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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 84RS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00904

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245245**
2.STATE VENDOR OR MEDICAID NO.
(L2) **936651200**

3. NAME AND ADDRESS OF FACILITY
(L3) **HERITAGE MANOR**
(L4) **321 NORTHEAST SIXTH STREET**
(L5) **CHISHOLM, MN** (L6) **55719**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/08/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 12/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/27/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/14/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245245

January 27, 2017

Mr. Geoffrey Ryan, Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, Minnesota 55719

Dear Mr. Ryan:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program

Effective November 25, 2016 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 23, 2016

Mr. Geoffrey Ryan, Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, Minnesota 55719

RE: Project Number S5245028

Dear Mr. Ryan:

On November 8, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 20, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On December 8, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 29, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 20, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 25, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 20, 2016, effective November 25, 2016 and therefore remedies outlined in our letter to you dated November 8, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245245 Y1	A. Building B. Wing Y2	12/8/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0309	Correction	ID Prefix F0412	Correction	ID Prefix F0428	Correction
Reg. # 483.25	Completed	Reg. # 483.55(b)	Completed	Reg. # 483.60(c)	Completed
LSC	11/25/2016	LSC	11/25/2016	LSC	11/25/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/25/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	12/23/2016	29433	12/08/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/20/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245245	A. Building 01 - HERITAGE MANOR B. Wing	11/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 11/14/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
x	TL/mm	12/23/2016	29433	11/29/2016
REVIEWED BY CMS RO	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/18/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 84RS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00904

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245245**

2.STATE VENDOR OR MEDICAID NO.
(L2) **936651200**

3. NAME AND ADDRESS OF FACILITY
(L3) **HERITAGE MANOR**
(L4) **321 NORTHEAST SIXTH STREET**
(L5) **CHISHOLM, MN** (L6) **55719**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/20/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susan Frericks, HPRSWS — 12/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 12/14/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 8, 2016

Mr. Chester FIshel, Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, Minnesota 55719

RE: Project Number S5245028

Dear Mr. Fishel:

On October 20, 2016, a standard survey was completed at your facility by the Minnesota Departments 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 29, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by January 20, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 April 20, 2017 (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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (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.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper positioning was maintained during dining to enable feeding for 1 of 2 residents (R24) reviewed for positioning. Findings include: R24's Disease Diagnosis and Allergy sheet	F 309	F309: It's Heritage Manor's policy to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. DON and/or designee will implement	11/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 309	Continued From page 1 printed 10/20/16, indicated R24's diagnoses included hip fracture, muscle weakness and osteoarthritis. R24's quarterly Minimum Data Set (MDS) dated 10/4/16, indicated R24 was independent with eating after staff set up. R24's care plan dated 9/5/16, indicated R24 was independent with eating. The care plan directed staff to bring R24's food to the table, put within reach and set up items, butter bread, cut meat, open packages. On 10/18/16, R24 was constantly observed in the main dining room during the evening meal from 4:35 p.m. through 5:15 p.m. R24 was seated in the wheelchair with her buttocks slid forward on the seat and her back against the back of the wheelchair. At the small of her back was a space of approximately five inches between her back and the back of the wheelchair. At 4:45 p.m. R24 received her meal of cubed carrots, mashed potatoes and gravy, a pastie (not cut), bread, cranberry juice and coffee. During the entire meal while attempting to feed herself R24 continued to lean back and hold onto the table with her left hand. R24 was trying to push her buttocks back in the wheelchair. R24's torso area was approximately 10 inches from the table. R24 was trying but was unable to lean forward to reach the food. R24 dropped fork in her lap, there were carrots on the table, R24 and the floor. R24 had to fully extend her arms to reach her plate. R24's bread slid off the plate onto the table. R24 attempted to cut the pastie but was unable. R24 used her fork and fingers to pull the pastie apart but was unable and did not eat it. The food continued to slid off the edge of the plate. R24's tablemate moved the dessert and coffee closer to R24. At 5:05 p.m. R24 quit eating. R24 continued	F 309	corrective action for resident R24 affected by this practice by: • On admission from the hospital on 10/17/16 R24 was referred to Occupational Therapy (OT) to evaluate her w/c positioning needs and was under treatment by OT on 10/18/16 when the surveyor observed the resident during the AM meal. On 10/18/16, OT replaced the resident's wheelchair with a hi back chair, which she utilized for the next week, and was then transitioned back to a standard wheelchair as her condition had improved enough to sit in the appropriate position in her wheelchair. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who utilize wheelchairs in the dining room have the potential to be affected by a deficient practice in this area. DON and/or designee will implement measures to ensure that this practice does not recur including: • All residents were observed in the dining room on 11-11-2016 to ensure that their individual needs and preferences were met r/t wheelchair positioning. • Nursing staff will be re-educated on repositioning residents in the dining room at in-services on 11-15 and 11-16-2016.	

