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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MXTE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00288

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245405**

2.STATE VENDOR OR MEDICAID NO.
(L2) **924240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HERITAGE LIVING CENTER**
(L4) **619 WEST SIXTH STREET**
(L5) **PARK RAPIDS, MN** (L6) **56470**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/04/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)
13.Total Certified Beds **52** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathleen Lucas, Unit Supervisor 10/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 10/13/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/05/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245405 October 9, 2017

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, MN 56470

Dear Mr. Hansen:

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 September 26, 2017 the above facility is recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 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.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 9, 2017

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, MN 56470

RE: Project Number S5405028

Dear Mr. Hansen:

On September 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 17, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 4, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 27, 2017 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 August 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 26, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 17, 2017, effective September 26, 2017 and therefore remedies outlined in our letter to you dated September 1, 2017, 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 electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697
cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 9, 2017

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, MN 56470

Re: Reinspection Results - Project Number S5405028

Dear Mr. Hansen:

On October 4, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 17 with orders received by you on September 1, 2017. At this time these correction orders were found corrected.

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.

Please feel free to call me with any questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MXTE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00288

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245405**

2.STATE VENDOR OR MEDICAID NO.
(L2) **924240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HERITAGE LIVING CENTER**
(L4) **619 WEST SIXTH STREET**
(L5) **PARK RAPIDS, MN** (L6) **56470**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/17/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
LoAnne DeGagne, HFE - NE II 09/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 10/03/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 1, 2017

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, MN 56470

RE: Project Numbers S5405028 & H5405013

Dear Mr. Hansen:

On August 17, 2017, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the August 17, 2017 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5405013 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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 September 26, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 26, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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.

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 November 17, 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 February 17, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

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 electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	**619 WEST SIXTH STREET PARK RAPIDS, MN 56470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On August 14, 15, 16, and 17, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5405013 was completed. The complaint was not substantiated.	F 000		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 166		9/11/17

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

Electronically Signed | 09/05/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	**619 WEST SIXTH STREET PARK RAPIDS, MN 56470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 1 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	**619 WEST SIXTH STREET PARK RAPIDS, MN 56470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 2 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure efforts were made to resolve a concern related to missing compression stockings for 1 of 2 residents (R69) reviewed for missing personal property. Findings include:	F 166	It is the policy and procedure of HLC to resolve any verbalized concerns of residents in cases of missing items, concerns of environmental temperatures, or any concerns verbalized. 1. Corrective Action: DON called Drug Store and ordered new compression	

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F 166	Continued From page 3 R69's Admission Record, dated 7/24/17, identified diagnoses which included weakness, multiple fractures, acute pain due to trauma, and localized edema. R69's admission Minimum Data Set (MDS), dated 8/6/17, identified R69 was cognitively intact and required extensive assistance for dressing and personal hygiene. R69's physician orders, dated 7/25/17, included, "Apply Ted hose compression stockings [fitted stockings used to decrease swelling in legs] in AM-off PM. Dx [diagnosis] edema." R69's initial careplan, dated 8/9/17, directed staff to observe for signs of increased edema/increased weight related to fluid retention and to document and report to the physician as necessary, however, did not include information regarding compression stockings. R69's treatment administration record for 7/24/17-7/31/17 and 8/1/17-8/17/17, included, "Ted stockings on in am off in pm...for edema." During an interview on 8/15/17, at 8:54 a.m. R69 stated she had a brand new pair of special socks that she received while in the hospital, prior to her admission to the facility, with directions to wear the stockings during the day. R69 stated, "They disappeared. Now I have to wear someone else's and they are worn and have holes in the heels." R69 added, "Today they were wet and I couldn't put them on." During an observation on 8/15/17, at 3:46 p.m. R69 was sitting in a reclining chair in her room.	F 166	stockings for R69 on 08/15/17. DON followed up with R69 on 08/16/17 and Resident was wearing new compression stockings. 2. As it relates to other residents: A. From 08/18/17 to 09/07/17 the DON provided education to all staff. Each staff member was given a copy of the policy and the proper form to fill out if resident discussed a concern with them. B. Social Worker will take the form with her to Care Conferences and fill it out immediately when concern is voiced. Missing or damaged item forms will be reviewed and kept by Social Service until issues are resolved. 3. Reoccurrence will be prevented by weekly and PRN QA of missing items and concerns for three months. Results will be taken to QAPI meeting to determine if any further action is needed. 4. Plan of Correction will be monitored by: Social Service, DON, Unit Managers. 5. Date of Correction: 09/11/17	

