DEPARTMENT OF HEALTH						DICARE & MEDICAID SERVICES		
	_		-		AND TRANSMITTAL	ID: 84RS		
	PART I -	TO BE COMP	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00904		
1. MEDICARE/MEDICAID PROVIDE	R NO.	3. NAME AND AI (L3) HERITAGE		CILITY		4. TYPE OF ACTION: <u>7</u> (L8)		
(L1) 245245 2.STATE VENDOR OR MEDICAID N	0	(L4) 321 NORTH		STDFFT		1. Initial 2. Recertification		
(L2) 936651200	0.	(L5) CHISHOLM		SIKELI	(L6) 55719	3. Termination4. CHOW5. Validation6. Complaint		
						7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF C	OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey After Complaint		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA			
6. DATE OF SURVEY 12/08/		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		06/30		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	00/50		
11LTC PERIOD OF CERTIFICATION	[10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		X A. In Complia	ance With		And/Or Approved Waivers Of I	The Following Requirements:		
To (b) :			equirements		2. Technical Personnel	6. Scope of Services Limit		
		Compliane	e Based On:		3. 24 Hour RN	7. Medical Director		
12. Total Facility Beds	70 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size		
13.Total Certified Beds	70 (L17)	B Not in Comr	liance with Progra	am	5. Life Safety Code	9. Beds/Room		
13. Total Certified Beds	70 (EI7)	-	and/or Applied V		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
70								
(L37) (L38)	(L39)	(L42)	(L43)					
			NCELLATION					
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	BLE SHOW LIC CA	ANCELLATION I	DALE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Teresa Ament, HFE NEII		1	2/13/2016		Mark meath	, Enforcement Specialist 01/27/2017		
				(L19)	• •	(L20)		
PAR	RT II - TO BE (COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OR SINGLE ST	FATE AGENCY		
19. DETERMINATION OF ELIGIBILI	ТҮ	20. COM	IPLIANCE WITH	H CIVIL	21. 1. Statement of Finan	icial Solvency (HCFA-2572)		
X 1. Facility is Eligible to Pa	rticinate	RIGI	TTS ACT:		2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)			
2. Facility is not Eligible	interpate				3. Both of the Above :			
2. Taeinty is not Englote	(L21)							
22. ORIGINAL DATE	22 LTC ACREE	AENT 2	4 LTC ACREEN	(ENT	2 TERMINATION ACTION.	(120)		
	23. LTC AGREEN		4. LTC AGREEN		26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	I DATE	ENDING DA	ΓE	<u>VOLUNTARY</u> <u>00</u>			
09/01/1982					01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		03-Risk of Involuntary Termination			
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			04-Other Reason for Withdrawal	OTHER		
	A. Suspension	n of Admissions:	(1.44)		0+-other reason for whitehawar	07-Provider Status Change 00-Active		
(L27)	B Rescind Si	spension Date:	(L44)			00-Active		
	D. Reseniu St	ispension Date.	(1.45)					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE				
	(L32)	12/14/2016		(L33)	DETERMINATION APPR	ROVAL		



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



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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	
245245 Y1	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).

ITEI	м	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix Reg. # LSC	F0309 483.25	Correction Completed 11/25/2016	ID Prefix F0412 Reg. # 483.55		ID Prefix Reg. # LSC	F0428 483.60(c)	Correction Completed 11/25/2016
ID Prefix Reg. # LSC	F0465 483.70(h)	Correction Completed 11/25/2016	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
REVIEWE STATE AG REVIEWE CMS RO	BENCY X	REVIEWED BY (INITIALS) TA/mm REVIEWED BY (INITIALS)	DATE 12/23/2016 DATE	SIGNATURE OF SURVEYOR 29433 TITLE		DATE	/2016
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?					

POST-CERTIFICATION REVISIT REPORT

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

ITEI	м	DATE	ITEM	DATE	ITEM	DATE	
Y4		Y5	Y4	Y5	Y4	Y5	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed	
LSC	K0052	11/14/2016	LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed	
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		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed	
LSC			LSC		LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/mm	DATE 12/23/2016	SIGNATURE OF SURVEYOR	29433	DATE 11/29/2016	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/18/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICATIO PART I - TO BE COMPLETED BY THE S							
1. MEDICARE/MEDICAID PROVIDER N (L1) 245245 2.STATE VENDOR OR MEDICAID NO. (L2) 936651200	0.	 NAME AND ADE (L3) HERITAGE N (L4) 321 NORTHE (L5) CHISHOLM, 	MANOR CAST SIXTH STR		(L	6) 55719	 TYPE OF ACTION: Initial Termination Validation 	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (1 13 PTIP	L7) 22 CLIA	 On-Site Visit Full Survey After Com 	9. Other plaint
6. DATE OF SURVEY 10/20, 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2016 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING E 06/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 70 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	70 (L18) 70 (L17) 19 SNF (L39) S (IF APPLICABLE S	X B. Not in Comp Requirements a ICF (L42)	ce With juirements Based On: cceptable POC bliance with Program nd/or Applied Waive IID (L43)	rs:	2. T 3. 2 4. 7. 5. L * Code: 15. FACILITY	echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code B *	Following Requirements: 6. Scope of Servic 7. Medical Directo 8. Patient Room Si 9. Beds/Room (L12) (L15)	es Limit r
17. SURVEYOR SIGNATURE	SWS	Date : 1	2/12/2016	(110)		URVEY AGENCY APP	PROVAL Enforcement Specialist	12/14/2016
	PART II - TO	BE COMPLETEI) BY HCFA RE	(L19) GIONAL	OFFICE OF	R SINGLE STAT	EAGENCY	(L20)
 DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Part 2. Facility is not Eligible 			PLIANCE WITH CI' TS ACT:	VIL	2		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-	1513)
22. ORIGINAL DATE OF PARTICIPATION 09/01/1982 (L24)	23. LTC AGREEMI BEGINNING I (L41)		 LTC AGREEMEN ENDING DATE (L25) 	ΫT	<u>VOLUNTARY</u> 01-Merger, Cl		05-Fail to Mee	<u>RY</u> t Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L44)			oluntary Termination on for Withdrawal	<u>OTHER</u> 07-Provider S 00-Active	tatus Change
28. TERMINATION DATE:	29 (L28)	INTERMEDIARY/C. 03001	(L45) ARRIER NO.	(L31)	30. REMARK	S		
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION O	F APPROVAL DATI	E (L33)	DETERMI	NATION APPROV	VAL	