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F 309	Continued From page 2 to try to sit forward by pulling on the table but was unable. R24 stated to the tablemate, "It's too hard to eat." The tablemate stated, "You should have someone here to help you." The tablemate assisted R24 to remove the cover up and stated, "I'll wait with you until someone comes and takes you back to your room." The remainder of the food on R24's plate was on the front 1/2 of the plate. Staff did not reposition or assist R24 with the meal. There were several staff in the main dining room passing trays and assisting other residents. At 5:15 p.m. staff brought R24 to her room. At that time staff pulled R24 back in the wheelchair. R24 stated she had sciatica, and it was hurting through supper, and she felt better now that she was sitting back further. R24 stated she was still hungry and would have eaten more if she could. On 10/2/016, at 10:00 a.m. registered nurse (RN)-B stated R24 should have been repositioned in the wheelchair and/or received assistance to eat. On 10/20/16, at 10:15 a.m. the director of nursing (DON) stated she would expect staff to reposition R24 and assist her to eat if needed. A positioning during meals policy was requested but not provided.	F 309	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random w/c positioning audits will be completed by DON/designee daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly to ensure proper w/c positioning is being provided and used for all residents as needed beginning the week of 11-21-2016. • Audit results will be brought to the QAPI committee for review and further recommendation. Completion Date: 11-25-2016	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each	F 412		11/25/16

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F 412	Continued From page 3 resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide dental services to repair loose dentures for 1 of 3 residents (R33) reviewed for dental. Findings include: R33's face sheet dated 10/20/16, indicated R33's diagnoses included anemia, gastro-esophageal reflux disease, and cerebrovascular disease. R33's quarterly Minimum Data Set (MDS) dated 8/25/16, indicated R33 required extensive assistance with personal hygiene, had a mechanically altered diet, and weight loss. The MDS also identified R33 had broken or loosely fitting full or partial dentures. R33's care plan dated 5/13/16, indicated had short term memory deficits with periods of confusion/disorientation/forgetfulness. The care plan also indicated R33 had dentures and required limited assistance with oral care, and directed nursing staff to arrange dental appointments as indicated or requested. The care plan goal for R33's oral care was for R33 to have optimum oral health. The nursing assistant care guide sheets indicated R33 required limited assist of one staff for oral	F 412	F412: Heritage Manor assists the residents in obtaining dental services. Social Service and/or designee will implement corrective action for resident R33 affected by this practice by: • Resident R33 had a dental services appointment scheduled, however she passed away on 11-07-2016. Social Service and/or designee will assess residents having the potential to be affected by this practice including: • All residents with dentures have the potential to be affected by this deficient practice. Social Service and/or designee will implement measures to ensure that this practice does not recur including: • Resident and/or responsible party will be offered dental services at each residents quarterly care conference and documented in the social services notes. • SS and nursing staff will be re-educated on the facility's Dental Care assessment and process at in-services on	