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F 166	Continued From page 4 R69 stated she still did not have compression stockings on today because they weren't dry yet, and pointed to the compression stockings hung over the handle on her dresser. Upon observation, the white compression stockings appeared yellowed, had several large and small holes in each heel, and were stretched and had no elasticity. Although the compression stockings were labeled with R69's name, she stated they were not hers. R69 stated, "They're quite worn. Mine were new." R69 stated she had talked to several staff about the missing stockings and stated staff had told her they didn't know where hers were. When interviewed on 8/17/17, at 9:34 a.m. R69 stated she had the stockings on today and was able to put them on herself because, "these are so stretched out." R69 stated she didn't think the compression stockings were "doing their job," due to the lack of elasticity in them. During an interview on 8/17/17, at 9:36 a.m. nursing assistant (NA)-A stated he was aware that R69's compression stockings were missing. NA-A stated R69 wore them the first day she was here, and the next day, they were gone. NA-A stated, "We couldn't find them. I told the nurse," but couldn't recall who he had told. During an interview on 8/17/17, at 9:39 a.m. director of nursing (DON) stated a form should be completed if a resident had a missing personal item. DON stated she was not aware of R69's missing compression stockings and placed a phone call to licensed social worker (LSW). LSW told DON she had not received a missing items form for R69, and that no one had reported the missing compression stockings to her.	F 166		

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F 166	Continued From page 5 During an interview on 8/17/17, at 9:40 a.m. dietary manager (DM) stated she was aware of R69's missing compression stockings and stated R69 and staff had talked about it at R69's care conference on 8/9/17. DM stated she looked through R69's room, checked in the laundry area, and couldn't find them. DM stated, "We have to order her some new ones." When reviewed, R69's Care Conference Summary, dated 8/9/17, indicated she answered, "Yes," when asked if she had any missing personal items and "Yes," she had told staff about it. Also noted, a hand written note in the left margin included, "Ted socks are missing." When interviewed on 8/17/17, at 9:50 a.m. LSW stated she was present at the care conference on 8/9/17 but didn't recall talking about the missing compression stockings. LSW stated she "should have followed up on that." LSW indicated she would be ordering new compression stockings for R69. Review of the facility's policy, Missing Items/Concern/Grievance, revised 10/16, staff were directed to respond quickly to residents' missing or damaged items and to resolve complaints/grievances in a timely and appropriate manner. The staff were directed to record the information on the facility's grievance form and send it to Social Services, and an investigation would be completed by Social Services.	F 166		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to-	F 167		9/11/17

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F 167	Continued From page 6 (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post notice of availability of the last three years of State Agency survey results. This had the potential to affect all 44 current residents, visitors, and staff who wished to review this information. Findings include: During initial tour of the facility on 8/14/17, at 2:40 p.m. survey results were not located.	F 167	It is the Policy and Procedure of HLC to post the most recent survey of the facility. HLC was not aware of the rule change from March 2017 to post three years of results. 1. Corrective Action: After education was given by the MDH the updated regulation along with a letter from the Administrator was posted in the three ring binder. Additional surveys were put in a new three ring binder for easy access to those who	

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F 167	Continued From page 7 During an observation on 8/15/17, at 9:50 a.m. the administrator pointed out a red 3-ring folder displayed on a table under the television near the front entrance area. Inside the red folder was a copy of the Minnesota Department of Health survey results, dated 9/22/16. No additional surveys were in the binder. There was no signage notifying residents, family and staff that an additional 2 years of results were available. During an interview on 8/15/17, at 9:52 a.m. the administrator stated only the most recent survey results were posted. The administrator stated he was not aware three years of survey results needed to be available. The administrator stated he would place a note in the 3 ring binder indicating that additional other surveys were available and where they could be obtained.	F 167	were interested in obtaining that information. This was completed on 08/15/17. 2. Reoccurrence will be prevented by: Monthly QA checks for three months and then random QA checks by Administrator to make sure binder is still in its designated place. 3. Plan of correction will be monitored by: Administrator 4. Date of Correction: 09/11/2017.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services as directed by the care plan for proper positioning for 1 of 3 residents (R3) who was reviewed for pressure ulcers.	F 282	It is the policy and procedure of HLC to follow each resident's written plan of care. 1. Corrective Action: Education and counseling provided to staff members involved. Resident R3's care plan was updated to indicate his increase in	9/26/17

