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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SEIU

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 **10/12/2014** (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 **64** (L18)

13.Total Certified Beds **64** (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
	64			
(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
Lyla Burkman, Unit Supervisor
Date : 09/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 10/14/2014 (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
Posted 10/23/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245405

October 14, 2014

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, Minnesota 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 5, 2014 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 14, 2014

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

RE: Project Number S5405024

Dear Mr. Hansen:

On August 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 14, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On October 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 14, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 14, 2014, effective September 5, 2014 and therefore remedies outlined in our letter to you dated August 28, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

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

s5405r14

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245405	A. Building B. Wing	10/12/2014

Name of Facility	Street Address, City, State, Zip Code
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/05/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/05/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/05/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/05/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/05/2014**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/05/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/05/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	10/14/2014	28035	10/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/14/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SEIU

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 **08/14/2014** (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 **64** (L18)

13.Total Certified Beds **64** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(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 :
Jane Aandal, HFE NEII — 09/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 10/14/2014 (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
Posted 10/15/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SEIU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00288

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(L1) **245405**

2.STATE VENDOR OR MEDICAID NO.
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(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**
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8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/12/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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

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From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

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Compliance Based On:
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And/Or Approved Waivers Of The Following Requirements:
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___ 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
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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Lyla Burkman, Unit Supervisor
Date : 09/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 10/14/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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3. Both of the Above :
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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
Posted 10/23/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245405

October 14, 2014

Mr. Kurt Hansen, Administrator
Heritage Living Center
619 West Sixth Street
Park Rapids, Minnesota 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 5, 2014 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 14, 2014

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

RE: Project Number S5405024

Dear Mr. Hansen:

On August 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 14, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On October 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 14, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 14, 2014, effective September 5, 2014 and therefore remedies outlined in our letter to you dated August 28, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

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

s5405r14

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245405	A. Building B. Wing	10/12/2014

Name of Facility	Street Address, City, State, Zip Code
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/05/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/05/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/05/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/05/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/05/2014**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/05/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/05/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	10/14/2014	28035	10/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/14/2014			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 28, 2014

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

RE: Project Number S5405024

Dear Mr. Hansen:

On August 14, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 23, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 14, 2014 (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 14, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING _____ B. WING _____	08/14/2014

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		9/5/14

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

Electronically Signed | 09/04/2014

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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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was updated to include current fall interventions for 2 of 5 residents (R53, R12) reviewed for accidents. Findings include: R53's care plan was not updated to include current fall interventions. R53's quarterly Minimum Data Set (MDS) dated 6/22/14, indicated R53 was diagnosed with Alzheimer's dementia, had severe cognitive impairment, had 1 fall with minimal injury and required extensive assistance of 2 staff for transfers, bed mobility and ambulation. R53's care plan dated 1/14, indicated a potential for injury related to falls. Interventions included: pressure pad bed alarm, tab alarm in wheelchair, non-skid footwear, call light within reach and cleared pathways. The care plan does not address visual safety checks nor the use of anti-tippers attached to the wheelchair. According to the Confidential Peer Review Document Resident Incident Reports R53 sustained nine falls between 12/14/13, and 7/14/14. The report dated 2/14/13, indicated staff would continue to do visual checks on R53. The report dated 3/1/14, indicated staff were reminded to do visual checks every two hours. The 3/5/14, report indicated staff would be reminded to do visual checks of R53. The 6/12/14, report indicated staff were to do visual checks of R53.	F 280	It is the policy of Heritage Living Center to have resident/family participate in planning care and treatment and changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment. 1. Corrective Action: A.) R53 and R12 care plans were reviewed and updated. Interventions on fall assessments were added to care plan. (Visual safety check, floor strips, anti-lock brakes and anti-tippers.) B.) Visual checks for R52 and R12 were updated on care plan. Staff education provided. C.) R53 and R12 will have QA monitoring after each incident to make sure care plan is updated after each new intervention. D.) R12 had anti-lock brakes put on new chair. E.) Education provided on 08/18/14 to RN staff regarding care plan update and HLC P&P. F.) P&P regarding care plan updates/revisions were given to the MDH at time of survey. 2. Corrective Action as it relates to other residents: A.)All residents who have had an incident report in past three months care plans were reviewed and revised as indicated. B.) Education provided to floor staff regarding fall/care plan P&P. 3. Re-occurrence will be prevented by: A.) QA audit will be done after every	

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F 280	Continued From page 2 The report dated 7/13/14, indicated staff would continue to do visual checks. On 8/13/14, at 7:02 a.m. R53 was observed seated in the wheelchair near the nurses station. The tab alarm was observed clipped to the back of his shirt. R53's wheelchair was also observed to have anti-tippers attached to the lower back of his wheelchair. On 8/14/14, at 10:40 a.m. the director of nursing (DON) verified visual safety checks were initiated for R53 on 12/14/13, however,stated the frequency of the checks was not identified. At 10:51 a.m. the DON confirmed the fall report dated 7/13/14, also had not indicated how often the visual checks would be done. At 12:30 p.m. the DON reviewed R53's care plan and verified it did not address the visual safety checks nor the use of the wheelchair anti-tippers. R12's care plan was not updated to include current fall interventions. R12's quarterly MDS dated 6/4/14, indicated R12 was diagnosed with dementia, had moderate cognitive impairment, had 2 falls with no injury and required extensive assistance of 1-2 staff for transfers, walking and bed mobility. R12's care plan dated 6/14, indicated R12 was at risk for falls and interventions included: ensure the call light was within reach, cleared pathways, non-skid footwear, Call don't Fall sign, toilet every 2 hours, and between 2-3 p.m. and tab alarm in	F 280	incident report for 90 days. B.) QA results will be taken to QA Committee and reviewed to determine if further action is needed. 4. The POC will be monitored by: IDT team, QA Committee, and DON. 5. Correction Date: 09/05/14.	