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F 412	Continued From page 4 cares. The care guide sheets lacked indication R33 had dentures. Social Service Progress Notes dated 5/20/16, indicated R33 daughter was offered dental services, but declined and stated R33 had no concerns. General Nurse's Observations dated 5/26/16, through 6/30/16, indicated R33 had dentures. The General Nurse's Observations completed 7/11/16, through 8/29/16, indicated R33 had broken or loosely fitting dentures. General Nurse's Observations completed 9/8/16, through 10/13/16, indicated R33 had dentures, but lacked documentation of loose-fitting dentures. Dietary Progress Notes dated 6/23/16, indicated R33 had a mechanical soft diet and was able to chew that texture effectively. Dietary Progress Notes dated 7/28/16, indicated R33 had weight loss and had been changed to a pureed diet per speech therapy recommendations. Social Service Progress Notes dated 8/31/16, indicated R33 was cognitively intact and was able to make her needs known, but lacked documentation regarding dental services. On 10/18/16, at 1:03 p.m. R33 stated her dentures were loose, she had not seen a dentist, and had not been asked if she wanted to see a dentist. R33's dentures were observed at that time to be loose in her mouth and falling down. R33 stated staff were aware of her loose dentures and put stuff on them, but it doesn't last. R33 denied problems chewing. On 10/20/16, at 10:12 a.m. registered nurse	F 412	11-15 and 11-16-2016. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits of residents with dentures 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly to ensure dental needs were assessed, services were offered prn, and care conference documentation is present beginning the week of 11-21-2016. • Audit results will be brought to the QAPI committee for review and further recommendation. Completion Date: 11-25-2016	

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F 412	Continued From page 5	F 412		

(RN)-C stated oral assessments are done and had noted R33 had dentures, but did not document loose dentures. RN-C verified they should be asking and documenting quarterly regarding dental status in social services notes.

On 10/20/16, at 3:01 p.m. social worker (SW)-B stated the RN had told her about the dental visit request, and R33's granddaughter was called to ask if R33 had a dentist. SW-B stated the facility asks on admission and annually. SW-B stated during interviews with R33, she had not noted the denture being loose.

On 10/20/16, at 3:05 p.m. R33's granddaughter called SW-B, and stated R33 did not have a dentist, but could see a dentist if needed. SW-B stated the facility would attempt to make an appointment with a dentist and set up transportation.

On 10/20/16, at 3:56 p.m. RN-B stated she documents a visual oral assessment, but usually just documents if the resident has dentures. RN-B stated she looks at the resident in the morning before they have their dentures in for the day. RN-B stated they usually ask the resident about a dental visit with the initial, annual and significant change MDS's.

On 10/20/16, at 4:13 p.m. director of nursing (DON) stated the oral status is assessed annually and they talk about it during the resident's care conference. DON stated R33's loose dentures were a potential factor in R33's nutritional intake. DON verified the documentation indicated R33's dentures were loose and state the facility should contact the family again. DON verified documentation indicated R33's loose dentures

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F 412	Continued From page 6 had not been followed-up on, and services had not been offered. The facility was unable to provide a policy and procedure regarding dental services.	F 412		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document, the facility failed to act on the consultant pharmacist recommendations in a timely manner for 1 of 5 residents (R27) reviewed for unnecessary medications. Findings include: R27's Resident Disease History, printed 10/20/16, indicated diagnoses that included dementia with behavioral disturbances, and severe recurring depression with psychological symptoms. R27's annual Minimum Data Set (MDS), dated 10/11/16, indicated R27 was severely cognitively impaired, exhibited no delirium, hallucinations or	F 428	F428: Heritage Manor's follows up on Pharmacy Recommendations regarding drug irregularities. DON and/or designee will implement corrective action by: • R27's Pharmacy recommendations were reviewed by the resident's Physician and a trial reduction of the medications began on 10-18-2016. On 11-01-2016 2 of the 3 medications were increased back to original dosages. The Physician will document a risk versus benefit for the Antipsychotic medication by 11-25-2016.	11/25/16

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F 428	Continued From page 7 delusions and minimal signs of depression. The MDS further indicated R27 exhibited behavior 1-3 days in the assessment period that included verbal and physical behaviors towards others and to herself, but did not pose a significant risk to others or herself, nor did these behaviors impact her life. R27's MDS also indicated R27 had received antipsychotic, antianxiety and antidepressant medications each day of the assessment period. Review of R27's medical record revealed consultant pharmacist reviews monthly for 2016. The months of February, April and August 2016, the reviews noted, "Irregularities identified. See Report." The consultant pharmacist requested a risk versus benefit for the use of R27's Seroquel (an antipsychotic medication). The Report indicated no change in dosage was recommended, however a risk versus benefit documentation was required. This recommendation was accepted and signed by the director of nursing (DON) and an attending physician, however lacked a risk vs. benefits statement. R27's medical record lacked a risk versus benefit for the continued use of the medication. On 10/19/16, at 1:40 p.m. registered nurse (RN)-C stated recommendations are faxed when immediate action was needed, or they were put in the rounds book for physicians to address on their next rounds. RN-C confirmed not been addressed by the physician and there was no obvious risk versus benefit for R27's medications including the Seroquel as requested in February, April, and August. RN-C stated a substitute physician had rounded in August and R27's	F 428	DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents are potentially affected by this practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • All other residents Pharmacist's Monthly Drug Regimen Reviews were reviewed for proper follow-up. • Nursing staff will be re-educated on the updated process for following up on the Pharmacist's Monthly Drug Regimen Review (DRR) at in-services held on 11-15 and 11-16-2016. • Pharmacy consultant and DON will make sure that MD will write a statement. Pharmacy consultant will alert a DON if the risk/benefit statement is not written and needs to be readdressed. Nursing staff will fax a physician the request and not wait until another rounding day. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Monthly audits of Pharmacists DRR will be performed to ensure ongoing compliance beginning after his next review. • Audit results will be brought to the QAPI committee for review and further	