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F 282	Continued From page 8 Findings include: R3's admission minimum data set (MDS) dated 6/15/17, indicated R3 had severe cognitive impairment, and required extensive staff assistance with bed mobility and transfers. Diagnosis included dementia and coronary artery disease. The MDS also indicated R3 was at risk for developing pressure ulcers, and had 2 stage I pressure ulcers and 1 stage II pressure ulcer. R3's plan of care dated 6/30/17, indicated impaired skin integrity related to pressure ulcers to right and left buttocks, and instructed staff: - administer treatments as ordered - assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress - avoid positioning resident on his back - elevate heels off the bed using pillows - the resident needs supervision/cueing to turn/reposition at least every 2 hours, with extensive physical assist of one with positioning legs on pillows - the resident requires pressure relieving/reducing device on bed/chair - weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate On 8/16/17, at 1:18 p.m. NA-B assisted R3 to transfer to bed, placing him directly on his back, and placing a pillow beneath his calves. However, the heels were not floated, and were observed to be directly touching the mattress. When interviewed on 8/16/17, at 1:33 p.m. NA-B stated R3 currently had no skin concerns on his	F 282	independence. 2. Corrective Action as it relates to other residents: A. Education provided 09/05/17 by Cheryl Krause, BSN, Certified Wound Specialist, QA nurse for Ecumen. B.Residents needing staff assistance for mobility will have their care plans reviewed by Unit Manager and/or MDS RN. C. Nursing order added to TAR to check skin weekly with bath by nursing staff and make a note in PCC progress note. 3. Reoccurrence will be prevented by weekly and random QA audits for three months. Results will be taken to QAPI meeting to determine if any further action is needed. 4. Corrective Action will be monitored by: DON, UM, MDS, and charge nurses. 5. Correction Date: 09/26/17	

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F 282	Continued From page 9 buttocks, but did on admission. During interview and observation on 8/16/17, at 2:12 p.m. with registered nurse (RN)-A, R3 was observed in bed. RN-A verified R3 was lying on his back, and heels were directly on the bed, not floated. RN-A then adjusted the pillow to allow heels to float and stated staff education would be provided. When interviewed on 8/17/17, at 9:05 a.m. the director of nursing (DON) stated all staff are expected to update and follow the plan of care. When interviewed on 8/17/17, at 2:40 p.m. RN-B stated R3 is not to be lying on his back in bed, and heels should not be touching the bed. Facility policy on plan of care was requested but not provided.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	F 314		9/26/17

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F 314	Continued From page 10 healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to prevent possible reoccurrence of a pressure ulcer for 1 of 3 resident (R3) reviewed for pressure ulcers. Findings include: R3's admission minimum data set (MDS) dated 6/15/17, indicated R3 had severe cognitive impairment, and required extensive staff assistance with bed mobility and transfers. Diagnosis included dementia and coronary artery disease. The MDS also indicated R3 was at risk for developing pressure ulcers, and had 2 stage I pressure ulcers and 1 stage II pressure ulcer. Order Summary Report dated 8/3/17, identified an order for Tegaderm (a transparent dressing) to the right buttock topically every 72 hours as needed for an open wound (discontinued 8/4/17). R3's plan of care dated 6/30/17, indicated impaired skin integrity related to pressure ulcers to right and left buttocks, and instructed staff: -administer treatments as ordered. -assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. -avoid positioning resident on his back. -elevate heels off the bed using pillows. -the resident needs supervision/cueing to turn/reposition at least every 2 hours, with extensive physical assist of one with positioning	F 314	It is the policy and procedure of HLC to provide necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing. 1. Corrective Action: Resident R3 was admitted to HLC with pressure ulcers on his right and left buttock. These areas were healed. Resident is also needing less assistance with mobility now then on admission. Care plan was updated and staff education provided on needs of resident. 2. Corrective action as it applies to other residents: Education was provided 09/05/17 by Cheryl Krause, BSN, Certified Wound Nurse, QA nurse for Ecumen. Residents needing assistance with mobility will have their care plan and ADL status reviewed by Unit Managers and/or MDS RN. 3. Reoccurrence will be prevented by: Weekly and random QA audits for three months. These results will be taken to QAPI to determine if further action is needed. 4. Corrective Action will be monitored by: Charge Nurses, Unit Managers, MDS Nurses and DON. 5. Date of Correction: 09/26/17.	

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F 314	Continued From page 11	F 314		

legs on pillows.
-the resident requires pressure relieving/reducing device on bed/chair.
-weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate

Nursing assistant (NA) care sheet undated, instructed staff that R3 required limited to extensive physical assist of one to turn and reposition in bed as necessary, and indicated R3 is not to be positioned on his back.

Skin Assessment form dated 6/9/17, identified the right buttock had a 1 x 1.5 centimeter (cm) red area stage II, and left buttock 1 x 3 cm red area that does not blanch in center.

On 8/16/17, at 1:18 p.m. NA-B assisted R3 to transfer to bed, placing him directly on his back, and placing a pillow beneath his calves. However, the heels were not floated, and were observed to be directly touching the mattress.

On 8/17/17, at 7:50 a.m. NA-C was observed assisting R3 to toilet. R3's buttocks was observed, with no current redness or open area.

When interviewed on 8/16/17, at 1:33 p.m. NA-B stated R3 currently had no skin concerns on his buttocks, but did on admission.

When interviewed on 8/16/17, at 2:00 p.m. licensed practical nurse (LPN)-A stated on admission R3 had something on the buttocks, but it has cleared. Staff should offer to have R3 on his side in bed, but he likes to lie on his back.