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F 280	Continued From page 3 wheelchair and bed. According to the Confidential Peer Review Document Resident Incident Reports R12 sustained two falls on 7/14/14, and 7/21/14. -The 7/14/14, post fall Root Cause Analysis form dated 7/21/14, indicated R12 utilized a tab alarm in bed and the wheelchair and staff performed visual safety checks of R12. - The 7/21/14, Resident Incident Report indicated staff were to engage R12's wheelchair brakes after laying her in bed due to self transfer attempts. The post fall Root Cause Analysis form dated 8/4/14, indicated R12 utilized a tab alarm, had non skid strips on the floor and educated staff on performing visual checks. On 8/13/14, at 7:06 a.m. R12 was observed in bed with the tab alarm clipped to her clothes. -At 8:20 a.m. NA-B was observed to transfer R12 into the wheelchair. NA-B stated she thought R12 had anti-lock brakes attached to her wheelchair, however, about a month ago R12 received a different wheelchair and the anti-lock brakes must not have been switched over. At 11:30 a.m. NA-C stated R12 used to have anti-tippers on her wheelchair but no anti-lock brakes. At 12:50 p.m. NA-B stated some staff would put R12's wheelchair by her closet to prevent R12 from attempting to transfer into it but on the day shift we left the wheelchair next to R12's bed and locked the brakes. Additionally, NA-C stated R12 should have the anti-lock brake on her wheelchair. On 8/14/14, at 8:38 a.m. physical therapist (PT)-A	F 280		

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F 280	Continued From page 4 confirmed R12 did have anti-lock brakes on her wheelchair and it was a total oversight that they did not get put on R12's new chair. At 9:02 a.m. the DON confirmed R12's care plan was not updated to include floor strips, visual safety checks and the use of anti-lock brakes and stated it should have been. On 8/14/14, at 10:13 p.m. the DON stated there was no policy regarding care plan updates / revisions.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 ensure 1 of 2 residents (R53) reviewed for urinary incontinence received timely toileting assistance as directed by their individual care plan. Findings include: R53's quarterly Minimum Data Set (MDS) dated 6/22/14, indicated R53 was diagnosed with Alzheimer's dementia and had severe cognitive impairment. R53's care plan dated 1/14, indicated R53	F 282	It is the policy and procedure of Heritage Living Center to do a comprehensive assessment and individualize each resident's need for toileting assistance. This plan is then care planned for staff to follow. 1. Corrective Action: A.) The two individual staff were educated/counseled on HLC P&P for toileting. The appropriate action was discussed with them. B.) R53's care plan was shared with all staff working with him. Reviewed action to take when resident is resistive with cares	9/5/14

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F 282	Continued From page 5 required extensive staff assistance to toilet as requested or every 2 hours. The care plan also directed staff to change R53's incontinent brief every 2 hours during the night. Additionally, the care plan indicated R53 was resistive to cares at times. On 8/13/14, at 7:02 a.m. R53 was observed seated in the wheelchair by the nurses station. -At 7:25 a.m. R53 was observed at the breakfast table. R53 was continuously observed to remain at the table until 8:42 a.m. -At 8:42 a.m. R53 was assisted to his room. Nursing assistant (NA)-B and NA-C were observed to transfer R53 to bed. R53 was not toileted nor was his incontinent brief checked. -At 9:14 a.m. R53 was observed in bed, asleep on his back. -At 10:30 a.m. R53 was observed to remain in bed, asleep on his on back. -At 11:25 a.m. R53 was observed to remain in bed, asleep on his back. -At 11:33 a.m. NA-B entered the room. R53 was observed sound asleep. At this time, NA-A stated R53's incontinent brief was last changed at 7:00 a.m. NA-A stated staff did not check R53's brief prior to laying him down because this would upset him.. -At 11:40 a.m. R53's brief was removed and R53 was observed to have been incontinent of urine. At 11:44 a.m. NA-A stated at 7:00 a.m. R53's brief was wet and verified R53 was to be toileted/or changed every 2 hours. NA-A again verified R53 was not checked for incontinence from 7:00 a.m. until 11:40 a.m. (4 hours & 40 minutes). NA-A stated the normal routine for R53 would be to lay him down after breakfast without	F 282	with all staff directly caring for R53. 2. Corrective Action as it applies to other resident's: A.) Staff education provided for all staff. B.) QA monitor will be done weekly and PRN for 90 days. Results will be taken to QA Committee to see if any further action is needed. 3. RE-occurrence will be prevented by: A.) QA audits will be done weekly and PRN for R53. B.) All residents on toileting assistance will be monitored PRN for compliance. C.) Results will be reviewed by QA Committee and any further needed action will be taken. 4. POC will be monitored by: IDT Team, QA Committee, RN staff. 5. Completion Date: 09/05/14.	

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F 282	Continued From page 6 checking or changing his brief to avoid a behavior. On 8/14/14, at 12:48 p.m. the director of nursing (DON) stated R53 was to be checked for incontinence every 2 hours. The DON confirmed R53's care plan was not followed. The facility's policy titled, The Care Planning Team policy revised 5/11, indicated care was planned to help attain or maintain the resident's/patient's highest practicable physical, mental and psychosocial well being.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting / incontinence care for 1 of 2 residents (R53) reviewed for incontinence care. Findings include: R53's The Urinary Incontinence Care Area	F 315	It is the policy and procedure of HLC to provide appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 1. Corrective Action: A.) The two staff involved with the incident were educated on HLC P&P as it relates	9/5/14

