic gout. R37's care plan didn't indicate a hospice status or contain coordination of care with St. Croix Hospice. During an observation and interview on 6/26/25 at 8:38 a.m., R37's St. Croix Hospice binder was stored at the central nurse's station, it didn't contain any information. R37's hard chart was also stored at the nurse's station, and that chart didn't contain any hospice information. The hospice binder had sections for hospice contact information, admission documentation, charting forms for nursing assistants (NA)s, nurses, and care plans, all of which were blank forms. Registered nurse (RN)-A confirmed the absence of hospice documentation in the hard chart and stated St. Croix provided their own binders for the hospice documentation. RN-A stated the case manager had to give them a new binder because R37's wife took the other one. RN-A stated the admission paperwork, and interdisciplinary team (IDT) care plans were with the health unit coordinator (HUC). During an interview on 6/26/25 at 8:47 a.m., the HUC stated she didn't keep hospice paperwork for St. Croix, any documents they had should be in the hard chart. During observations and interview on 6/26/25 at 9:01 a.m., the director of nursing (DON) stated St. Croix did a binder and that was in R37's room, but the hospice nurse needed to chart in Point Click Care (PCC, electronic health record), and just the NA just charted in the binder. R37's wife wanted the book in his room so she could look at it. At 9:10 a.m., the DON talked to R37, and he didn't know where the book was. The DON walked to the nurse's station on the 100s unit and checked the file cabinet and medication room but didn't find it there. The DON then checked with licensed practical nurse (LPN)-D, the nurse for the unit, and she didn't know where it was.		F0842				

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F0842 SS = D	Continued from page 69 During an interview on 6/26/25 at 12:21 p.m., St. Croix Hospice case manager (HCM) stated the hospice admission nurse normally brought the binder to the facility at admission and it contained the certificate of terminal illness (CTI), care plan and every 2 weeks after IDT the care plans get faxed over every 2 weeks, he puts them in the St. Croix binder. Not sure if the consents/agreements. The HCM stated R37's binder was in his room, but last Friday the hospice aid had said she couldn't find it. Would typically provide the forms that are, they don't do stickers on the hard charts. Main contact for Jim it is usually Jamie the charge nurse. He would say that information should be in the chart, so that people know the info they need. During an interview on 6/26/25 at 10:20 a.m., the DON would expect there to be a hospice care plan for R37. The DON stated she called R37's wife and she hadn't seen the binder either and didn't know where it was. The DON added she had contacted St. Croix Hospice to let them know they didn't have a hospice binder here. An undated Hospice Respite Care Agreement between Chisholm Heritage Manor and St. Croix Hospice, identified the facility shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Respite Care. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day.	F0842			
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	F880: Infection Prevention and Control DON or designee will implement corrective action for residents affected by this practice (R41) R41 had infection control measures put in place for a resident MDRO All residents have potential to be impacted by this deficient practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: Enhanced Barrier Precautions policy was reviewed, no updates needed. All nursing staff will be educated on enhanced barrier precautions, to include written competencies, and	08/20/2025	

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F0880 SS = D	Continued from page 70 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport	F0880	Continued from page 70 educated which current residents are currently on EBP. Audit to ensure all resident required to have EBP in place and have required signage, supplies and bins in place. Random audits on enhanced barrier precautions by DON and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	

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F0880 SS = D	Continued from page 71 linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to have infection control measures in place for a resident colonized with a multi-drug-resistant bacteria (MDRO, bacteria resistant to one or more classes of antimicrobial agents) for 1 of 1 resident (R41) reviewed for infection control. Findings include: R41's significant change Minimum Data Set (MDS) dated 4/1/25, identified intact cognition and diagnoses of obstructive and reflux uropathy, benign prostatic hyperplasia (BPH, non-malignant swelling of the prostate), and extended-spectrum beta-lactamase (ESBL, enzymes produced by certain types of bacteria that make them resistant to many common antibiotics) resistance, and urinary tract infection (UTI). The MDS also indicated R41 was occasionally incontinent of urine and had no catheter or toileting plan. R41's care plan dated 1/31/25, identified an activities of daily living (ADL) self-care performance deficit with interventions to assist with toilet use and hygiene when R41 requested. The care plan also identified intermittent bladder incontinence with an intervention for enhanced barrier precautions (EBP) due to a history of ESBL. R41's electronic medical record (EMR) included a banner identifying enhanced barrier precautions (EBP) were in place related to ESBL. Review of R41's progress notes identified a note on 4/14/25, from the assistant director of nurses (ADON) and infection preventionist noted the final urinary culture results received and uploaded into chart, the report indicated greater than 100,000 colony-forming units (CFU) per milliliter (mL) klebsiella pneumoniae (a type of bacteria) present. A note from 6/16/25 identified R41 returned from a urology appointment and received new orders to continue changing depends (incontinent brief) every three to four hours and as needed. Start timed voiding every two hours. Bacteriuria (bacteria in urine without signs of		F0880				