During interview and observation on 8/16/17, at

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F 314	Continued From page 12 2:12 p.m. with registered nurse (RN)-A, R3 was observed in bed. RN-A verified R3 was lying on his back, and heels were directly on the bed, not floated. RN-A then adjusted the pillow to allow heels to float and stated staff education would be provided. When interviewed on 8/17/17, at 9:05 a.m. the director of nursing (DON) stated all staff are expected to update and follow the plan of care. When interviewed on 8/17/17, at 2:40 p.m. RN-B stated staff are expected to follow the resident's plan of care. R3 is not to be lying on his back in bed, and heels should not be touching the bed.	F 314		
F 431 SS=B	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient	F 431		9/26/17

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F 431	Continued From page 13 detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a system to minimize the risk of loss and/or diversion of controlled substance medications for 5 of 20 residents (R32, R2, R15, R33, and R26) with current orders for narcotics in the facility.	F 431	It is the policy of Heritage Living Center to label and store all medications, including narcotics, correctly. 1. Corrective Action: A.) Policy and Procedure was written and education provided to all TMAs, LPNs, and RNs from 08/19/17 through 08/31/17.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 Findings include: On 8/16/17, at 11:45 a.m. the second floor nursing cart narcotic storage was observed with the following medications noted to be in bubble packs, with tape on the back of a select number of bubbles with pills in them, which were either punctured or ripped: R32 - hydrocodone-acetaminophen 5-325 (2 pills per bubble) had 1 area taped in the back - hydrocodone-acetaminophen 5-325 (1 pill per bubble) had 2 areas taped in the back - morphine sulfate 7.5 milligrams (mg) had 2 areas taped in the back. R2 - hydrocodone-acetaminophen 5-325 had 10 areas taped in the back R15 - oxycodone-acetaminophen 5-325 had 1 area taped in the back When interviewed on 8/17/17, at 11:55 a.m. licensed practical nurse (LPN)-B stated staff should never tape the back of the cards. "This is a big no-no". If the back was ripped, the pill would be placed in the cabinet for destruction with another nurse, and a progress note would be made in the resident's chart. On 8/16/17, at 12:25 p.m. the first floor nursing cart narcotic storage was observed with the following medications noted to be in bubble packs, with tape on the back of a select number of bubbles with pills in them, which were either punctured or ripped:	F 431	B.) Drug Store notified and asked not to send more than one card at a time to make room in the storage bin. C.) Pharmacist assisted HLC staff to dispose of all medications that had been taped in cards per appropriate protocol. This was done 08/21/17. 2. Corrective Action as it applies to other residents: Pharmacist will be providing training for nursing staff 09/18/17. 3. Reoccurrence will be prevented by: Weekly QA audits by DON to make sure there is no tape on cards and that the policy and procedure is being followed. This will be done for three months and results will be taken to QAPI committee to determine if further education is needed. 4. Corrective Action: Will be monitored by DON. 5. Correction Date: 09/26/2017	

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	245405	A. BUILDING _____ B. WING _____	C 08/17/2017

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F 431	Continued From page 15 R33 - Ativan 0.5 had 2 pills taped on the back R26 - hydrocodone/acetaminophen 5/325 had two small poke holes in the back. When interviewed on 8/17/17, at 12:25 p.m. LPN-C stated if a problem was noted on the back of the bubble packs, she would tape them. When interviewed on 8/17/17, at 12:42 p.m. director of nursing (DON) stated the pills are not to be taped on the back. If there was a problem with the pack, a progress note would be made in the resident's record, and the pill would be placed in the bin by two staff for destruction by the pharmacist . There is no policy, but the pharmacy did come out to provide an inservice on this issue, informing staff there should be no taping of the back of the bubble packs. When interviewed on 8/17/17, at 3:57 p.m. consultant pharmacist (CS) stated taping the backs of the bubble packs is not a practice that is recommended. If this practice was noted during a visit, he would recommend that the medications are double checked to be sure they match, and look for diversion. Education would be provided on not taping the backs of the bubble packs. Further, CS stated if this was noted during the destruction of the medications, it would be brought to the attention of the DON. Facility policy was requested but not provided.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		9/26/17

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F 441	Continued From page 16 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		

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F 441	Continued From page 17 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a program to prevent Legionella in the facility water systems to prevent an outbreak of Legionnaires' Disease (a type of pneumonia caused by legionella bacteria). This had the potential to effect all 44 residents residing in the facility, visitors, and staff. Findings include: When interviewed on 8/15/17, at 3:00 p.m. the administrator stated the facility was "not at risk"	F 441	It is the policy and procedure to provide a safe environment for residents, staff and visitors. HLC receives their water source from the city of Park Rapids, the city does test water on an on gong basis. 1. Plan of Correction: Administrator and Environmental Services will complete facility risk assessment for HLC. Policy and Procedure will be put in place. HLC will work with city of Park Rapids and Hubbard County to ensure the policy is effective.	