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F 315	Continued From page 7 Assessment (CAA) dated 12/30/13, indicated R53 required assistance for toileting related to diagnoses of Alzheimer's dementia and severe cognitive impairment. R53's Bowel & Bladder Assessment dated 12/20/13, indicated R53 was to be toileted every 2 hours and upon request. In addition, the assessment also indicated R53 could be resistive to incontinence care. R53's care plan dated 1/14, indicated R53 required extensive staff assistance to toilet as requested or every 2 hours during the day and to change R53's incontinent brief every 2 hours during the night. The care plan also indicated R53 was resistive to cares at times. R53's quarterly Minimum Data Set (MDS) dated 6/22/14, indicated R53 was diagnosed with Alzheimer's dementia, had severe cognitive impairment, had no behaviors, was always incontinent of bladder and required extensive assistance of two staff for transferring, toileting and personal hygiene. On 8/13/14, at 7:02 a.m. R53 was observed seated in the wheelchair by the nurses station. -At 7:25 a.m. R53 was observed at the breakfast table. R53 was continuously observed to remain seated at the table until 8:42 a.m. -At 8:42 a.m. R53 was assisted to his room. Nursing assistant (NA)-B and NA-C were observed to transfer R53 to bed. R53 was not toileted nor was his incontinent brief checked. -At 9:14 a.m. R53 was observed in bed, asleep on his back. -At 10:30 a.m. R53 was observed to remain in bed, asleep on his on back.	F 315	to incontinent residents. B.) R53 care plan and treatment reviewed with staff involved including what to do if R53 became resistive with cares. C.) Education provided to all staff who care for R53. 2. Corrective Action as it applies to other residents: A.) Staff education provided regarding P&P for incontinent care. B.) QA will be done weekly and PRN for residents receiving an incontinence program for 90 days. C.) Results will be taken to QA Committee to see if further action is needed. 3. Re-occurrence will be prevented by: A.) PRN QA monitoring. B.) On going staff education in regards to B&B programs. 4. The POC will be monitored by: IDT, QA Committee and RN staff. 5. Date of completion: 09/05/14.	

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F 315	Continued From page 8 -At 11:25 a.m. R53 was observed to remain in bed, asleep on his back. -At 11:33 a.m. NA-B entered R53's room. R53 was observed sound asleep. At this time, NA-A stated R53's incontinent brief was last changed at 7:00 a.m. NA-A stated staff did not check R53's brief prior to laying him down because this would upset him.. -At 11:40 a.m. R53's brief was removed and R53 was observed to have been incontinent of urine. At 11:44 a.m. NA-A stated at 7:00 a.m. R53's brief was wet and verified R53 was to be toileted/or changed every 2 hours. NA-A again verified R53 was not checked for incontinence from 7:00 a.m. until 11:40 a.m. (4 hours & 40 minutes). NA-A stated the normal routine for R53 would be to lay him down after breakfast without checking or changing his brief in order to avoid a behavior. On 8/14/14, at 12:48 p.m. the director of nursing (DON) stated R53 was to be checked for incontinence every 2 hours and if R53 acted as though he was going to be resistive, staff should have left him in a safe manner and had someone else attempt to provide cares 10-15 minutes later. The DON stated this was "not acceptable" practice. The DON further stated R53's care plan was not followed. The Urinary Incontinence policy revised 5/14, indicated an incontinent resident must be treated according to the comprehensive assessment and care plan.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		9/5/14

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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 323	Continued From page 9 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure frequent visual safety checks were implemented for 1 of 1 resident (R53), failed to ensure anti-lock brakes were implemented for 2 of 2 residents (R12, R59) who were identified as at risk for falls. In addition, the bed alarm was not being used as an effective fall intervention as the box was not secured to any surface for 1 of 1 resident (R12) reviewed with a bed tab alarm. Findings include: R53's care plan was not updated to include current fall interventions in order to minimize the risk of falls and injury. R53's Fall Care Area Assessment (CAA) dated 12/30/13, indicated R53 had seven falls in the past quarter due to self transfers secondary to dementia. R53 used a tab alarm in the wheelchair and a pressure alarm in his bed. The CAA also indicated R53 was receiving medications to treat depression and anxiety which could have contributed to the falls. R53's Fall Risk Assessment dated 12/30/13, indicated R53 was at high risk for falls and	F 323	It is the policy and procedure of HLC to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Corrective Action: A.) Visual checks will be recorded for R53. B.) R12 Safety anti-lock brakes were applied to new wheelchair on 08/14/14. C.) R59 anti-lock brakes were fixed on 08/13/14. D.) R12 bed alarm was changed to pressure alarm to prevent if from not being secured. E.) R53 Care plan updated to include the interventions listed on incident report assessment. F.) R53 tab alarm in chair changed to a pressure alarm. G.) R12 and R 59 care plans were reviewed and revised as needed. 2. Corrective Action as it relates to other residents: A.) All residents with incidents the past three months were reviewed and care plans updated as indicated.	

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F 323	Continued From page 10 utilized a tab alarm in the wheelchair and pressure pad alarm in bed. The updated fall assessment section dated 6/22/4, indicated R53 remained at risk due to self transfer attempts, lacked safety awareness and utilized a tab alarm in wheelchair and pressure pad alarm in the bed. R53's care plan dated 1/14, indicated R53 had a potential for injury related to falls. The interventions included a pressure pad alarm on bed, tab alarm in wheelchair, non-skid footwear, call light within reach and clear pathways. R53's quarterly Minimum Data Set (MDS) dated 6/22/14, indicated R53 was diagnosed with Alzheimer's dementia, had severe cognitive impairment, had no behaviors, had 1 fall with minimal injury and required extensive assistance of two staff for transfers, bed mobility and ambulation. According to the Confidential Peer Review Document Resident Incident Reports R53 sustained the following falls: -12/14/13, at 3:55 a.m. R53 was found on the floor at end of his bed, no injuries and his bed alarm did not sound. Staff checked the alarm and it was determined to be functioning properly. Documented interventions for R53 indicated staff removed R53's socks, would continue to do visual checks on R53 throughout the shift and would continue with the sensor alarm on the bed. -12/17/13, at 2:10 a.m. R53 ambulated from his wheelchair and went outside. The alarm from the wheelchair and the front door were both sounding. Documented interventions for R53 indicated staff would monitor resident closely and	F 323	B.) Staff education provided on safety devices and use. C.) HLC will order all pressure alarms and will not use tab alarms on any resident that can remove them. D.) QA audit will be done weekly on alarms and incident reports for 90 days. Results will be taken to QA Committee for further action needs. 3. Re-occurrence will be prevented by: A.) Weekly QA audits for 90 days then PRN. B.) Input from IDT and QA Committee. C.) Education for new staff and with incident reports. 4. The POC will be monitored by: QA Committee, IDT, RN staff. 5. Date of Completion: 09/05/14.	