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F0880 SS = D	Continued from page 72 infection) in R41 due to colonization with a very resistant strain of klebsiella and will defer treatment since he is asymptomatic. If symptomatic (fevers, dysuria, confusion, flank pain, etc.) will need intravenous antibiotics and infectious disease consult. During an observation and interview on 6/23/25 at 5:19 p.m., R41 stated he had UTIs one after the other. It was observed there were no EBP in place in R41's room, no sign on or near the door, and no personal protective equipment (PPE) in the room. During an interview on 6/24/25 at 1:27 p.m., nursing assistant (NA)-E stated R41 needed help once in a while with brief changing and incontinence care. NA-E stated they didn't need to wear PPE when helping him. NA-E looked at R41's door and stated, no he didn't have precautions. During an interview on 6/24/25 at 1:49 p.m., NA-H stated they did have to help R41 in the bathroom sometimes when he needed help cleaning up after an incontinent episode. During an interview on 6/24/25 at 1:53 p.m., the assistant director of nurses (ADON) and infection preventionist stated R41 was colonized with ESBL and should have EBP because it was important to help prevent the spread of ESBL. A policy, Enhanced Barrier Precautions dated 8/20/24, identified its purposed was to provide guidelines to staff in the application of EBP to safely care for residents colonized or infected with MDROs. The procedure identified EBP shall be used when providing high-contact care to residents who are infected or colonized with an MDRO when other precautions don't apply. The procedure identified transferring, hygiene care, toileting, incontinent care and dressing as high-contact activities for which EBP should be worn. Posted signage on the resident's door and chart should indicated appropriate use of PPE.		F0880				
F0919 SS = E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-		F0919	F919 Call Light system The Environmental Services Director or designee will implement corrective action for residents affected by this practice (R36, R47, R111, R6) R36, R47, R111, and R6 had a call light cord placed within reach from the bathroom floor. Approximately 4-6 inches from the floor. All residents have potential to be impacted by this		08/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Heritage Manor			STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719	
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F0919 SS = E	Continued from page 73 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure resident call lights were within reach from the bathroom floor in resident bathrooms for 4 of 4 residents (R36, R47, R111, R6) reviewed for call light accessibility. Findings include: During an observation on 6/23/25 at 2:33 p.m., the bathroom call light cord in R6's room was approximately three feet from the bathroom floor. During an observation on 6/23/25 at 5:31 p.m., the bathroom call light cord in R111's room was approximately three feet from the bathroom floor. During an observation on 6/23/25 at 6:18 p.m., the bathroom call light cord in R36's room was approximately three feet from the bathroom floor. During an observation on 6/24/25 at 9:14 a.m., the bathroom call light cord in R47's room was approximately three feet from the bathroom floor. On 6/24/25 at 12:08 p.m., maintenance director (M)-A went to each bathroom (405, 407, 410, 413) and verified the call lights were "too short", M-A stated the call light cord should be reachable from the floor in case of fall in the bathroom. On 6/26/25 at 12:48 p.m., the director of nursing verified the call light cords should be reachable from the floor in case a resident fell in the bathroom. The policy Call Light dated 10/23/17, did not address call light cord length in resident bathrooms.	F0919	Continued from page 73 deficient practice. The Call Light Policy was reviewed on 7/7/25 by the Administrator and updated to include: All bathroom call lights will have a cord that is within reach from the floor (approximately 4-6 inches from the floor). Staff to report any concerns to Environmental Services. All staff will be educated on the Call Light policy, including all bathroom call lights need to have a cord that is within reach from the floor (approximately 4-6 inches from the floor) and if any concerns, to report to Environmental Services. All bathroom call lights will be audited and replaced if needed. Random audits of bathroom call lights to ensure they are within reach from the floor, will be completed by ESD and/or designee starting 8/12/25, three times a week for three weeks, two times a week for two weeks, and weekly thereafter Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 8/20/25	

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NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/26/2025. At the time of this survey, Heritage Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145		K0000			08/20/2025	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. basement. The original building was constructed in 1953 and was determined to be built of Type II(111) construction. In 1981 and 2001, two additions were constructed to the building and determined to be built of Type II(111) construction. Heritage Manor is fully protected throughout by an automatic fire sprinkler system. In addition, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that		K0000				

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K0000	Continued from page 2 are monitored for automatic fire department notification. The facility is divided into smoke compartments and separated from an apartment building by a two-hour fire-rated wall. Heritage Manor new addition completed in 2022 that includes 21 resident beds. The addition was determined to be built of Type II(111) construction. The addition is fully protected by automatic fire sprinklers and has smoke detection in the corridors, spaces open to the corridors, and resident rooms. The facility has a capacity of 65 beds and had a census of 54 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0223 SS = D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have an isolated impact on the residents within the facility.	K0223	Environmental Services Director/Designee will be responsible for corrective action The janitors closet (127) identified will have a self-closing device installed. Maintenance staff will be educated on self-closing door requirements Random weekly audits on doors requiring self-closing devices will be conducted by ESD or Designee. Any doors in need of self-closing devices will have them installed. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 8/20/25	08/20/2025