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F 441	Continued From page 18 for an outbreak of Legionnaires' disease and indicated he was working to coordinate their emergency preparedness and disaster planning with Hubbard county. The administrator indicated staff from Hubbard county would assist with the assessment process and policies for Legionnaire's disease during those discussions. The administrator indicated they currently had no policy in place for Legionnaire's disease and had not conducted a facility risk assessment to identify where waterborne pathogens could grow and spread in the water system, and stated this would not be completed until the facility construction was completed in September or October. The administrator indicated he was not aware that this requirement needed to be in place now, as he thought it didn't need to be completed until November, 2017.	F 441	2. Reoccurrence will be prevented by: Administrator and Environmental Service reviewing and updating the Policy and Procedure on an annual and as needed basis. 3. Corrective Action: Will be monitored by Administrator and Environmental Services. 4. Date of Correction: 09/26/17	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 1, 2017

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, MN 56470

Re: Enclosed State Nursing Home Licensing Orders - Project Numbers S5405028 & H5405013

Dear Mr. Hansen:

The above facility was surveyed on August 14, 2017 through August 17, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5405013 that was found to be unsubstantiated. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 Kathleen Lucas, Unit Supervisor, at kathleen.lucas@state.mn.us or (320) 223-7343.

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.

Please feel free to call me with any questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00288	A. BUILDING: _____ B. WING _____	C 08/17/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On August 14, 15, 16, and 17, 2017, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, complaint investigation(s) were also completed at the time of the licensing survey. An investigation of complaint/s H5405013 was completed. The complaint/s was not substantiated.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services as directed by the care plan for proper positioning for 1 of 3 residents (R3) who was reviewed for pressure ulcers. Findings include: R3's admission minimum data set (MDS) dated 6/15/17, indicated R3 had severe cognitive impairment, and required extensive staff assistance with bed mobility and transfers. Diagnosis included dementia and coronary artery disease. The MDS also indicated R3 was at risk for developing pressure ulcers, and had 2 stage I	2 565	It is the policy and procedure of Heritage Living Center to follow each resident's written plan of care. 1. Corrective Action: Education and Counseling provided to staff members involved. Resident R3's care plan was updated to indicate his increase in independent mobility. 2. Corrective Action as it relates to other residents: A.) Education provided 09/05/17 by Cheryl Kraus, BSN, Certified wound nurse, and QA nurse for Ecumen. B.) Residents needing staff assistance with mobility will have their care plans	9/26/17

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2 565	Continued From page 3 pressure ulcers and 1 stage II pressure ulcer. R3's plan of care dated 6/30/17, indicated impaired skin integrity related to pressure ulcers to right and left buttocks, and instructed staff: - administer treatments as ordered - assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress - avoid positioning resident on his back - elevate heels off the bed using pillows - the resident needs supervision/cueing to turn/reposition at least every 2 hours, with extensive physical assist of one with positioning legs on pillows - the resident requires pressure relieving/reducing device on bed/chair - weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate On 8/16/17, at 1:18 p.m. NA-B assisted R3 to transfer to bed, placing him directly on his back, and placing a pillow beneath his calves. However, the heels were not floated, and were observed to be directly touching the mattress. When interviewed on 8/16/17, at 1:33 p.m. NA-B stated R3 currently had no skin concerns on his buttocks, but did on admission. During interview and observation on 8/16/17, at 2:12 p.m. with registered nurse (RN)-A, R3 was observed in bed. RN-A verified R3 was lying on his back, and heels were directly on the bed, not floated. RN-A then adjusted the pillow to allow heels to float and stated staff education would be provided.	2 565	reviewed by Unit Managers and/or MDS nurses. C.) Nursing order added to TAR to check skin weekly with bath by LPN and write a progress note in PCC. 3. Reoccurrence will be prevented by: Weekly and random QA audits for three months by Unit Managers. Results will be taken to QAPI meeting to determine if further action is needed. 4. Corrective Action will be monitored by: DON, Unit Managers, MDS Nurses, and LPN charge nurses. 5. Correction Date: 09/26/17	

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2 565	Continued From page 4 When interviewed on 8/17/17, at 9:05 a.m. the director of nursing (DON) stated all staff are expected to update and follow the plan of care. When interviewed on 8/17/17, at 2:40 p.m. RN-B stated R3 is not to be lying on his back in bed, and heels should not be touching the bed. Facility policy on plan of care was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent	2 900		9/26/17