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F 428	Continued From page 8 primary physician rounded earlier in October. On 10/20/16, at 11:08 a.m. RN-B, stated pharmacist recommendations are either faxed to a physician if they need to be addressed right away or put in the doctor's rounding book. RN-B stated she would expect the physician to address the recommendation (accept or reject) at the next rounding. RN-B stated if a risk versus benefit was requested in February, she would expect the recommendation be addressed at the next rounding at the latest. On 10/20/16, at 2:55 p.m. the DON stated the consultant pharmacist comes monthly to the facility. After his reviews, he emails sheets with the recommendations and she will put the recommendation sheets in the physician's rounds book to agree or disagree. The DON stated at times they won't get discussed and she will try to readdress the recommendation at the next rounding. On 10/20/16, at 3:33 p.m. the consultant pharmacist stated he has not received a reply or a risk versus benefit on his recommendations from February or April, which is why he rewrote the recommendation in August. The consultant pharmacist confirmed he resent the April report to the facility DON on 10/19/16. The facility was unable to provide a policy on following the pharmacist's recommendations.	F 428	recommendation. Completion Date: 11-25-2016	
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465		11/25/16

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F 465	Continued From page 9 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 9 of 35 resident rooms, a tub room, and the facility dining room were well maintained and clean. Findings include: During an environmental tour on 10/20/16, at 9:21 a.m. the following was observed and confirmed by the Environmental Services Director (ESD): Room 307 had large dark gray stain approximately two feet long on the bathroom floor. In addition the bedroom door had an area of chipped wood near the inner edge of the handle, approximately 3 inches by 3 inches that caused a rough uncleanable surface. Room 311 had a wall that was scraped and marred. Room 313 had stained ceiling tiles and flies in the light fixtures. Room 401-1 had wall paint chipped down to exposed sheet rock behind the recliner and radiator paint scraped off to the metal. Room 405 had blue foam taped to bilateral side rails. The ESD stated this was added by the therapy department and agreed it was not a cleanable surface. In addition there were scuff marks on the wall behind the recliner.	F 465	F465: Heritage Manor provides a safe, functional, sanitary and comfortable environment for residents, staff and the public. ESD and/or designee will implement corrective action by: • Issues in rooms 307, 311, 313, 401-1, 405, 412, 413-1, 413-2, and 414-1 were cleaned and/or repaired. • The shower ramp is being repaired and will be completed by 11-22-2016. • The tiles needing replacement had been on a list that was being written until there were enough tiles for a tile layer to feel it was enough to justify coming to the facility. ESD and/or designee will assess residents having the potential to be affected by this practice including: • All residents are potentially affected by this practice. ESD and/or designee will implement measures to ensure that this practice does not recur including: • Housekeeping and Nursing staff will	