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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Weath

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

		AND HUMAN SERVICES			FOF	MAPPROVED
	<u>IS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		тірі		O. 0938-0391 ATE SURVEY
-	F CORRECTION	IDENTIFICATION NUMBER:				OMPLETED
		245245	B. WING		1	0/20/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAG	E MANOR			-	21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	000		
F 309 SS=D	WILL SERVE AS YO COMPLIANCE UPO ACCEPTANCE. YC BOTTOM OF THE CMS-2567 FORM V VERIFICATION OF UPON RECEIPT O ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE WI 483.25 PROVIDE O HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho	COMPLIANCE. F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. CARE/SERVICES FOR	F 3	809		11/25/16
	by: Based on observat review, the facility fa positioning was ma enable feeding for 1 reviewed for positio Findings include:	NT is not met as evidenced ion, interview and document ailed to ensure proper intained during dining to 1 of 2 residents (R24) ning.			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	
	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(X6) DATE
Electron	ically 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.

PRINTED: 12/12/2016

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-039 SURVEY PLETED
		245245	B. WING			10/00/0010	
	PROVIDER OR SUPPLIER	245245	D. Willia		STREET ADDRESS, CITY, STATE, ZIP CODE	10/2	20/2016
	SE MANOR			3	21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	included hip fractur osteoarthritis. R24's quarterly Min 10/4/16, indicated F eating after staff se 9/5/16, indicated R2 eating. The care pla food to the table, pu items, butter bread. On 10/18/16, R24 w main dining room d 4:35 p.m. through 5 the wheelchair with the seat and her ba wheelchair. At the s of approximately fiv and the back of the received her meal of potatoes and gravy cranberry juice and while attempting to lean back and hold hand. R24 was tryin in the wheelchair. F approximately 10 in trying but was unab food. R24 dropped carrots on the table to fully extend her a	inum Data Set (MDS) dated R24 was independent with t up. R24's care plan dated 24 was independent with an directed staff to bring R24's ut within reach and set up , cut meat, open packages. was constantly observed in the uring the evening meal from 5:15 p.m. R24 was seated in her buttocks slid forward on tock against the back of the small of her back was a space ve inches between her back wheelchair. At 4:45 p.m. R24 of cubed carrots, mashed , a pastie (not cut), bread, coffee. During the entire meal feed herself R24 continued to onto the table with her left ng to push her buttocks back R24's torso area was toches from the table. R24 was ble to lean forward to reach the fork in her lap, there were e, R24 and the floor. R24 had arms to reach her plate. R24's ate onto the table. R24	F	309	 corrective action for resident R24 at by this practice by: On admission from the hospital 10/17/16 R24 was referred to Occupational Therapy (OT) to evaluher w/c positioning needs and was at treatment by OT on 10/18/16 when surveyor observed the resident duri AM meal. On 10/18/16, OT replace resident's wheelchair with a hi back which she utilized for the next week was then transitioned back to a star wheelchair as her condition had impenough to sit in the appropriate posher wheelchair. DON and/or designee will assess residents having the potential to be affected by this practice including: All residents who utilize wheelch the dining room have the potential to affected by a deficient practice in tharea. DON and/or designee will implement the including: All residents who utilize wheelch the dining room have the potential to the affected by a deficient practice in tharea. 	on uate under the ng the ed the chair, , and ndard proved ition in hairs in o be is nt ce he re that	
	attempted to cut the used her fork and fi but was unable and continued to slid off tablemate moved th	e pastie but was unable. R24 ingers to pull the pastie apart I did not eat it. The food f the edge of the plate. R24's ne dessert and coffee closer to R24 quit eating. R24 continued			Nursing staff will be re-educated repositioning residents in the dining at in-services on 11-15 and 11-16-2	room	

		AND HUMAN SERVICES				FORM	12/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245245	B. WING _			10/2	20/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR			-	11 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	to try to sit forward unable. R24 stated to eat." The tablem someone here to he assisted R24 to ren "I'll wait with you un you back to your roo food on R24's plate plate. Staff did not r the meal. There we dining room passing residents. At 5:15 p room. At that time s wheelchair. R24 sta was hurting through now that she was s she was still hungry she could. On 10/2/016, at 10: (RN)-B stated R24	by pulling on the table but was to the tablemate, "It's too hard ate stated, "You should have elp you." The tablemate nove the cover up and stated, til someone comes and takes om." The remainder of the was on the front 1/2 of the reposition or assist R24 with re several staff in the main g trays and assisting other o.m. staff brought R24 to her staff pulled R24 back in the ated she had sciatica, and it n supper, and she felt better itting back further. R24 stated v and would have eaten more if 00 a.m. registered nurse	F 30	09	 DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions includ. Random w/c positioning audits completed by DON/designee daily f 1wk, 3x/wk. for 2 weeks, 2x/wk. for weeks, and then monthly to ensure w/c positioning is being provided an for all residents as needed beginnin week of 11-21-2016. Audit results will be brought to t QAPI committee for review and furt recommendation. Completion Date: 11-25-2016 	will be or 2 proper d used g the he	
F 412 SS=D	assistance to eat. On 10/20/16, at 10: (DON) stated she w R24 and assist her A positioning during but not provided. 483.55(b) ROUTINI SERVICES IN NFS The nursing facility an outside resource §483.75(h) of this p covered under the S	15 a.m. the director of nursing yould expect staff to reposition to eat if needed. g meals policy was requested E/EMERGENCY DENTAL	F 41	12			11/25/16