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2 900	Continued From page 5 new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to prevent possible reoccurrence of a pressure ulcer for 1 of 3 resident (R3) reviewed for pressure ulcers. Findings include: R3's admission minimum data set (MDS) dated 6/15/17, indicated R3 had severe cognitive impairment, and required extensive staff assistance with bed mobility and transfers. Diagnosis included dementia and coronary artery disease. The MDS also indicated R3 was at risk for developing pressure ulcers, and had 2 stage I pressure ulcers and 1 stage II pressure ulcer. Order Summary Report dated 8/3/17, identified an order for Tegaderm (a transparent dressing) to the right buttock topically every 72 hours as needed for an open wound (discontinued 8/4/17). R3's plan of care dated 6/30/17, indicated impaired skin integrity related to pressure ulcers to right and left buttocks, and instructed staff: -administer treatments as ordered. -assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. -avoid positioning resident on his back. -elevate heels off the bed using pillows. -the resident needs supervision/cueing to turn/reposition at least every 2 hours, with extensive physical assist of one with positioning	2 900	It is the policy of Heritage Living Center to provide necessary treatment and services , consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing. 1. Corrective Action: Resident R3 was admitted to HLC with pressure ulcers on his right and left buttock. These areas have been healed at HLC. This resident is also needing less assistance with mobility now then on admission. Care plan was updated and staff education provided on needs of resident. 2. Corrective Action as it relates to other residents: On 09/05/17 education was provided by Cheryl Kraus, BSN, Certified wound nurse, QA nurse for Ecumen. Residents needing assistance with bed mobility will have their care plans reviewed by Unit Manager and/or MDS RN. 3. Reoccurrence will be prevented by: Weekly and random QA audits for three months. Results will be taken to QAPI meeting to determine if any further action is needed. 4. Corrective Action will be monitored by: LPN Charge Nurse, UM, MDS Nurses and DON. 5. Date of Correction: 09/26/17.	

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2 900	Continued From page 6	2 900		

legs on pillows.
-the resident requires pressure relieving/reducing device on bed/chair.
-weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate

Nursing assistant (NA) care sheet undated, instructed staff that R3 required limited to extensive physical assist of one to turn and reposition in bed as necessary, and indicated R3 is not to be positioned on his back.

Skin Assessment form dated 6/9/17, identified the right buttock had a 1 x 1.5 centimeter (cm) red area stage II, and left buttock 1 x 3 cm red area that does not blanch in center.

On 8/16/17, at 1:18 p.m. NA-B assisted R3 to transfer to bed, placing him directly on his back, and placing a pillow beneath his calves. However, the heels were not floated, and were observed to be directly touching the mattress.

On 8/17/17, at 7:50 a.m. NA-C was observed assisting R3 to toilet. R3's buttocks was observed, with no current redness or open area.

When interviewed on 8/16/17, at 1:33 p.m. NA-B stated R3 currently had no skin concerns on his buttocks, but did on admission.

When interviewed on 8/16/17, at 2:00 p.m. licensed practical nurse (LPN)-A stated on admission R3 had something on the buttocks, but it has cleared. Staff should offer to have R3 on his side in bed, but he likes to lie on his back.

During interview and observation on 8/16/17, at 2:12 p.m. with registered nurse (RN)-A, R3 was

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	00288	A. BUILDING: _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 7 observed in bed. RN-A verified R3 was lying on his back, and heels were directly on the bed, not floated. RN-A then adjusted the pillow to allow heels to float and stated staff education would be provided. When interviewed on 8/17/17, at 9:05 a.m. the director of nursing (DON) stated all staff are expected to update and follow the plan of care. When interviewed on 8/17/17, at 2:40 p.m. RN-B stated staff are expected to follow the resident's plan of care. R3 is not to be lying on his back in bed, and heels should not be touching the bed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise the pressure ulcer protocol. In addition, the DON could provide education to the nursing staff on the importance of assessing pressure ulcers and implementing pressure reducing interventions. The DON could develop a system for the nursing staff to monitor that interventions are implemented. The quality assessment and assurance committee could do random audits of pressure ulcers to ensure residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as	21880		9/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21880	Continued From page 8 patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

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21880	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure efforts were made to resolve a concern related to missing compression stockings for 1 of 2 residents (R69) reviewed for missing personal property. Findings include: R69's Admission Record, dated 7/24/17, identified diagnoses which included weakness, multiple fractures, acute pain due to trauma, and localized edema. R69's admission Minimum Data Set (MDS), dated 8/6/17, identified R69 was cognitively intact and required extensive assistance for dressing and personal hygiene. R69's physician orders, dated 7/25/17, included, "Apply Ted hose compression stockings [fitted stockings used to decrease swelling in legs] in AM-off PM. Dx [diagnosis] edema." R69's initial careplan, dated 8/9/17, directed staff to observe for signs of increased edema/increased weight related to fluid retention and to document and report to the physician as necessary, however, did not include information regarding compression stockings. R69's treatment administration record for 7/24/17-7/31/17 and 8/1/17-8/17/17, included, "Ted stockings on in am off in pm...for edema." During an interview on 8/15/17, at 8:54 a.m. R69 stated she had a brand new pair of special socks that she received while in the hospital, prior to her admission to the facility, with directions to wear	21880	It is the policy and procedure of HLC to resolve any verbalized concerns of residents in cases of missing items, concerns of environmental temperatures, or any concerns brought forth by the resident and/or family. 1. Corrective Action: DON called drug store 08/15/17 and new compression stockings were ordered. DON followed up on 08/16/17 and resident was wearing her new compression stockings. 2. As it relates to other residents: A.) From 08/18 until 09/07/17 DON provided education to all staff . Each staff member was given a copy of the policy and procedure along with the appropriate form to fill out if resident voiced a concern to them. B.) Social Worker will take the form with her to Care Conferences and fill the appropriate form out immediately. Missing or damaged forms will be kept and reviewed by Social Service until the concern is resolved. Forms of past concerns will be kept for three years by Social Service. 3. Reoccurrence will be prevented by: Weekly and PRN QA for missing items or concerns. This will be done for three months. Results will be taken to QAPI meeting to determine if any further action is needed. 4. Plan of Correction will be monitored by: Social Service, DON, Unit Managers 5. Correction date: 09/11/17	