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F 323	Continued From page 11 offer the bathroom often. R53 did not sustain an injury. -3/1/14, at 4:30 a.m. found R53 on the floor in room B-7. Documented interventions for R53 indicated staff were reminded to do visual checks every 2 hours, and offer the bathroom every 2 hours and as needed. R53 sustained a reddened area to his right shoulder and mid back. -3/5/14, at 3:00 a.m. a nursing assistant (NA) witnessed R53 as he stood up from the wheelchair, the alarm sounded but the NA was unable to reach R53 before he fell against the wall hitting a receptacle box and scraping his back. Documented interventions for R53 indicated he had medication changes over the last month, would remind staff to do visual checks and offer fluids and ambulation. R53 sustained abrasions and a scrape on his mid-back. -5/3/14, 1:30 p.m. R53 was found on the floor, in his room sitting up next to his recliner trying to put on his hat. R53's family member (FM)-A had left R53 on the couch unattended and had not notified the staff. The documented intervention was to ask FM-A to notify staff when she left the building. R53 did not sustain an injury, -6/12/14, at 3:30 p.m. R53 was in the dining room, attempted to stand up from the chair and it scooted out from underneath him. The alarm sounded and R53 was ambulated. Documented interventions for R53 indicated staff do visual checks on R53. R53 did not sustain an injury, -6/13/14, at 11:15 p.m. R53 had walked into hallway unassisted from his the bed and fell. R53 was left up in the wheelchair as he did not want to	F 323		

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F 323	Continued From page 12	F 323		

go to bed. Registered Nurse (RN)-A documented R53 had removed the tab alarm and the care plan was being followed. R53 sustained a skin tear on his wrist, thumb and elbow.

-7/13/14, at 6:00 p.m. R53 was transferred to a regular chair in the dining room by FM-A. FM-A did not put the tab alarm on R53 or let anyone know prior to leaving. FM-A was instructed to make sure the tab alarm was on R53 prior to her leaving him alone. Documented interventions for R53 indicated staff would continue to do visual checks on R53. R53 sustained an open area on his left lower arm wand had hit his head on another resident's wheelchair.

-7/14/14, at 10:20 a.m. R53 was in the wheelchair and tried to get up and walk. R53 was moved to a room closer to the nurses station to minimize falls. Documented interventions for R53 indicated a pressure sensor alarm was placed on the bed. R53 sustained an abrasion to his left elbow and back of left hand.

On 8/13/14, at 7:02 a.m. R53 was observed seated in the wheelchair near the nurses station. The tab alarm was observed clipped to the back of his shirt. R53's wheelchair was also observed to have anti-tippers attached to the back of his wheelchair.

At 8:42 a.m. nursing assistants (NA)-B and NA-C were observed to transfer R53 to bed. The tab alarm was attached to R53 and the sensor alarm box was secured on the headboard.
At 9:14 a.m. R53 remained asleep on his back in bed.

At 11:33 a.m. NA-B and NA-C entered the room.

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F 323	Continued From page 13 The bed sensor alarm sounded when R53 sat up on the edge of the bed. On 8/14/14, at 8:02 a.m. NA-B stated not very often anymore had R53 attempted to stand up alone. NA-B stated they went to the bed sensor alarm after R53 disconnected the tab clip alarm in bed. NA-B stated they attempt ambulation with R53 twice daily. At 10:40 a.m. the director of nursing (DON) verified safety visual checks were initiated for R53 on 12/14/13, however, stated the frequency of the checks was not identified. At 10:51 a.m. the DON also stated when R53 fell on 7/13/14, the documentation did not reflect how often the visual checks would be done. At 12:30 p.m. the DON confirmed R53's care plan did not address the wheelchair anti-tippers not the visual safety checks. The DON stated staff were not documenting the safety checks for R53 and indicated they would work on that. On 8/14/14, at 1:40 p.m. licensed practical nurse (LPN)-B stated they do "peek" in on R53 when he was in bed and in the dining room. LPN-B stated the visual safety checks were not documented in the clinical record. R12's care plan was not updated to include current fall interventions in order to minimize the risk of falls and / or injury. R12's annual MDS dated 12/11/13, indicated R12 was diagnosed with dementia, had cognitive impairment. R12's quarterly MDS dated 6/4/14,	F 323		

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F 323	Continued From page 14 indicated R12 had moderate cognitive impairment, required extensive assist of one-two staff for transfers and walking and had sustained two falls. R12's Fall CAA dated 12/11/13, indicated R12 was at high risk for falls and required extensive assistance with bed mobility, transfers, locomotion and ambulation. . Risk factors included R12 forgetting to use walker, and not using the call light. The assessment indicated R12 had ongoing physical and occupational therapy plans. R12's Fall Risk Assessment dated 12/11/3, indicated R12 was at high risk for falls and a tab alarm in the bed and wheelchair were in place. The updated assessment section dated 6/3/14, indicated R12 had three falls and indicated an alarm reduction was attempted and failed due to alarms had aided in staff preventing falls and directed staff to continue with plan of care. R12's care plan dated 6/14, indicated R12 was at risk for falls, had a history of falls and attempted self transfers. The plan directed staff to keep R12's call light within reach, clear pathways, non-skid footwear, tab alarm in bed and wheelchair, Call don't Fall sign and take to the bathroom every 2 hours, and between 2-3 p.m. related to falls during that time period. R12's Occupational Therapy (OT) daily treatment note dated 6/26/14, indicated OT to position R12 in a high back wheelchair with increased depth to accommodate long legs, resident appears comfortable and positioned appropriately in wheelchair.	F 323		