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	12/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245245	B. WING	i		10/2	0/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR			-	21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	making appointment transportation to an must promptly refer damaged dentures This REQUIREMENt by: Based on observat review, the facility fa services to repair lo residents (R33) revi Findings include: R33's face sheet da diagnoses included reflux disease, and R33's quarterly Min 8/25/16, indicated F assistance with pers mechanically altere MDS also identified fitting full or partial of R33's care plan dat short term memory confusion/disorienta plan also indicated required limited ass directed nursing sta appointments as into plan goal for R33's optimum oral health	Accessary, assist the resident in hts; and by arranging for d from the dentist's office; and residents with lost or to a dentist. AT is not met as evidenced ion, interview, and document ailed to provide dental ose dentures for 1 of 3 iewed for dental. Atted 10/20/16, indicated R33's anemia, gastro-esophageal cerebrovascular disease. imum Data Set (MDS) dated R33 required extensive sonal hygiene, had a d diet, and weight loss. The R33 had broken or loosely dentures. ed 5/13/16, indicated had deficits with periods of ation/forgetfulness. The care R33 had dentures and istance with oral care, and diff to arrange dental dicated or requested. The care oral care was for R33 to have h.	F	412	 F412: Heritage Manor assists the residents in obtaining dental service Social Service and/or designee will implement corrective action for residents affected by this practice by: Resident R33 had a dental service appointment scheduled, however ship assed away on 11-07-2016. Social Service and/or designee will assess residents having the potential be affected by this practice including. All residents with dentures have potential to be affected by this defici practice. Social Service and/or designee will implement measures to ensure that practice does not recur including: Resident and/or responsible par be offered dental services at each residents quarterly care conference documented in the social services not service and services in the social services in	dent ices ne al to g: the ient this rty will and iotes.	
		nt care guide sheets indicated d assist of one staff for oral			 SS and nursing staff will be re-educated on the facility's Dental (assessment and process at in-service) 		

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ND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245245	B. WING			10/2	20/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE MANOR			-	21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
	cares. The care gui R33 had dentures.	de sheets lacked indication	F 4	12	11-15 and 11-16-2016.		
	indicated R33 daug services, but declin concerns.	press Notes dated 5/20/16, hter was offered dental ed and stated R33 had no			 DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions inclu Random audits of residents wirdentures 3x/wk. for 2 weeks, 2x/wk 	th k. for 2	
	through 6/30/16, ind The General Nurse 7/11/16, through 8/2 broken or loosely fit	bservations dated 5/26/16, dicated R33 had dentures. 's Observations completed 29/16, indicated R33 had ting dentures. General ns completed 9/8/16, through			weeks, and then monthly to ensure needs were assessed, services we offered prn, and care conference documentation is present beginning week of 11-21-2016.	ere	
	documentation of lo	R33 had dentures, but lacked bose-fitting dentures.			 Audit results will be brought to QAPI committee for review and fur recommendation. 		
	R33 had a mechan chew that texture e Notes dated 7/28/1	otes dated 6/23/16, indicated ical soft diet and was able to ffectively. Dietary Progress 6, indicated R33 had weight changed to a pureed diet per ommendations.			Completion Date: 11-25-2016		
	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.						
	dentures were loos and had not been a dentist. R33's dentu time to be loose in l R33 stated staff we	3 p.m. R33 stated her e, she had not seen a dentist, sked if she wanted to see a ures were observed at that her mouth and falling down. re aware of her loose uff on them, but it doesn't last. ns chewing.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245245	B. WING		·····	10/:	20/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	E MANOR				21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 412	(RN)-C stated oral a had noted R33 had document loose deshould be asking ar regarding dental state of the RN had t request, and R33's ask if R33 had a de asks on admission during interviews widenture being loose. On 10/20/16, at 3:0 called SW-B, and s dentist, but could se stated the facility we appointment with a transportation. On 10/20/16, at 3:5 documents a visual just documents if th RN-B stated she loo morning before the day. RN-B stated the oral about a dental visit significant change N On 10/20/16, at 4:1 (DON) stated the oral they talk about conference. DON s were a potential fac DON verified the dot dentures were loose contact the family a conference.	 assessments are done and dentures, but did not nures. RN-C verified they nd documenting quarterly atus in social services notes. 1 p.m. social worker (SW)-B cold her about the dental visit granddaughter was called to entist. SW-B stated the facility and annually. SW-B stated ith R33, she had not noted the set of the R33 did not have a see a dentist if needed. SW-B could attempt to make an dentist and set up 6 p.m. RN-B stated she oral assessment, but usually se resident has dentures. coks at the resident in the y have their dentures in for the twith the initial, annual and MDS's. 3 p.m. director of nursing ral status is assessed annually it during the resident's care tated R33's loose dentures coumentation indicated R33's e and state the facility should 	F 4	112			

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TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	IPLE CONSTRUCTION		(X3) DAT	<u>. 0938-039</u> E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		NG			IPLETED
		245245	B. WING			10/	20/2016
NAME OF I	PROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CODE		
HERITAC	E MANOR			321 NORTHEAS CHISHOLM, M	T SIXTH STREET N 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOL EFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 412	had not been follow not been offered.	ge 6 /ed-up on, and services had able to provide a policy and	F 4	12			
F 428 SS=D	procedure regardin	g dental services. EGIMEN REVIEW, REPORT	F 4	28			11/25/16
	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.						
	the attending physic	ist report any irregularities to cian, and the director of reports must be acted upon.					
	by:	NT is not met as evidenced		E 400: 11-ri	·····		
failed to act recommend residents (F	failed to act on the recommendations i	v and document, the facility consultant pharmacist n a timely manner for 1 of 5 iewed for unnecessary		Pharmacy drug irregu DON and/c	or designee will impler	garding	
	Findings include:			were review	Pharmacy recomment wed by the resident's	Physician	
	indicated diagnoses behavioral disturba	ease History, printed 10/20/16, s that included dementia with nces, and severe recurring ychological symptoms.		and a trial r began on 1 of the 3 me to original o	reduction of the medic 10-18-2016. On 11-01 edications were increa dosages. The Physici a risk versus benefit fo	ations -2016 2 sed back an will	
	10/11/16, indicated	num Data Set (MDS), dated R27 was severely cognitively no delirium, hallucinations or			tic medication by 11-2		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245245 **B** WING 10/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET HERITAGE MANOR CHISHOLM, MN 55719 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 428 Continued From page 7 F 428 delusions and minimal signs of depression. The DON and/or designee will assess MDS further indicated R27 exhibited behavior 1-3 residents having the potential to be days in the assessment period that included affected by this practice including: verbal and physical behaviors towards others and All residents are potentially affected to herself, but did not pose a significant risk to by this practice. others or herself, nor did these behaviors impact her life. R27's MDS also indicated R27 had received antipsychotic, antianxiety and DON and/or designee will implement antidepressant medications each day of the measures to ensure that this practice assessment period. does not recur including: All other residents Pharmacist's Review of R27's medical record revealed Monthly Drug Regimen Reviews were consultant pharmacist reviews monthly for 2016. reviewed for proper follow-up. The months of February, April and August 2016, the reviews noted, "Irregularities identified. See Nursing staff will be re-educated on Report." The consultant pharmacist requested a the updated process for following up on risk versus benefit for the use of R27's Seroquel the Pharmacist's Monthly Drug Regimen (an antipsychotic medication). The Report Review (DRR) at in-services held on 11indicated no change in dosage was 15 and 11-16-2016. recommended, however a risk versus benefit documentation was required. This Pharmacy consultant and DON will make sure that MD will write a statement. recommendation was accepted and signed by the director of nursing (DON) and an attending Pharmacy consultant will alert a DON if physician, however lacked a risk vs. benefits the risk/benefit statement is not written statement. and needs to be readdressed. Nursing staff will fax a physician the request and R27's medical record lacked a risk versus benefit not wait until another rounding day. for the continued use of the medication. On 10/19/16, at 1:40 p.m. registered nurse DON and/or designee will monitor (RN)-C stated recommendations are faxed when corrective actions to ensure the immediate action was needed, or they were put in effectiveness of these actions including: the rounds book for physicians to address on Monthly audits of Pharmacists DRR their next rounds. RN-C confirmed not been will be performed to ensure ongoing addressed by the physician and there was no compliance beginning after his next obvious risk versus benefit for R27's medications review. including the Seroguel as requested in February, April, and August. RN-C stated a substitute Audit results will be brought to the physician had rounded in August and R27's QAPI committee for review and further