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K0223 SS = D	Continued from page 3 Findings include: On 06/26/2025 @ 1055, it was revealed by observation that the janitors closet (127) did not have a self closing device. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.		K0223				
K0226 SS = F	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell arrangement and markings per NFPA 101 (2012 edition), Life Safety Code, section 19.1.1.4.1.1, 19.1.1.4.1.2, 19.1.1.4.1.3, 19.2.2.2.7, Chapter 7, section 7.2.1.8.2(1) through 7.2.1.8.2(4). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/26/2025 @ 0845, it was revealed by observation that the door in the fire barrier wall was blocked by flower bine carts and other service materials, door location was D005. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.		K0226	Environmental Services Director/Designee will be responsible for corrective action The door D005 will not be blocked to prevent closure All staff will be educated on blocking fire barrier doors Random weekly audits on doors will be conducted by ESD or Designee. Any items blocking a fire barrier door will be immediately removed Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 8/20/25		08/20/2025	
K0324 SS = D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities		K0324	Environmental Services Director/Designee will be responsible for corrective action the fired stove and griddle located on the cooking line in the kitchen will be marked to ensure the appliances was returned to an approved design location after it		08/20/2025	

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K0324 SS = D	Continued from page 4 Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. This deficient finding could have an isolated impact on the residents within the facility. The findings include: On 06/26/2025 @ 1155, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of alignment marking to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and deep fat fryer cooking device. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K0324	Continued from page 4 has been moved. Maintenance staff will be educated on marking requirements Random weekly audits on the marking for the stove and griddle will be conducted by ESD or Designee to ensure the markings remain intact Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 8/20/25	
K0363 SS = D	Corridor - Doors	K0363	Environmental Services Director/Designee will be	08/20/2025

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K0363 SS = D	Continued from page 5 CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/26/2025 @ 1122, it was revealed by observation		K0363	Continued from page 5 responsible for corrective action The storage door in the therapy room will be adjusted to close and latch. Random weekly audits will be conducted by ESD or Designee Maintenance staff will be educated on door latching requirements. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 8/20/25			

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K0363 SS = D	Continued from page 6 that storage room in therapy area did not close and/or latch.		K0363				
K0372 SS = F	An interview with the Maintenance Manager verified this deficient finding at the time of discovery. Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/26/2025 @ 0845, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following area: 1) Near date closet , Wind Hill 2) Entry to dining room		K0372	Environmental Services Director/Designee will be responsible for corrective action Maintenance staff will be educated on penetration requirements. The penetrations located in areas 1-4 will be sealed. Random weekly audits will be conducted by ESD or Designee Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 8/20/25		08/20/2025	

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K0372 SS = F	Continued from page 7 3) Entry to Park addition 4) Entry to Lake View An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K0372		
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/26/2025 @ 0845, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement, First shift 09/27/24 @ 1245, 12/27/24 @ 1345 and 03/27/25 @ 1350. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K0712	Environmental Services Director will be responsible implement corrective action. Maintenance staff will be educated on fire drills under varied times is completed and documented Random weekly audits on fire drills will be completed by ESD or designee. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 8/20/25	08/20/2025
K0741 SS = F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations	K0741	Environmental Services Director will be responsible implement corrective action. All staff will be educated on not smoking on the loading dock	08/20/2025

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NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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K0741 SS = F	Continued from page 8 Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to implement a staff smoking policy per NFPA 101 (2012 edition), Life Safety Code section 19.7.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/26/2025 @ 0948, it was revealed by observation that the smoking was occurring by loading dock area as evident by discarded cigarette butts and a visible pack of cigarettes in grass area. Metal can was provided, but staff are not using can for safe containment. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.		K0741	Continued from page 8 Random weekly audits will be completed by ESD or designee. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 8/20/25			
K0761	Maintenance, Inspection & Testing - Doors		K0761	Environmental Services Director will be responsible		08/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE MANOR B. WING		(X3) DATE SURVEY COMPLETED 06/26/2025	
NAME OF PROVIDER OR SUPPLIER Heritage Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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K0761 SS = F	Continued from page 9 CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/26/2025 between 8.00am and 12:00pm, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags. 1) Fire doors leading to Apartments - missing tags on door frame 2) Fire doors leading to Loading Dock - missing tags on door frame 3) Fire doors leading to elevators on upper level - missing tags on door frame			K0761	Continued from page 9 implement corrective action. Doors 1-5 identified will have door rating tags. Maintenance staff will be educated on door rating tag requirements Random weekly audits will be completed by ESD or designee. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 8/20/25		

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K0761 SS = F	Continued from page 10 4) Fire doors leading to elevators on lower level - missing tags on door frame 5) Fire doors in the lower level smoke wall - missing tags on door frame An interview with the Director of Maintenance verified these deficient findings at the time of discovery.		K0761				
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include:		K0920	Environmental Services Director will be responsible implement corrective action. Extension/ multiplug cord will be removed from the activities office. All staff will be educated on power cords and extension cords. Random weekly audits will be completed by ESD or designee. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 8/20/25		08/20/2025	

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K0920 SS = D Bldg. 01	Continued from page 11 On 06/26/2025 @ 1002, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; Extension cord/milti plug in Activities Office. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.			K0920			