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F 465	Continued From page 10 Room 412 had gouges in the bathroom way and scrapes on the bathroom doorway. Room 413-1 had a brown stain under the heat register in the room, flies in the bathroom light, a stained ceiling tile, broken floor tile under the sink and duct tape on the toilet top. Room 413-2 had gouges in the wall above the bed. Room 414-1 had moisture staining on the wall behind and next to the toilet, and on the tile under the sink. In addition, the bedroom floor tile has dark marring on both side of the bed and the bathroom door had several dark marred areas. The dining room had floor tiles that were cracked in dining room entry way hutch (areas had corners pulling up), between the pillars that framed the front and back area of the first dining room (doorways), by the door to the serving area, below the serving counter, below the fire extinguisher, and in front of the ice machines. The shower ramp in the C Hall tub room was cracked, had dark stains and was in need of repair. The facility was unable to provide a policy on maintaining a clean, homelike environment.	F 465	be re-educated on the process for notifying maintenance for any extra cleaning or repairs needed in the facility at in-services on 11-15 and 11-16-2016. ESD and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Maintenance Director is rounding 1x/wk. for 4 weeks, then monthly to check for any areas that need extra cleaning or repair. These issues will be put on a calendar to be addressed as soon as practicable. • Administrator/designee will conduct random observational audits of the facility on a weekly basis, to ensure these issues are being identified and addressed. • Audit results will be brought to the QAPI committee for review and further recommendation. Completion Date: 11-25-2016	

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	245245	A. BUILDING **01 - HERITAGE MANOR** B. WING _____	**10/18/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Heritage Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPCC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/14/2016

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01 - HERITAGE MANOR** B. WING _____	**10/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
K 000	Continued From page 1	K 000		

Or by email to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Heritage Manor, is a 1-story building with a full basement. The original building was constructed in 1953 and was determined to be of Type II(111) construction. In 1981 & 2001 additions were constructed to the building that was determined to be of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building also has an apartment complex attached that is properly separated.

The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance

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K 000	Continued From page 2 with the Minnesota State Fire Code. The facility has a capacity of 78 beds and had a census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 30 of 62 residents, as well as an undetermined number of staff, and visitors Findings include: On facility tour between 11:00 a.m. to 2:00 p.m. on 10/18/2016, observation revealed, that the smoke detector located by resident rooms 205 and 304 were installed within 36 inches of a HVAC vent diffuser.	K 052	K052 CHC will properly test and maintain our fire alarm system. In order to comply with 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. The smoke detector located by resident rooms 205 and 304 were moved to be more than the required 36 inches away from a HVAC vent diffuser. All other smoke detectors were inspected for compliance. Completion Date: 11/14/2016	11/14/16

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K 052	Continued From page 3 This deficient condition was verified by a Maintenance Supervisor.	K 052		

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 8, 2016

Mr. Chester Fishel, Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, Minnesota 55719

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5245028

Dear Mr. Fishel:

The above facility was surveyed on October 17, 2016 through October 20, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Teresa Ament at (218) 302-6151 or email: teresa.ament@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00904	A. BUILDING: _____ B. WING _____	10/20/2016

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HERITAGE MANOR	**321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/17/16, through 10/20/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting	2 000		

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2 000	Continued From page 1 the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors' findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.	2 905		11/25/16

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2 905	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper positioning was maintained during dining to enable feeding for 1 of 2 residents (R24) reviewed for positioning. Findings include: R24's Disease Diagnosis and Allergy sheet printed 10/20/16, indicated R24's diagnoses included hip fracture, muscle weakness and osteoarthritis. R24's quarterly Minimum Data Set (MDS) dated 10/4/16, indicated R24 was independent with eating after staff set up. R24's care plan dated 9/5/16, indicated R24 was independent with eating. The care plan directed staff to bring R24's food to the table, put within reach and set up items, butter bread, cut meat, open packages. On 10/18/16, R24 was constantly observed in the main dining room during the evening meal from 4:35 p.m. through 5:15 p.m. R24 was seated in the wheelchair with her buttocks slid forward on the seat and her back against the back of the wheelchair. At the small of her back was a space of approximately five inches between her back and the back of the wheelchair. At 4:45 p.m. R24 received her meal of cubed carrots, mashed potatoes and gravy, a pastie (not cut), bread, cranberry juice and coffee. During the entire meal while attempting to feed herself R24 continued to lean back and hold onto the table with her left hand. R24 was trying to push her buttocks back in the wheelchair. R24's torso area was	2 905	Corrected	