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the stockings during the day. R69 stated, "They disappeared. Now I have to wear someone else's and they are worn and have holes in the heels." R69 added, "Today they were wet and I couldn't put them on."

During an observation on 8/15/17, at 3:46 p.m. R69 was sitting in a reclining chair in her room. R69 stated she still did not have compression stockings on today because they weren't dry yet, and pointed to the compression stockings hung over the handle on her dresser. Upon observation, the white compression stockings appeared yellowed, had several large and small holes in each heel, and were stretched and had no elasticity. Although the compression stockings were labeled with R69's name, she stated they were not hers. R69 stated, "They're quite worn. Mine were new." R69 stated she had talked to several staff about the missing stockings and stated staff had told her they didn't know where hers were.

When interviewed on 8/17/17, at 9:34 a.m. R69 stated she had the stockings on today and was able to put them on herself because, "these are so stretched out." R69 stated she didn't think the compression stockings were "doing their job," due to the lack of elasticity in them.

During an interview on 8/17/17, at 9:36 a.m. nursing assistant (NA)-A stated he was aware that R69's compression stockings were missing. NA-A stated R69 wore them the first day she was here, and the next day, they were gone. NA-A stated, "We couldn't find them. I told the nurse," but couldn't recall who he had told.

During an interview on 8/17/17, at 9:39 a.m. director of nursing (DON) stated a form should be

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completed if a resident had a missing personal item. DON stated she was not aware of R69's missing compression stockings and placed a phone call to licensed social worker (LSW). LSW told DON she had not received a missing items form for R69, and that no one had reported the missing compression stockings to her.

During an interview on 8/17/17, at 9:40 a.m. dietary manager (DM) stated she was aware of R69's missing compression stockings and stated R69 and staff had talked about it at R69's care conference on 8/9/17. DM stated she looked through R69's room, checked in the laundry area, and couldn't find them. DM stated, "We have to order her some new ones."

When reviewed, R69's Care Conference Summary, dated 8/9/17, indicated she answered, "Yes," when asked if she had any missing personal items and "Yes," she had told staff about it. Also noted, a hand written note in the left margin included, "Ted socks are missing."

When interviewed on 8/17/17, at 9:50 a.m. LSW stated she was present at the care conference on 8/9/17 but didn't recall talking about the missing compression stockings. LSW stated she "should have followed up on that." LSW indicated she would be ordering new compression stockings for R69.

Review of the facility's policy, Missing Items/Concern/Grievance, revised 10/16, staff were directed to respond quickly to residents' missing or damaged items and to resolve complaints/grievances in a timely and appropriate manner. The staff were directed to record the information on the facility's grievance form and send it to Social Services, and an investigation

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21880	Continued From page 12 would be completed by Social Services. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff on the requirement to address resident concerns and make a good faith attempt to resolve the grievances. The director of nursing could develop a monitoring system to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

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	245405	A. BUILDING 02 B. WING _____	08/18/2017

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal division. At the time of this survey Heritage Living Center 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/06/2017

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.

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K 000	Continued From page 1 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two buildings. The Heritage Living Center is a one story building with a partial basement under the kitchen area which was constructed in 1960 and is a Type II (111) construction. In 1969 an addition was constructed to the north and was determined to be of Type II (111) construction. In 1990 the chapel addition was constructed to the south and is separated with a 2 hour fire barrier. In 1994 the laundry addition was added to the north and was determined to be of Type II (111) construction and is separated with a 2 hour fire barrier. In 2000 a main entrance addition was added to the chapel addition to connect the nursing home with the new apartment building to the south west and	K 000		

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	245405	A. BUILDING **02** B. WING _____	**08/18/2017**

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K 000	Continued From page 2 was determined to of Type V (111) construction and is separated from the apartment building with a 2 hour fire barrier. In 2016 a two story resident wing replaced the 1960 B-wing and is a Type II (111) construction. The entire building and additions are sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems . The facility has a manual fire alarm system with sleeping room smoke detection, detection in common areas and at smoke barrier doors that are held open, installed in accordance with NFPA 72 "The National Fire Alarm Code" . The 2016 addition has smoke detection in the resident rooms, corridors and spaces open to the corridors. The facility has a capacity of 52 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be	K 321		9/11/17