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F 323	Continued From page 15 According to the Confidential Peer Review Document Resident Incident Reports R12 sustained the following falls: -7/14/14, at 12:50 p.m. R12 attempted to get herself from the bed to the wheelchair. Call light was in reach. Bed alarm was sounding. R12 was found sitting on the floor leaning against her bed. R12 did not sustain an injury. The anti-lock wheelchair brakes were not on the chair. -7/21/14, at 4:30 p.m. R12 tried to get up into the wheelchair from bed. R12 did not sustain an injury. The documented interventions were to lock the wheelchair brakes before leaving the room, add strips on the floor in front of the bed and to do visual safety checks. The anti-lock wheelchair brakes were not on the chair. On 8/12/14, at 3:15 p.m. R12 was observed in her room seated in the wheelchair. The clip alarm was attached to the back of her shirt. On 8/13/14, at 7:06 a.m. R12 was observed in bed, asleep. The clip alarm was attached to her clothes and the box for the alarm was lying on the bed, next to the pillow. -At 7:20 a.m. until 8:35 a.m. R12 was observed to remain in bed with the tab alarm box lying on the bed next to her pillow. -At 8:47 a.m. NA-B stated the night staff had stated R12 had a hard night as she was upset with the staff. NA-B stated some days R12 would sleep until 11:00 a.m. and if they were to wake her R12 would become upset. -At 9:00 a.m. R12 remained in bed, asleep. The clip alarm was attached to her shirt and the alarm box remained lying on the bed next to the pillow	F 323		

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F 323	Continued From page 16 and not affixed to the headboard. -At 10:30 a.m. R12 was observed to remain in bed, asleep. The alarm remains on bed next to the pillow. Velcro tabs were observed on the headboard. . -At 10:55 a.m. NA-C stated NA-B was in to check on R12. NA-B and NA-C both stated they had tried to wake R12 with no luck. NA-C stated R12 was awake most of the night. -At 11:11 a.m. remained the same with the box lying on the bed next to the pillow. -At 11:26 a.m. R12 was observed on the bedside commode. NA-C was observed to stand R12 with use of the walker. NA-C stated she was going to get the bed tab alarm hooked up. -At 11:27 a.m. NA-C transferred R12 into the wheelchair. The alarm was attached to her shirt. -At 11:30 a.m. NA-C stated R12 had anti-tippers on the wheelchair but no anti-lock brakes. At 12:50 p.m. NA-B stated R12 forgot to ask for help and would fall when she attempted to get in or out of bed. NA-B stated R12 should have anti-lock brakes on the wheelchair. NA-B stated they had issues with the Velcro pad on the headboard of the bed not being effective as the alarm box would not stay securely affixed to it. NA-B confirmed the alarm box should be securely attached to the headboard. On 8/14/14, at 8:20 a.m. NA-B was observed to stand R12. There were no anti-lock brakes on the wheelchair. NA-B stated about a month ago, R12 received a different wheelchair and she thought her other wheelchair had the anti-lock brakes on and they were not switched over to the new chair. In addition, NA-B stated they use to have containers on the bed to put the alarm box in.	F 323		

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F 323	Continued From page 17 At 8:38 a.m. physical therapist (PT)-A confirmed OT did switch R12's wheelchair and verified R12 had the anti-lock brakes on the previous chair and stated it was a total oversight that the anti-lock brakes were not switched over to the new chair. At 9:02 a.m. the DON stated at one point they had put anti-tippers on R12's chair and had also implemented visual safety checks, however, confirmed they did not identify how frequent the visual checks were to occur. The DON also stated she had not seen any documentation of the visual checks even being performed. In addition, the DON stated the bed alarm box was to be affixed to the headboard and confirmed R12's anti-lock brakes were not placed on her new wheelchair and should have been. At 9:53 a.m. the DON stated staff have had training and know the alarm box was to be affixed to a surface. The DON reviewed R12's care plan and verified the plan should have been updated include the anti-tippers, anti-lock brakes, strips by the bed and frequency of visual checks. R59's auto-lock brakes were not functioning properly in order to minimize the risk for falls and injury. R59's annual MDS dated 6/14/14, indicated R59 had dementia, severe cognitive impairment and anxiety. The MDS also indicated R59 was at risk for falls, required extensive assist of two staff to transfer and walk and had two falls with no injury. R59's Falls CAA dated 6/19/14, indicated 59 had fallen twice this past quarter without injury due to self-transfer attempts.	F 323		

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R59's care plan, dated 6/14, indicated R59 was at risk for falls due to weakness, dementia, decreased mobility and R59 required two staff assist to walk with use of walker, ability fluctuated. The plan directed staff provide clear pathways, non-skid footwear, call don't fall, gripper tape on floor in front of recliner and bed, tab alarm in wheelchair and recliner, pressure pad alarm in bed and auto lock brakes (device that engages a braking mechanism on the wheelchair when the resident stands up, to prevent the wheelchair rolling backward) on wheel chair to prevent falls.

R59's Falls risk assessment, dated 6/14/14, indicated R59 was at high risk for falls due to severe cognitive impairment, lack of safety awareness and had two falls without injury in the past quarter secondary to self transfers.

Review of R59's nursing progress notes revealed falls on 8/15/14, 8/11/14, 8/3/14, 5/28/14, 5/22/14, 5/9/14, 4/8/14, and 3/29/14. Four of the eight falls occurred after self-transfer attempts from the wheelchair.

On 8/13/14, at 7:15 a.m. R59 was observed lying in bed on his left side.
-At 8:21 a.m. R59 was observed in the central hallway near the restroom. R59 was observed to attempt to self transfer from the wheelchair into the bathroom and was assisted by PT-A.
-At 8:31 a.m. NA-A was observed to lay R59 into bed. R59's wheelchair was left sitting alongside his bed. The wheelchair auto brakes did not appear to be in contact with the wheelchair with visible daylight between the brake mechanism and the wheels.