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2 905	Continued From page 3	2 905		

approximately 10 inches from the table. R24 was trying but was unable to lean forward to reach the food. R24 dropped fork in her lap, there were carrots on the table, R24 and the floor. R24 had to fully extend her arms to reach her plate. R24's bread slid off the plate onto the table. R24 attempted to cut the pastie but was unable. R24 used her fork and fingers to pull the pastie apart but was unable and did not eat it. The food continued to slid off the edge of the plate. R24's tablemate moved the dessert and coffee closer to R24. At 5:05 p.m. R24 quit eating. R24 continued to try to sit forward by pulling on the table but was unable. R24 stated to the tablemate, "It's too hard to eat." The tablemate stated, "You should have someone here to help you." The tablemate assisted R24 to remove the cover up and stated, "I'll wait with you until someone comes and takes you back to your room." The remainder of the food on R24's plate was on the front 1/2 of the plate. Staff did not reposition or assist R24 with the meal. There were several staff in the main dining room passing trays and assisting other residents. At 5:15 p.m. staff brought R24 to her room. At that time staff pulled R24 back in the wheelchair. R24 stated she had sciatica, and it was hurting through supper, and she felt better now that she was sitting back further. R24 stated she was still hungry and would have eaten more if she could.

On 10/2/016, at 10:00 a.m. registered nurse (RN)-B stated R24 should have been repositioned in the wheelchair and/or received assistance to eat.

On 10/20/16, at 10:15 a.m. the director of nursing (DON) stated she would expect staff to reposition R24 and assist her to eat if needed.

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2 905	Continued From page 4 A positioning during meals policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are properly positioned. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide dental	21325	Corrected	11/25/16

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21325	Continued From page 5	21325		

services to repair loose dentures for 1 of 3 residents (R33) reviewed for dental.

Findings include:

R33's face sheet dated 10/20/16, indicated R33's diagnoses included anemia, gastro-esophageal reflux disease, and cerebrovascular disease.

R33's quarterly Minimum Data Set (MDS) dated 8/25/16, indicated R33 required extensive assistance with personal hygiene, had a mechanically altered diet, and weight loss. The MDS also identified R33 had broken or loosely fitting full or partial dentures.

R33's care plan dated 5/13/16, indicated had short term memory deficits with periods of confusion/disorientation/forgetfulness. The care plan also indicated R33 had dentures and required limited assistance with oral care, and directed nursing staff to arrange dental appointments as indicated or requested. The care plan goal for R33's oral care was for R33 to have optimum oral health.

The nursing assistant care guide sheets indicated R33 required limited assist of one staff for oral cares. The care guide sheets lacked indication R33 had dentures.

Social Service Progress Notes dated 5/20/16, indicated R33 daughter was offered dental services, but declined and stated R33 had no concerns.

General Nurse's Observations dated 5/26/16, through 6/30/16, indicated R33 had dentures. The General Nurse's Observations completed 7/11/16, through 8/29/16, indicated R33 had

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broken or loosely fitting dentures. General Nurse's Observations completed 9/8/16, through 10/13/16, indicated R33 had dentures, but lacked documentation of loose-fitting dentures.

Dietary Progress Notes dated 6/23/16, indicated R33 had a mechanical soft diet and was able to chew that texture effectively. Dietary Progress Notes dated 7/28/16, indicated R33 had weight loss and had been changed to a pureed diet per speech therapy recommendations.

Social Service Progress Notes dated 8/31/16, indicated R33 was cognitively intact and was able to make her needs known, but lacked documentation regarding dental services.

On 10/18/16, at 1:03 p.m. R33 stated her dentures were loose, she had not seen a dentist, and had not been asked if she wanted to see a dentist. R33's dentures were observed at that time to be loose in her mouth and falling down. R33 stated staff were aware of her loose dentures and put stuff on them, but it doesn't last. R33 denied problems chewing.

On 10/20/16, at 10:12 a.m. registered nurse (RN)-C stated oral assessments are done and had noted R33 had dentures, but did not document loose dentures. RN-C verified they should be asking and documenting quarterly regarding dental status in social services notes.

On 10/20/16, at 3:01 p.m. social worker (SW)-B stated the RN had told her about the dental visit request, and R33's granddaughter was called to ask if R33 had a dentist. SW-B stated the facility asks on admission and annually. SW-B stated during interviews with R33, she had not noted the denture being loose.