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM A	12/12/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(E SURVEY PLETED
		245245	B. WING _			10/2	20/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
HERITAC	GE MANOR			321 NORTHEAST SIXTH STREE CHISHOLM, MN 55719	ſ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD I THE APPROPR	BE	(X5) COMPLETION DATE
F 428	Continued From pa primary physician r	ige 8 ounded earlier in October.	F 42	8 recommendation.			
	pharmacist recomm a physician if they r away or put in the c stated she would ex the recommendation rounding. RN-B state was requested in F	08 a.m. RN-B, stated nendations are either faxed to need to be addressed right doctor's rounding book. RN-B xpect the physician to address on (accept or reject) at the next ated if a risk versus benefit ebruary, she would expect the e addressed at the next est.		Completion Date: 11-25-	·2016		
	consultant pharmac facility. After his re the recommendation recommendation sl book to agree or dis times they won't ge	5 p.m. the DON stated the cist comes monthly to the views, he emails sheets with ons and she will put the heets in the physician's rounds sagree. The DON stated at t discussed and she will try to mmendation at the next					
	pharmacist stated h a risk versus benef from February or A the recommendation	3 p.m. the consultant ne has not received a reply or it on his recommendations pril, which is why he rewrote on in August. The consultant ed he resent the April report to 10/19/16.					
F 465 SS=B	following the pharm 483.70(h)	able to provide a policy on nacist's recommendations. AL/SANITARY/COMFORTABL	F 46	5			11/25/16
	The facility must pr	ovide a safe, functional,					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 245245 B. WING 10/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET HERITAGE MANOR CHISHOLM, MN 55719 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 465 Continued From page 9 F 465 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced bv: F465: Heritage Manor provides a safe, Based on observation, interview and document functional, sanitary and comfortable review, the facility failed to ensure 9 of 35 resident rooms, a tub room, and the facility dining environment for residents, staff and the room were well maintained and clean. public. Findings include: ESD and/or designee will implement corrective action by: During an environmental tour on 10/20/16, at 9:21 Issues in rooms 307, 311, 313, 401-1, a.m. the following was observed and confirmed 405, 412, 413-1, 413-2, and 414-1 were by the Environmental Services Director (ESD): cleaned and/or repaired. Room 307 had large dark gray stain The shower ramp is being repaired approximately two feet long on the bathroom and will be completed by 11-22-2016. floor. In addition the bedroom door had an area of chipped wood near the inner edge of the handle, The tiles needing replacement had approximately 3 inches by 3 inches that caused a been on a list that was being written until rough uncleanable surface. there were enough tiles for a tile layer to feel it was enough to justify coming to the Room 311 had a wall that was scraped and facility. marred. Room 313 had stained ceiling tiles and flies in the ESD and/or designee will assess residents having the potential to be light fixtures. affected by this practice including: Room 401-1 had wall paint chipped down to All residents are potentially affected exposed sheet rock behind the recliner and by this practice. 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 ESD and/or designee will implement therapy department and agreed it was not a measures to ensure that this practice cleanable surface. In addition there were scuff does not recur including: marks on the wall behind the recliner. Housekeeping and Nursing staff will

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PRINTED: 12/12/2016

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245245 B. WING 10/20/2016 NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	ON	FORM MB NO.	12/12/2016 APPROVED 0938-0391 SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HERITAGE MANOR 321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719 IX4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x4) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x6) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x6) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x7) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x7) (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 465 Room 412 had gouges in the bathroom way and scaapes on the bathroom doorway. 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.	AND PLAN C)F CORRECTION						
HERITAGE MANOR 321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719 Image: CACH DEFICIENCY MUST BE PRECEDED BY FULL 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 BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CHISHING CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMIPLET CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY) CMIPLET CROSS TO THE APPR			245245	B. WING			10/2	20/2016
HERITAGE MANOR CHISHOLM, MN 55719 Image: Chick of the set of th	NAME OF I	PROVIDER OR SUPPLIER						
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLET DATEF 465Continued From page 10F 465Room 412 had gouges in the bathroom way and scrapes on the bathroom doorway.F 465Room 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.F 465Room 413-2 had gouges in the wall above the bed.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.EMD and the soon as practicable.	HERITAC	E MANOR						
 Boom 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 413-1 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 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. 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
 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	Room 412 had gou scrapes on the bath Room 413-1 had a register in the room stained ceiling tile, I and duct tape on th Room 413-2 had go bed. Room 414-1 had m behind and next to the sink. In addition dark marring on bot bathroom door had The dining room ha in dining room entry corners pulling up), framed the front an room (doorways), b below the serving c extinguisher, and in The shower ramp in cracked, had dark s repair. The facility was una	ges in the bathroom way and nroom doorway. brown stain under the heat a flies in the bathroom light, a broken floor tile under the sink e toilet top. buges in the wall above the oisture staining on the wall the toilet, and on the tile under a, the bedroom floor tile has th side of the bed and the several dark marred areas. Ad floor tiles that were cracked y way hutch (areas had between the pillars that d back area of the first dining by the door to the serving area, ounter, below the fire a front of the ice machines. In the C Hall tub room was stains and was in need of	F 4	465	 notifying maintenance for any extra cleaning or repairs needed in the fain-services on 11-15 and 11-16-2014 ESD and/or designee will monitor corrective actions to ensure the effectiveness of these actions include. Maintenance Director is roundir 1x/wk. for 4 weeks, then monthly to for any areas that need extra cleani repair. These issues will be put on a calendar to be addressed as soon a practicable. Administrator/designee will contrandom observational audits of the set are being identified and addressed. Audit results will be brought to t QAPI committee for review and furth recommendation. 	cility at 6. ding: ng check ng or a as duct facility issues the	