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F 323	Continued From page 19 -At 8/13/14, at 9:24 a.m. the auto brakes were again observed with light visible between the auto brakes and the wheelchair tires. Maintenance staff member (MT)-A was present and stated R59's auto brakes were not set correctly and verified the brakes allowed the chair to freely move back and forth. MT-A stated there was no preventive maintenance schedule for the auto brakes. MT-A stated he tried to check wheelchairs as often as able, however, this was difficult due to recent turnover of staff in his department. The Fall Prevention policy revised 9/10, indicated there was an ongoing system for monitoring and analyzing incidents of falls in order to determine causal factors and implement appropriate interventions. A "Post Fall Analysis" was to be completed within 24 hours by a registered nurse (RN) after each fall and any change in interventions were to be noted on the resident's care plan.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		9/5/14

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F 329	Continued From page 20 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction (GDR) of an antipsychotic medication (Seroquel) was completed or the clinical contraindications documented for 1 of 5 residents (R59) reviewed for unnecessary drug use. Findings include: R59's undated, Record Of Admission form indicated R59 was diagnosed with dementia, hallucinations and anxiety. R59's annual Minimum Data Set (MDS) dated 6/14/14, indicated R59 had severe cognitive impairment, no behaviors or mood indicators. R59's Psychotropic Drug Use Care Area Assessment (CAA) dated 6/19/14, indicated R59 had a history of hallucinations and the Seroquel was effective in decreasing the hallucinations. The CAA also indicated staff had not noticed any hallucinations.	F 329	It is the policy and procedure of HLC to ensure that resident's are free from unnecessary medications. Residents who receive antipsychotic medications receive gradual dose reductions and behavioral interventions. The goal is to give the lowest therapeutic dose. 1. Correction: A.) FAX have been sent every six months to physician about reducing R59's Seroquel. Wife and physician have been reluctant to decrease medication due to hallucinations and behavior concerns (Became resistive with cares)in the past. After survey another call was placed to wife and FAX was re-sent to physician. Medication was decreased from 75 mg to 50 mg on 08/18/14. B.)Resident was started on decreased dose and behavior monitoring every shift was continued. C.) R59 has had an increase in hallucinations. (EG: thought a staff was	

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F 329	Continued From page 21 R59's care plan, dated 6/14, indicated received Seroquel for dementia and history of hallucinations. The plan also indicated family reported R59 informed them that people would rearrange his room when no changes were made. Under the behavior section of the care plan indicated R59 had no behaviors while at the facility. The care plan indicated the goal was for R59 to be on the least dose possible with decreased episodes of anxiety and behaviors. The plan directed staff to administer the medication as ordered and to offer R59 activities of interest, music, assist R59 to call his spouse for comfort, validate concerns, encourage resident to ambulate, monitor side effects and referrals as needed. A fax to R59's physician dated 4/1/14, prepared by registered nurse (RN)-A, indicated a request for an order for R59 to remain on Seroquel as ordered as it worked well with decreased hallucinations and anxiety. R59's physician responded by writing an order on the return fax (same page) for R59 to continue the Seroquel related to diagnosis of psychosis. R59's Psychotropic Medication Assessment, dated 6/20/14, indicated R59 received Seroquel for dementia. The assessment indicated R59 currently received 75 milligrams (mg) orally at bedtime for anxiety and hallucinations. The assessment further indicated a fax was sent in March 2014, to the physician requesting a gradual dose reduction. However, at that time, R59's primary care physician did not want the dose changed due to its effectiveness, unsure of how often the target behaviors were occurring. Lastly, the assessment indicated non-drug interventions included 1:1 visits, redirection and	F 329	his partner on the police force and talked about how fast he could draw his pistol, also stated he was on a "stakeout" and would not let staff or other residents in the day room, sold cars that had been seized in the drug busts to his room mate). Physician was FAXED about the increase in hallucinations. Staff do not feel his increase in hallucinations warrants increasing the Seroquel back at this time. Will continue to closely monitor for any signs of resident distress. At this time are able to redirect without injury to self or others. D.) Education given to staff on P&P. E.) QA will be done weekly on behavior/anxiety and hallucinations and reported to physician as indicated. 2. Correction as it relates to other residents: A.) QA will be done for all residents receiving antipsychotic medications to ensure that GDR has been attempted in a timely manner. B.) QA results will be taken to QA Committee and reviewed to see if further action is needed. 3.) Re-occurrence will be prevented by: A.) QA audit by RN/DON monthly for 90 days. Results will be reviewed by QA Committee. 4. The POC will be monitored by: IDT, QA Committee, RN Group and DON 5. Date of Correction: 09/05/14.	

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 _____	08/14/2014

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 329	Continued From page 22 indicated the goal for the Seroquel use was for R59's improved self-esteem, decreased agitation and less hallucinations. R59's Physician Orders form dated 7/6/14, indicated an order for Seroquel 75 milligrams (mg) every evening for hallucinations, anxiety and dementia. Review of R59's progress notes, dated 8/7/14, indicated R59 was taking Seroquel 75 mg for hallucinations and anxiety. The note indicated at times R59 would hallucinate, however, knew that's what it was and what he was seeing was not there. On 8/11/14, at 6:40 p.m. R59 was observed seated in a wheelchair in front of the nursing station and attempting to lean forward in his chair. He was redirected by the director of nursing (DON). At 7:11 p.m. R59 was observed to stand up by himself from the wheelchair. A clip alarm sounded. Another staff member (unidentified) was observed to wheel him to a music activity. On 8/13/14, at 7:15 a.m. R59 was observed lying on his side, in bed. At 8:21 a.m. R59 was observed in the central hallway with a pleasant facial expression and stated he enjoyed the "stick rolls" he ate for breakfast. R59 wheeled himself to a restroom and attempted to self-transfer to the toilet. R59 was assisted to the bathroom by physical therapy assistant (PT)-A. -At 8:31 a.m. nursing assistant (NA)-A was observed to assist R59 into bed.	F 329		