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21325	Continued From page 7 On 10/20/16, at 3:05 p.m. R33's granddaughter called SW-B, and stated R33 did not have a dentist, but could see a dentist if needed. SW-B stated the facility would attempt to make an appointment with a dentist and set up transportation. On 10/20/16, at 3:56 p.m. RN-B stated she documents a visual oral assessment, but usually just documents if the resident has dentures. RN-B stated she looks at the resident in the morning before they have their dentures in for the day. RN-B stated they usually ask the resident about a dental visit with the initial, annual and significant change MDS's. On 10/20/16, at 4:13 p.m. director of nursing (DON) stated the oral status is assessed annually and they talk about it during the resident's care conference. DON stated R33's loose dentures were a potential factor in R33's nutritional intake. DON verified the documentation indicated R33's dentures were loose and state the facility should contact the family again. DON verified documentation indicated R33's loose dentures had not been followed-up on, and services had not been offered. The facility was unable to provide a policy and procedure regarding dental services. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents have optimal oral health including proper fitting dentures. The Director of Nursing or designee could educate all appropriate staff on the policies and	21325		

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21325	Continued From page 8 procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R76, R11, R109) received the baseline tuberculosis (TB)	21426	Corrected	11/25/16

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HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719

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21426	Continued From page 9	21426		

screening prior to administration of the tuberculin skin test (TST). In addition, the facility failed to ensure 1 of 5 residents (R76) received the two step TST according to the Centers for Disease Control & Prevention (CDC) guidelines.
Findings include:
The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Setting, 2005, directed that all residents must receive a baseline TB screening. The baseline TB screening should consist of assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis.
R76 was admitted to the facility on 5/15/15. R76's Baseline TB Screening Tool for Patients was undated. R76's electronic medication administration record (EMAR) dated 5/15/15, indicated R76 had received the first step TST on 5/15/15. R76's electronic treatment administration record (ETAR) dated 5/15/15, indicated R76's first step TST had been read on 5/15/15 (same day as administration). R76's medical record lacked documentation of administration of the second step TST.
R11 was admitted to the facility on 5/11/15. R11's Baseline TB Screening Tool for Patients was dated as being completed on 5/12/15. R11's EMAR dated 5/11/15, indicated R11 had received the first step TST on 5/11/16 (which indicated the TST test had been administered prior to the completion of the written screening assessment tool being completed).
R109 was admitted to the facility on 10/5/16. R109's Baseline TB Screening Tool for Patients was undated. R109's EMAR dated 10/5/16, indicated R109 had received the first step TST on 10/5/16, with results appropriately read on 10/7/16.

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21426	Continued From page 10 On 10/20/16, at 10:45 a.m. registered nurse (RN)-A, who oversaw the facility's infection control program, confirmed the above noted findings. RN-A stated the TB screening should be done upon admission and completed prior to the administration of the first step of the TST. In addition, the first step TST should be read on the third day after administration and then the second step TST given on day 15. RN-A confirmed all of this information should be documented in the resident's medical record. Tuberculosis Policy dated 3/5/16, indicated each resident admitted to the facility would be required to have a written assessment of the resident's risk factors for TB along with any current TB symptoms and a standard two-step TST initiated within 72 hours after admission to the facility. In addition, when reading the TST, staff should confirm that the TST had been administered within 48-72 hours prior to reading. The second step of the TST must be repeated within 1-3 weeks after the date that the initial TST was read. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure residents are properly screened for TB and that the TST was administered appropriately. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy.	21530		11/25/16

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21530	Continued From page 11 This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document, the facility	21530	Corrected	

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21530	Continued From page 12 failed to act on the consultant pharmacist recommendations in a timely manner for 1 of 5 residents (R27) reviewed for unnecessary medications. Findings include: R27's Resident Disease History, printed 10/20/16, indicated diagnoses that included dementia with behavioral disturbances, and severe recurring depression with psychological symptoms. R27's annual Minimum Data Set (MDS), dated 10/11/16, indicated R27 was severely cognitively impaired, exhibited no delirium, hallucinations or delusions and minimal signs of depression. The MDS further indicated R27 exhibited behavior 1-3 days in the assessment period that included verbal and physical behaviors towards others and to herself, but did not pose a significant risk to others or herself, nor did these behaviors impact her life. R27's MDS also indicated R27 had received antipsychotic, antianxiety and antidepressant medications each day of the assessment period. Review of R27's medical record revealed consultant pharmacist reviews monthly for 2016. The months of February, April and August 2016, the reviews noted, "Irregularities identified. See Report." The consultant pharmacist requested a risk versus benefit for the use of R27's Seroquel (an antipsychotic medication). The Report indicated no change in dosage was recommended, however a risk versus benefit documentation was required. This recommendation was accepted and signed by the director of nursing (DON) and an attending physician, however lacked a risk vs. benefits statement.	21530		