Facility ID: 00904

If continuation sheet Page 11 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

IJ2USD26

PRINTED: 11/17/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		1	00400000	1	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION 01 - HERITAGE MANOR		E SURVEY PLETED
		245245	B, WING			10/	18/2016
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE MANOR				HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.					
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN 'ITH YOUR VERIFICATION.					
	Minnesota Departr Fire Marshal Divisi Heritage Manor wa compliance with th in Medicare/Medic 483.70(a), Life Sat edition of National	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, as found not in substantial e requirements for participation aid at 42 CFR, Subpart for Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), g Health Care.				_	
	PLEASE RETURN CORRECTION FO DEFICIENCIES TO	OR THE FIRE SAFETY			EPOC	a g	
	STATE FIRE MAR	STREET, SUITE 145					
LABORATOR	RY DIRECTOR'S OR PROV	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

11/14/2016

Electronically Signed

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.

Facility ID: 00904

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - HERITAGE MANOR	(X3) DA1	TE SURVEY MPLETED
		245245	B. WING		10	/18/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 321 NORTHEAST SIXTH STREE CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of y to correct the defic 2. The actual, or pr 3. The name and/or responsible for cor prevent a reoccurre Heritage Manor, is basement. The orig in 1953 and was do construction. In 19 constructed to the be of Type II(111) or original building an	: itate.mn.us n@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done	KOC			
	The building also h attached that is pro The building is fully facility has a fire al detection in the co corridors that is mo department notifica have either heat de	y sprinklered throughout, the larm system with smoke rridors and spaces open to the onitored for automatic fire ation. Other hazardous areas etection or smoke detection alarm system in accordance		Facility ID: 00904	If continuation s	hoat Page 2 of

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION 01 - HERITAGE MANOR	(X3) DATE S COMPL	
		245245	B. WING		10/18	8/2016
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR			21 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000		State Fire Code, apacity of 78 beds and had a	K 000			
K 052 SS=E	The requirement at NOT MET. NFPA 101 LIFE SA A fire alarm system be, tested, and ma NFPA 70 National National Fire Alarm available. The syst maintenance and t	e time of the survey. t 42 CFR, Subpart 483.70(a) is FETY CODE STANDARD in required for life safety shall intained in accordance with Electric Code and NFPA 72 in Code and records kept readily em shall have an approved esting program complying with nent of NFPA 70 and 72.	K 052		1	1/14/16
	This STANDARD Based on observa facility failed to insi system in accorda 2000 NFPA 101, S well as 1999 NFPA 2-3.5.1. These de adversely affect th system that could emergency actions affecting 30 of 62	is not met as evidenced by: tition and staff interview, the tall and maintain the fire alarm nce with the requirements of ections 19.3.4.1 and 9.6, as A 72, Sections 2-3.4.5.1.2, ficient practices could e functioning of the fire alarm delay the timely notification and s for the facility thus negatively residents, as well as an aber of staff, and visitors		K052 CHC will properly test and maintain fire alarm system. In order to comply with 2000 NFPA Sections 19.3.4.1 and 9.6, as well a NFPA 72, Sections 2-3.4.5.1.2, 2-3 The smoke detector located by res rooms 205 and 304 were moved to more than the required 36 inches from a HVAC vent diffuser. All other smoke detectors were inspected for	a 101, as 1999 .5.1. ident o be away er	
	on 10/18/2016, ob smoke detector lo	ween 11:00 a.m. to 2:00 p.m. servation revealed, that the cated by resident rooms 205 alled within 36 inches of a		compliance. Completion Date: 11/14/2016		

PRINTED: 11/17/2016

		AND HUMAN SERVICES			FORM): 11/17/2016 APPROVED): 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - HERITAGE MANOR	(X3) DA COI	TE SURVEY MPLETED
		245245	B. WING		10	/18/2016
NAME OF I	PROVIDER OR SUPPLIER	Į	1	STREET ADDRESS, CITY, STATE, ZIF		
HERITAC	E MANOR			321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 052	Continued From pa	age 3	КO	52		
	This deficient cond Maintenance Supe	ition was verified by a rvisor.				
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 84	RS21	Facility ID: 00904	If continuation s	heet Page 4 of



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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00904	B. WING		10/2	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIX M, MN 5571			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff the following correct indicate in your elect you have reviewed date when they will Minnesota Departm	gh 10/20/16, surveyors of this visited the above provider and tion orders are issued. Please ctronic plan of correction that these orders, and identify the				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 11/14/16