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F 329	Continued From page 23 On 8/13/14, at 8:45 a.m., NA-A verified she was a primary staff member on R59's wing and stated R59 had no behaviors or hallucinations. On 8/14/14, at 9:14 a.m. the consultant pharmacist (CP)-A stated he would have liked to see what had been done before (with regard to gradual dose reductions) for R59, who had been on the medication "quite a while." CP-A confirmed the last GDR for R59's Seroquel was attempted in August of 2012 and the physician had not wanted to reduce the medication after that. CP-A stated the doctors were not "perfect" with regard to psychotropic medication documentation. At 9:51 a.m. registered nurse (RN)-A stated sometimes R59 saw water on the floor but was aware it was not really there and sometimes thought he heard police officers talking, but was aware the police officers were not real. RN-A stated she was unaware if adverse consequences had resulted from previous Seroquel dose reductions. On 8/14/14, at 11:04 a.m. a message was left for R59's physician. No further information related to the dose reductions of the Seroquel were provided. The facility policy, dated 5/2011, entitled Psychotropic Medications indicated based on a comprehensive assessment, residents who have not used antipsychotic drugs would not be given these drugs unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and documented in the clinical record and residents who use antipsychotic drugs would	F 329		

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F 329	Continued From page 24 receive gradual dose reductions, behavioral interventions and unless clinically contraindicated in an effort to discontinue these drugs.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding	F 334		9/5/14

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	245405	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 334	Continued From page 25 the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the risks and benefits of a pneumococcal vaccination administration or refusal of the vaccination were reviewed with the resident and family for 1 of 5 residents (R95) reviewed for immunizations.	F 334	It is the policy and procedure of HLC to provide education for resident/family providing the risk/benefit of influenza vaccinations and pneumococcal immunization prior to giving the vaccines. 1. Corrective Action:	

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	245405	A. BUILDING _____ B. WING _____	08/14/2014

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F 334	Continued From page 26 Findings include: R95's undated, Record Of Admission sheet indicated R95 was admitted to the facility 6/14, and indicated R95's diagnoses included cerebral palsy with spasticity and weakness. R95's Pneumovax, Tetanus, and Flu Vaccine Inquiry, dated 6/20/14, indicated R95 had not previously received a Pneumovax (an immunization given to prevent pneumococcal infections). R95's Physician Orders dated 6/20/14, and signed by the physician on 8/5/14, identified Pneumovax, however, the date of R95 received was blank. On 8/13/14, at 10:41 a.m. the director of nursing (DON) stated the facility policy was to determine pneumococcal immunization status for new admissions and if the vaccination had not been given to determine why. On 8/14/14, at 8:39 a.m. R95 stated he could not recall being offered the vaccination. R95's family member (FM)-A stated family typically assist R95 with medical decision making and stated he was not consulted about the vaccination. On 8/14/14, at 8:39 a.m. registered nurse (RN)-A stated the nurse who signed R95's admission vaccination form should have reviewed the risks and benefits of the vaccination with the resident. RN-A confirmed R95 made many of his decisions in conjunction with his family. The facility policy entitled Influenza and PPV	F 334	A.) The nurse involved in the incident was educated on HLC P&P. B.) On 08/15/14 DON visited with R95. He did not wish to receive the pneumococcal immunization. Education sheet was given to him. C.) On 08/16/14 R95's father came to HLC. Unit Manager discussed with R95 and father and gave education to father. Resident did not want to receive immunization. D.) Education material and P&P reviewed with floor staff on 08/25/14. 2. Corrective Action as it related to other residents: A.) Staff education provided on HLC P&P. B.) A QA will be done on all new admits for 90 days. Results will be taken to QA Committee to see if further action is needed. C.) Copies of resident/family education put on each nurses station for easier access. 3. Re-occurrence will be prevented by: A.) QA audit for 90 days and then PRN. Results will be reviewed Quarterly with QA Committee and further action taken if needed. 4. The POC will be monitored by: QA Committee, Unit Managers, DON 5. Date Of Completion: 09/05/14.	

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F 334	Continued From page 27 [pneumococcal vaccine] Vaccinations, last revised 06/11, indicated each resident was informed about the benefits and risks of immunizations and had the opportunity to receive, unless medically contraindicated or refused or already immunized, the influenza and pneumococcal pneumonia vaccine (PPV) and Assure documentation in the resident's medical record of the information/education provided regarding the benefits and risks of immunization and the administration or the refusal of or medical contraindications to the vaccine(s).	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pharmacist identified the need for a gradual dose reduction (GDR) of an antipsychotic medication (Seroquel) was completed or the clinical contraindications documented for 1 of 5 residents (R95) reviewed for unnecessary drug use. Findings include:	F 428	It is the policy and procedure of HLC to have a pharmacist review of each resident's drug regimen at least once a month. 1. Correction: A.)Discussion held with pharmacist. The pharmacist states that there is notes about why they felt a reduction was not a good idea. Physician has reviewed at	9/5/14