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K 321	Continued From page 3 self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 13 of the 45 residents and an undetermined amount of staff and visitors. Findings include: At 11:15 am on 08-18-2017 observations revealed the storeroom in the 1960 wing did not have a self closing door. This deficient condition was confirmed by the Director of Maintenance.	K 321	It is the policy of Heritage Living Center to maintain a hazardous storage room in accordance with the 2012 Life Safety Code. 1.Corrective Action: Temporary storage room was put in place during construction and inadvertently the self closing door was not added. On 08/23/2017 the door was updated to provide a self closing hinges. 2. To prevent reoccurrence: Environmental Service will do routine monitoring of storage areas. This wing will be bull dozed down in the next few months. 3. Monitor Compliance: Environmental Services and Administrator. 4. Plan of Correction Date: 09/11/2017	

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K 341 SS=F	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect all 45 residents and an undetermined amount of patients, staff and visitors. Findings include: At 11:50 am on 08/18 2017 observations revealed the lower level maintenance room did not have a smoke detector for the main fire alarm panel. This deficient condition was confirmed by the Director of Maintenance.	K 341	It is the policy of HLC to install smoke detectors in accordance with NFPA 101 Life Safety Code. 1. Corrective Action: Davis Electric installed smoke detector in basement on 08/30/2017. 2. To Prevent Reoccurrence: Environmental Services will do routine monitoring of smoke detectors in building. (Annual and as needed testing by Protection Services) 3. Monitored By: Environmental Services and Administrator 4. Completion Date: 09/11/2017	9/11/17

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	245405	A. BUILDING **04 - WEST WING** B. WING _____	**08/18/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal division. At the time of this survey Heritage Living Center 04 Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS	K 000	EPOC	

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

Electronically Signed | 09/06/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING **04 - WEST WING** B. WING _____	**08/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	**619 WEST SIXTH STREET PARK RAPIDS, MN 56470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

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

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

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

2. The actual, or proposed, completion date.

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

This facility was surveyed as two buildings.

The Heritage Living Center is a one story building with a partial basement under the kitchen area which was constructed in 1960 and is a Type II (111) construction. In 1969 an addition was constructed to the north and was determined to be of Type II (111) construction. In 1990 the chapel addition was constructed to the south and is separated with a 2 hour fire barrier. In 1994 the laundry addition was added to the north and was determined to be of Type II (111) construction and is separated with a 2 hour fire barrier. In 2000 a main entrance addition was added to the chapel addition to connect the nursing home with the new apartment building to the south west and

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K 000	Continued From page 2 was determined to of Type V (111) construction and is separated from the apartment building with a 2 hour fire barrier. In 2016 a two story resident wing replaced the 1960 B-wing and is a Type II (111) construction. The entire building and additions are sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with sleeping room smoke detection, detection in common areas and at smoke barrier doors that are held open, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The 2016 addition has smoke detection in the resident rooms, corridors and spaces open to the corridors. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code 2007 edition and is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		9/11/17

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K 353	Continued From page 3 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 45 patients and an undetermined amount of staff and visitors. Findings include: At 10:10 am on 08/18/2017 observations revealed approximately 4 of the ceiling tiles in each neighborhood kitchen were removed for construction and not replaced. This deficient condition was confirmed by the Director of Maintenance.	K 353	It is the policy of HLC to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and to replace ceiling tiles that were removed for construction. 1. Corrective Action: On 08/23/17 ceiling tiles that were removed for construction were replaced in each neighborhood. 2. To prevent reoccurrence: A weekly QA will be done by Environmental Service or Administrator. Construction workers were notified of need to replace ceiling tiles as soon as they complete their work. 3. Monitor Compliance: Environmental Service and Administrator 4. Plan of Correction Date: 09/11/17	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System	K 918		9/26/17

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K 918	Continued From page 4 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on record review, observations and staff interview the facility failed to provide test documentation and emergency features in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for	K 918	It is the policy of HLC to provide test documentation and emergency features in accordance with the 2012 edition of the Life Safety Code (NFPA 101). 1. Corrective Action: Davis electric was notified 08/19/2017 to fix the concern.	

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K 918	Continued From page 5 Emergency and Standby Power Systems. This deficient practice could affect the safety of all of the 45 residents if the generator failed to operate during a power outage. Findings include: At 10:30 am on 08/18/2017 observations and staff interview revealed the new generator did not have an emergency shut off outside of the cabinet. This deficient condition was confirmed by the Director of Maintenance.	K 918	2. Reoccurrence will be prevented by: QA of new construction will be completed weekly and PRN by Environmental Service and Administrator. 3. Monitor Compliance: Environmental Service and Administrator. 4. Correction Date: 09/26/17	