STATE FORM

6899

If continuation sheet 1 of 18

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		10/	20/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
HERITAC	E MANOR		THEAST SIXT .M, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	Federal software. T	Correction Orders using ag numbers have been ota state statutes/rules for				
	column entitled "ID statute/rule number the state statute/rul in the "Summary St column and replace the correction order the findings which a statute after the sta as evidenced by." F	umber appears in the far left Prefix Tag." The state and the corresponding text of e out of compliance is listed atement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met following the surveyors' ggested Method of Correction d For Correction.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 905	MN Rule 4658.052	5 Subp. 4 Rehab - Positioning	2 905			11/25/16
	positioned in good I of residents unable must be changed a including periods of been put to bed for has documented th hours during this tir	g. Residents must be body alignment. The position to change their own position t least every two hours, time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval.				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00904	B. WING		10/	20/2016
	PROVIDER OR SUPPLIER		DRESS. CITY.	STATE, ZIP CODE		20/2010
	BE MANOR			TH STREET		
		CHISHOL	M, MN 5571	9		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 905	Continued From pa	ige 2	2 905			
	by: Based on observati review, the facility f positioning was ma	ent is not met as evidenced ion, interview and document ailed to ensure proper intained during dining to 1 of 2 residents (R24) oning.		Corrected		
	Findings include:					
	printed 10/20/16, in	gnosis and Allergy sheet dicated R24's diagnoses e, muscle weakness and				
	10/4/16, indicated F eating after staff se 9/5/16, indicated R2 eating. The care pla food to the table, pl	imum Data Set (MDS) dated R24 was independent with it up. R24's care plan dated 24 was independent with an directed staff to bring R24's ut within reach and set up , cut meat, open packages.				
	main dining room d 4:35 p.m. through 5 the wheelchair with the seat and her ba wheelchair. At the s of approximately fiv and the back of the received her meal of	was constantly observed in the luring the evening meal from 5:15 p.m. R24 was seated in her buttocks slid forward on ack against the back of the small of her back was a space ve inches between her back wheelchair. At 4:45 p.m. R24 of cubed carrots, mashed				
	cranberry juice and while attempting to lean back and hold hand. R24 was tryir	r, a pastie (not cut), bread, coffee. During the entire meal feed herself R24 continued to onto the table with her left ng to push her buttocks back R24's torso area was				

Minneso	ota Department of He	alth				APPROVE
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		10/	20/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
HERITA	GE MANOR		THEAST SIXT M, MN 55719.			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 905	approximately 10 in trying but was unab food. R24 dropped carrots on the table to fully extend her a bread slid off the pla attempted to cut the used her fork and fi but was unable and continued to slid off tablemate moved th R24. At 5:05 p.m. F to try to sit forward unable. R24 stated to eat." The tablema someone here to he assisted R24 to ren "I'll wait with you un you back to your roo food on R24's plate plate. Staff did not r the meal. There we dining room passing residents. At 5:15 p room. At that time s wheelchair. R24 state was hurting through now that she was s she was still hungry she could. On 10/20/16, at 10: (RN)-B stated R24 repositioned in the assistance to eat.	ches from the table. R24 was le to lean forward to reach the fork in her lap, there were , R24 and the floor. R24 had irms to reach her plate. R24's ate onto the table. R24 e pastie but was unable. R24 ngers to pull the pastie apart did not eat it. The food the edge of the plate. R24's ne dessert and coffee closer to 824 quit eating. R24 continued by pulling on the table but was to the tablemate, "It's too hard ate stated, "You should have elp you." The tablemate nove the cover up and stated, til someone comes and takes om." The remainder of the was on the front 1/2 of the reposition or assist R24 with re several staff in the main g trays and assisting other .m. staff brought R24 to her taff pulled R24 back in the ted she had sciatica, and it a supper, and she felt better itting back further. R24 stated and would have eaten more if 00 a.m. registered nurse should have been wheelchair and/or received				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00904	B. WING		10/	20/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
HERITAC	GE MANOR		RTHEAST SIXT LM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 905	Continued From pa	ige 4	2 905			
	A positioning during but not provided.	g meals policy was requested				
	SUGGESTED MET	HOD OF CORRECTION:				
	develop, review, an procedures to ensu positioned. The Director of Nur educate all appropr procedures. The Director of Nur	rsing or designee could id/or revise policies and ire residents are properly rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	9			
21325	MN Rule 4658.072 Emergency Oral He	5 Subp. 1 Providing Routine & ealth Ser	21325			11/25/16
	home must provide resource, routine de needs of each resid include dental exam fillings and crowns, oral surgery, bridge orthodontic procede that are provided for	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, es and removable dentures, ures, and adjunctive services or similar dental patients in the , as limited by third party icies.				
	by:	ent is not met as evidenced ion, interview, and document		Corrected		