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F 428	Continued From page 28 R59's undated, Record Of Admission form indicated R59 was diagnosed with dementia, hallucinations and anxiety. R59's annual Minimum Data Set (MDS) dated 6/14/14, indicated R59 had severe cognitive impairment, no behaviors or mood indicators. R59's Psychotropic Drug Use Care Area Assessment (CAA) dated 6/19/14, indicated R59 had a history of hallucinations and the Seroquel was effective in decreasing the hallucinations. The CAA also indicated staff had not noticed any hallucinations. R59's care plan, dated 6/14, indicated received Seroquel for dementia and history of hallucinations. The plan also indicated family reported R59 informed them that people would rearrange his room when no changes were made. Under the behavior section of the care plan indicated R59 had no behaviors while at the facility. The care plan indicated the goal was for R59 to be on the least dose possible with decreased episodes of anxiety and behaviors. The plan directed staff to administer the medication as ordered and to offer R59 activities of interest, music, assist R59 to call his spouse for comfort, validate concerns, encourage resident to ambulate, monitor side effects and referrals as needed. R59's Psychotropic Medication Assessment, dated 6/20/14, indicated R59 received Seroquel for dementia. The assessment indicated R59 currently received 75 milligrams (mg) orally at bedtime for anxiety and hallucinations. The assessment further indicated a fax was sent in March 2014, to the physician requesting a	F 428	least every six months did not want medication decreased. Wife, who had been caring for R95 prior to placement, did not want medication changed. B.) See under F-329 on specific resident correction. C.) Staff education provided. D.) Monitor R59 closely for hallucinations. He does not seem to be able to tell real from imaginary with recent reduction but staff have been able to redirect. E.) QA will be done on R59 assessments and GDR and physician will be notified of any changes. F.) Pharmacist will continue monthly reviews and will report any irregularities to physician and DON. These reports will be acted upon. 2. Correction as it relates to other residents: A.) All residents receiving psychotropic medications will be reviewed for their last GDR to ensure that it has a happened in a timely manner. B.) Monthly QA for 90 days on all psychotropic medications. Results will taken to QA Committee to see if further action is needed. C.) Education will be provided to staff on an annual and PRN basis to ensure the P&P is understood. D.) Pharmacist will continue to review all resident charts on a monthly basis and report any irregularities to physician and DON. All reports will be acted upon. 3. Re-occurrence will be prevented by: A.) QA audits will be done monthly for 90 days and then reviewed by QA Committee.	

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F 428	Continued From page 29 gradual dose reduction. However, at that time, R59's primary care physician did not want the dose changed due to its effectiveness, unsure of how often the target behaviors were occurring. Lastly, the assessment indicated non-drug interventions included 1:1 visits, redirection and indicated the goal for the Seroquel use was for R59's improved self-esteem, decreased agitation and less hallucinations. R59's Physician Orders form dated 7/6/14, indicated an order for Seroquel 75 milligrams (mg) every evening for hallucinations, anxiety and dementia. Further review of R95's physician's orders revealed a fax, dated 4/1/14, that was prepared by registered nurse (RN)-A. RN-A's comments to R95's physician included would like to see resident remain on this medication as it works well for him, hallucinations and anxiety decreased - could we please have an order to continue medications as ordered - thank you. R95's physician had signed the bottom form and indicated that R95 could remain on the medication for a diagnosis of psychosis. Review of R95's pharmacy consultanat reviews revealed the following entries: -10/24/13 - decrease Seroquel? Dr. [doctor] desires no change per our form. -1/23/14 - PN [physican notes] indicate hallucinations - leave Seroquel as is. -4/17/14 - physician fax signed 4/1/14, documents continued need for Seroquel at current dose, documentes benefit of seroquel and shows hallucinations still present at time may need to increase seroquel vs decrease. Follow up 9 or 10/14. -5/15/14 - No irregularities. -6/19/14 - No irregularities.	F 428	B.) Staff education will be given annually and PRN. 4. The POC will be monitored by: IDT, QA Committee, DON, RN group, and pharmacist. 5. Date of Completion: 09/05/14.	

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F 428	Continued From page 30 -7/17/14 - No irregularities. Review of R59's progress notes, dated 8/7/14, indicated R59 was taking Seroquel 75 mg for hallucinations and anxiety. The note indicated at times R59 would hallucinate, however, knew that's what is was and what he was seeing was not there. On 8/13/14, at 8:45 a.m., NA-A verified she was a primary staff member on R59's wing and stated R59 had no behaviors or hallucinations. On 8/14/14, at 9:14 a.m. the consultant pharmacist (CP)-A stated he would have liked to see what had been done before (with regard to gradual dose reductions) for R59, who had been on the medication "quite a while." CP-A confirmed the last GDR for R59's Seroquel was attempted in August of 2012 and the physician had not wanted to reduce the medication after that. CP-A stated the doctors were not "perfect" with regard to psychotropic medication documentation. At 9:51 a.m. registered nurse (RN)-A stated sometimes R59 saw water on the floor but was aware it was not really there and sometimes thought he heard police officers talking, but was aware the police officers were not real. RN-A stated she was unaware if adverse consequences had resulted from previous Seroquel dose reductions. On 8/14/14, at 11:04 a.m. a message was left for R59's physician. No further information related to the dose reductions of the Seroquel were provided.	F 428		

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F 428	Continued From page 31 The facility policy, revision date 5/11, entitled Psychotropic Medications directed residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue thsese drugs.	F 428		

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

F540502

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING **02 - 1960 BUILDING & 69, 90, 94, 2000 ADDITIONS** B. WING _____	**08/12/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY . A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Heritage Living Center 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Heritage Living Center is a 1-story building with a basement under the 1960 building. The 1960 building was determined to be of Type II(111) construction, is separated form the new assisted living building with a 2-hour fire barrier and has a basement. In 1969 an addition was constructed to the north of the 1960 building, was determined to be of Type II(111) construction and is separated form the 1960 building with 2-hour fire barriers. In 1990 the chapel addition was constructed to the south of the of the 1960 building, was determined to be of Type V(111) construction and is separated from the 1960 building with a 2-hour fire barrier. In 1994 the laundry addition was added to the north of the 1960 building, was determined to be of Type II(111) construction and is separated from the 1960 building and the new assisted living building with 2-hour fire barriers. 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, was determined to be of Type V (111) construction and	K 000		

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

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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	245405	A. BUILDING **02 - 1960 BUILDING & 69, 90, 94, 2000 ADDITIONS** B. WING _____	**08/12/2014**

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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 is separated form the apartment building with a 2-hour fire barrier. The building is divided into 5 smoke zones with 30 minute and 90 minute fire barriers. 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. 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 64 beds and had a census of 56 at the time of the survey. Because the building and all additions are sprinkler protected and meet the construction types allowed the facility was surveyed as a single building. (1-story Type V (111)) The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		