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21530	Continued From page 13 R27's medical record lacked a risk versus benefit for the continued use of the medication. On 10/19/16, at 1:40 p.m. registered nurse (RN)-C stated recommendations are faxed when immediate action was needed, or they were put in the rounds book for physicians to address on their next rounds. RN-C confirmed not been addressed by the physician and there was no obvious risk versus benefit for R27's medications including the Seroquel as requested in February, April, and August. RN-C stated a substitute physician had rounded in August and R27's primary physician rounded earlier in October. On 10/20/16, at 11:08 a.m. RN-B, stated pharmacist recommendations are either faxed to a physician if they need to be addressed right away or put in the doctor's rounding book. RN-B stated she would expect the physician to address the recommendation (accept or reject) at the next rounding. RN-B stated if a risk versus benefit was requested in February, she would expect the recommendation be addressed at the next rounding at the latest. On 10/20/16, at 2:55 p.m. the DON stated the consultant pharmacist comes monthly to the facility. After his reviews, he emails sheets with the recommendations and she will put the recommendation sheets in the physician's rounds book to agree or disagree. The DON stated at times they won't get discussed and she will try to readdress the recommendation at the next rounding. On 10/20/16, at 3:33 p.m. the consultant pharmacist stated he has not received a reply or a risk versus benefit on his recommendations	21530		

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21530	Continued From page 14 from February or April, which is why he rewrote the recommendation in August. The consultant pharmacist confirmed he resent the April report to the facility DON on 10/19/16. The facility was unable to provide a policy on following the pharmacist's recommendations. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure consultant pharmacist recommendations are rejected, or accepted and acted upon within a timely manner to the benefit of residents The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced	21685		11/25/16

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21685	Continued From page 15 by: Based on observation, interview and document review, the facility failed to ensure 9 of 35 resident rooms, a tub room, and the facility dining room were well maintained and clean. Findings include: During an environmental tour on 10/20/16, at 9:21 a.m. the following was observed and confirmed by the Environmental Services Director (ESD): Room 307 had large dark gray stain approximately two feet long on the bathroom floor. In addition the bedroom door had an area of chipped wood near the inner edge of the handle, approximately 3 inches by 3 inches that caused a rough uncleanable surface. Room 311 had a wall that was scraped and marred. Room 313 had stained ceiling tiles and flies in the light fixtures. Room 401-1 had wall paint chipped down to exposed sheet rock behind the recliner and radiator paint scraped off to the metal. Room 405 had blue foam taped to bilateral side rails. The ESD stated this was added by the therapy department and agreed it was not a cleanable surface. In addition there were scuff marks on the wall behind the recliner. Room 412 had gouges in the bathroom way and scrapes on the bathroom doorway. Room 413-1 had a brown stain under the heat register in the room, flies in the bathroom light, a	21685	Corrected	

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21685	Continued From page 16 stained ceiling tile, broken floor tile under the sink and duct tape on the toilet top. Room 413-2 had gouges in the wall above the bed. Room 414-1 had moisture staining on the wall behind and next to the toilet, and on the tile under the sink. In addition, the bedroom floor tile has dark marring on both side of the bed and the bathroom door had several dark marred areas. The dining room had floor tiles that were cracked in dining room entry way hutch (areas had corners pulling up), between the pillars that framed the front and back area of the first dining room (doorways), by the door to the serving area, below the serving counter, below the fire extinguisher, and in front of the ice machines. The shower ramp in the C Hall tub room was cracked, had dark stains and was in need of repair. The facility was unable to provide a policy on maintaining a clean, homelike environment. SUGGESTED METHOD OF CORRECTION: The Director of Environment or designee could develop, review, and/or revise policies and procedures to ensure consultant resident rooms and common areas are kept clean and in good repair. The Director of Environment or designee could educate all appropriate staff on the policies and procedures. The Director of Environment or designee could develop monitoring systems to ensure ongoing compliance.	21685		

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21685	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		