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		10/20/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXT LM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21325	Continued From pa	age 5	21325			
	services to repair lo residents (R33) rev	bose dentures for 1 of 3 riewed for dental.				
	Findings include:					
	diagnoses included	ated 10/20/16, indicated R33's I anemia, gastro-esophageal cerebrovascular disease.				
	8/25/16, indicated F assistance with per mechanically altere	nimum Data Set (MDS) dated R33 required extensive rsonal hygiene, had a ed diet, and weight loss. The R33 had broken or loosely dentures.				
	short term memory confusion/disorient plan also indicated required limited ass directed nursing sta appointments as in	ted 5/13/16, indicated had deficits with periods of ation/forgetfulness. The care R33 had dentures and sistance with oral care, and aff to arrange dental dicated or requested. The care oral care was for R33 to have h.				
	R33 required limite	ant care guide sheets indicated d assist of one staff for oral ide sheets lacked indication	ŀ			
	indicated R33 daug	gress Notes dated 5/20/16, ghter was offered dental led and stated R33 had no				
	through 6/30/16, in The General Nurse	bservations dated 5/26/16, dicated R33 had dentures. 's Observations completed 29/16, indicated R33 had				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00904	B. WING		10/	20/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXT _M, MN 55719	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21325	Continued From pa	ae 6	21325	DEFICIENC	Y)	
21020	broken or loosely fi Nurse's Observatio 10/13/16, indicated	tting dentures. General ns completed 9/8/16, through R33 had dentures, but lacked pose-fitting dentures.				
	R33 had a mechan chew that texture e Notes dated 7/28/1	otes dated 6/23/16, indicated ical soft diet and was able to ffectively. Dietary Progress 6, indicated R33 had weight changed to a pureed diet per ommendations.				
	indicated R33 was to make her needs	ress Notes dated 8/31/16, cognitively intact and was able known, but lacked arding dental services.				
	dentures were loos and had not been a dentist. R33's dentu time to be loose in R33 stated staff we	3 p.m. R33 stated her e, she had not seen a dentist, isked if she wanted to see a ures were observed at that her mouth and falling down. re aware of her loose uff on them, but it doesn't last. ns chewing.				
	(RN)-C stated oral had noted R33 had document loose de should be asking at	12 a.m. registered nurse assessments are done and dentures, but did not ntures. RN-C verified they nd documenting quarterly atus in social services notes.				
	stated the RN had t request, and R33's ask if R33 had a de asks on admission	1 p.m. social worker (SW)-B told her about the dental visit granddaughter was called to entist. SW-B stated the facility and annually. SW-B stated ith R33, she had not noted the e.				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		10/20/2	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21325	Continued From pa	ige 7	21325			
	called SW-B, and s dentist, but could so stated the facility w appointment with a transportation. On 10/20/16, at 3:5	95 p.m. R33's granddaughter stated R33 did not have a ee a dentist if needed. SW-B ould attempt to make an dentist and set up 66 p.m. RN-B stated she I oral assessment, but usually				
	just documents if th RN-B stated she lo morning before the day. RN-B stated th	ne resident has dentures. oks at the resident in the y have their dentures in for the ney usually ask the resident with the initial, annual and				
	(DON) stated the o and they talk about conference. DON s were a potential fac DON verified the do dentures were loos contact the family a documentation indi	3 p.m. director of nursing ral status is assessed annually it during the resident's care stated R33's loose dentures of in R33's nutritional intake. becumentation indicated R33's e and state the facility should again. DON verified cated R33's loose dentures yed-up on, and services had	/			
	The facility was una procedure regardin	able to provide a policy and g dental services.				
	SUGGESTED MET	HOD OF CORRECTION:				
	develop, review, an procedures to ensu- health including pro The Director of Nur	rsing or designee could Ind/or revise policies and Ire residents have optimal oral oper fitting dentures. rsing or designee could riate staff on the policies and				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	- (X3) DATE SURVEY COMPLETED	
		00904	B. WING		10/	20/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21325	Continued From pa	ige 8	21325			
		rsing or designee could systems to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	•			
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			11/25/16
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement (b) Written complia	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines.	t			
	be maintained by th This MN Requirem by: Based on interview facility failed to ens			Corrected		

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00904	B. WING		10/20/2016	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
HERITA	GE MANOR		THEAST SIXT _M, MN 55719			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET
21426	Continued From pa	ige 9	21426			
nnesota	skin test (TST). In ensure 1 of 5 reside step TST according Control & Preventic Findings include: The CDC Guideline Transmission of My Health Care Setting residents must rece The baseline TB so assessment for TB assessment for the p mycobacterium tub R76 was admitted t R76's Baseline TB was undated. R76' administration reco indicated R76 had n 5/15/15. R76's ele administration reco indicated R76's firs 5/15/15 (same day medical record lack administration of th R11 was admitted t Baseline TB Screen dated as being com EMAR dated 5/11/1 the first step TST o TST test had been completion of the w tool being complete R109 was admitted R109's Baseline TB was undated. R109 indicated R109 had	to the facility on 5/15/15. Screening Tool for Patients s electronic medication rd (EMAR) dated 5/15/15, received the first step TST on ectronic treatment rd (ETAR) dated 5/15/15, t step TST had been read on as administration). R76's ked documentation of e second step TST. o the facility on 5/11/15. R11's hing Tool for Patients was hpleted on 5/12/15. R11's 5, indicated R11 had received n 5/11/16 (which indicated the administered prior to the written screening assessment				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		10/	20/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
IERITAG	E MANOR		THEAST SIXTI _M, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21426	Continued From pa	ige 10 45 a.m. registered nurse	21426			
	findings. RN-A stat be done upon admit the administration of addition, the first stat third day after admit step TST given on a this information sho resident's medical r Tuberculosis Policy resident admitted to to have a written as risk factors for TB a symptoms and a st within 72 hours after addition, when read confirm that the TS within 48-72 hours step of the TST mu	ponfirmed the above noted ted the TB screening should ission and completed prior to of the first step of the TST. In ep TST should be read on the inistration and then the second day 15. RN-A confirmed all of build be documented in the record. If dated 3/5/16, indicated each to the facility would be required sessment of the resident's along with any current TB andard two-step TST initiated er admission to the facility. In ding the TST, staff should T had been administered prior to reading. The second ust be repeated within 1-3 te that the initial TST was read.				
	The director of nurs develop, review, an procedures to ensu screened for TB an administered appro designee could dev ensure ongoing cor	priately. The DON or velop monitoring systems to				
21530	MN Rule 4658.1310	0 A.B.C Drug Regimen Review	21530			11/25/16
	reviewed at least m	en of each resident must be onthly by a pharmacist by the Board of Pharmacy.				

PHEERX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) PHEERX TAG CROCHARCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 11 21530 211530 Continued From page 11 21530 21530 21530 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 Ioan 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 accted 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 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 Phetery astate Phetery astate Phetery a		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
MARE OF PROVIDER OR SUPPLER STREET ADDRESS, CITY. STATE. ZIP CODE 321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION, TAG PROVIDERS PLAN OF CORRECTION IEACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION, TAG PROVIDERS PLAN OF CORRECTION IEACH ORTHORY OR LSC DENTIFYING INFORMATION, TAG PROVIDERS OF TO SHOULD BE COLSPAND OF CONTRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY 21530 Continued From page 11 21530 Continued From page 11 21530 SUMMARY STATEMENT OF DEFICIENCIES Surveyor Procedures for Pharmaceutical Services Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary Ioan system. It is not solpert of frequent change. B. The pharmacist must report any irregularities to the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician, 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 erder and the attending physician for review to the quality assessment and assurance committer required by part 4658.0070. If the attending physician is the m			00904	B. WING		10/	20/2016
HERITIGGE MANON CHISHOLM, MN 55719 (X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION ECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) OC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21530 This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Services 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 Ioan 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 Delivers 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 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		PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		20/2010
(M4) D PPEFX TAG Use of the state of the	HERITAG	E MANOR					
This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Services 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, or does not provide adequate justification, and the pharmacists 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 ender and if the attending physician does not chave adequate justification for the order and if the attending physician does not chave adequate justification for the order and if the attending physician does not chave adequate justification for the order and if the attending physician does not chave 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	PRÉFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLET DATE
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 pharmacists 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 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	21530	Continued From pa	ige 11	21530			
must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced		Appendix N of the S Surveyor Procedure Requirements in Lo the Department of I Health Care Finance This standard is in available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or s pharmacist. For pu upon" means the a report and the sign of nursing services C. If the attend with the pharmacis not provide adequa pharmacist believe being adversely aff refer the matter to to if the medical direct physician does not must be referred fo assessment and as by part 4658.0070. the medical director must refer the matter assessment and as	State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan abject to frequent change. acist must report any director of nursing services abysician, and these reports in by the time of the next ooner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. Ing physician does not concur t's recommendation, or does the justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter r review to the quality surance committee required If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.				
by: Based on interview and document, the facility		by:			Corrected		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		10/	20/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HERITAC	E MANOR		THEAST SIXT M, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ige 12	21530			
	recommendations i	consultant pharmacist n a timely manner for 1 of 5 iewed for unnecessary				
	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.					
	10/11/16, indicated impaired, exhibited delusions and minin MDS further indicat days in the assess verbal and physical to herself, but did n others or herself, nu her life. R27's MDS received antipsycho	num Data Set (MDS), dated R27 was severely cognitively no delirium, hallucinations or mal signs of depression. The ted R27 exhibited behavior 1-3 ment period that included I behaviors towards others and ot pose a significant risk to or did these behaviors impact also indicated R27 had otic, antianxiety and dications each day of the				
	consultant pharmac The months of Feb the reviews noted, Report." The consu- risk versus benefit (an antipsychotic m indicated no chang recommended, how documentation was	vever a risk versus benefit				
nnesota D	director of nursing	(DON) and an attending lacked a risk vs. benefits				

Minnesota Department of Health STATE FORM

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If continuation sheet 13 of 18

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		10/	20/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
IERITAC	GE MANOR		THEAST SIXT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ige 13	21530			
	R27's medical record lacked a risk versus benefit for the continued use of the medication.					
	(RN)-C stated reco immediate action w the rounds book for their next rounds. F addressed by the p obvious risk versus including the Seroq April, and August. F physician had round	0 p.m. registered nurse mmendations are faxed when vas needed, or they were put in r physicians to address on RN-C confirmed not been hysician and there was no benefit for R27's medications uel as requested in February, RN-C stated a substitute ded in August and R27's ounded earlier in October.	1			
	pharmacist recomm a physician if they r away or put in the c stated she would ex the recommendation rounding. RN-B state was requested in F	08 a.m. RN-B, stated nendations are either faxed to need to be addressed right doctor's rounding book. RN-B xpect the physician to address on (accept or reject) at the next ated if a risk versus benefit ebruary, she would expect the e addressed at the next est.				
	consultant pharmad facility. After his re the recommendation recommendation sl book to agree or dis times they won't ge	55 p.m. the DON stated the cist comes monthly to the views, he emails sheets with ons and she will put the heets in the physician's rounds sagree. The DON stated at t discussed and she will try to mmendation at the next				
	pharmacist stated h	3 p.m. the consultant ne has not received a reply or it on his recommendations				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		10/	20/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
HERITAC	E MANOR		THEAST SIXT	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	ge 14	21530			
	the recommendation pharmacist confirm the facility DON on					
		able to provide a policy on acist's recommendations.				
	SUGGESTED MET	HOD OF CORRECTION:				
	develop, review, an procedures to ensu- recommendations a acted upon within a of residents The Director of Nur educate all appropri procedures. The Director of Nur	rsing or designee could id/or revise policies and are consultant pharmacist are rejected, or accepted and a timely manner to the benefit rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21685	MN Rule 4658.141 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			11/25/16
	including walls, floc systems, and equip continuous state of with regard to the h well-being of the re	blant. The physical plant, brs, ceilings, all furnishings, oment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	This MN Requirem	ent is not met as evidenced				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		10/	20/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIX LM, MN 5571	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From pa	ige 15	21685			
	review, the facility f	ion, interview and document ailed to ensure 9 of 35 ub room, and the facility dining intained and clean.		Corrected		
	Findings include:					
	a.m. the following v	nental tour on 10/20/16, at 9:21 vas observed and confirmed tal Services Director (ESD):				
	floor. In addition the chipped wood near	feet long on the bathroom e bedroom door had an area o the inner edge of the handle, ches by 3 inches that caused a				
	Room 311 had a wa marred.	all that was scraped and				
	Room 313 had stai light fixtures.	ned ceiling tiles and flies in the	•			
		all paint chipped down to c behind the recliner and bed off to the metal.				
	rails. The ESD state therapy departmen	e foam taped to bilateral side ed this was added by the t and agreed it was not a In addition there were scuff behind the recliner.				
	Room 412 had gou scrapes on the bat	ges in the bathroom way and nroom doorway.				
		brown stain under the heat n, flies in the bathroom light, a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00904	B. WING		10/	20/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HERITAG	E MANOR		THEAST SIXT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21685	Continued From pa	ige 16	21685			
	stained ceiling tile, and duct tape on th	broken floor tile under the sink te toilet top.				
	Room 413-2 had go bed.	ouges in the wall above the				
	behind and next to the sink. In addition dark marring on bo	oisture staining on the wall the toilet, and on the tile under h, the bedroom floor tile has th side of the bed and the several dark marred areas.				
	in dining room entry corners pulling up), framed the front an room (doorways), b below the serving o	ad floor tiles that were cracked y way hutch (areas had between the pillars that d back area of the first dining by the door to the serving area, counter, below the fire a front of the ice machines.				
		n the C Hall tub room was stains and was in need of				
		able to provide a policy on n, homelike environment.				
	SUGGESTED MET	HOD OF CORRECTION:				
	develop, review, an procedures to ensu	vironment or designee could Id/or revise policies and Ire consultant resident rooms is are kept clean and in good				
	The Director of Envelopment educate all appropri procedures.	vironment or designee could riate staff on the policies and vironment or designee could				
nagata D		systems to ensure ongoing				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		10/20/2016	
	00904					
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ERITAG	E MANOR		THEAST SIXT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	CTION SHOULD BE COMPLET THE APPROPRIATE DATE	
21685	Continued From page 17		21685			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				