**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: WI5G

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00904

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/20/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**06/30**

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

12. Total Facility Beds **78** (L18)

13. Total Certified Beds **78** (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 |
|---|---|---|---|---|
| | 78 | | | |
| (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):

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 02/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**12/26/2013**
(L33)

DETERMINATION APPROVAL

**C&T REMARKS - CMS 1539 FORM** **STATE AGENCY REMARKS**

CCN: 24-5245

Heritage Manor was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on November 7, 2013. On December 20, 2013 the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on November 7, 2013, effective December 17, 2013. Refer to the CMS-2567b for health only.

Effective December 17, 2013, the facility is certified for 78 skilled nursing facility beds.

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 24-5245

March 9, 2014

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

Dear Mr. Ryan:

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

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

Effective December 17, 2013 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

cc: Licensing and Certification File

*Protecting, Maintaining and Improving the Health of Minnesotans*

February 4, 2014

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

RE: Project Number S5245025

Dear Mr. Ryan:

On November 22, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 20, 2013, 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 November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 17, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 7, 2013, effective December 17, 2013 and therefore remedies outlined in our letter to you dated November 22, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-302-6151 Fax: 218-723-2359

Enclosure
cc: Licensing and Certification File

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245245 | A. Building<br>B. Wing | 12/20/2013 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| HERITAGE MANOR | 321 NORTHEAST SIXTH STREET<br>CHISHOLM, MN 55719 |

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

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix F0279<br>Reg. # 483.20(d), 483.20(k)(1)<br>LSC | 12/17/2013 | ID Prefix F0282<br>Reg. # 483.20(k)(3)(ii)<br>LSC | 12/17/2013 | ID Prefix F0315<br>Reg. # 483.25(d)<br>LSC | 12/17/2013 |
| ID Prefix F0329<br>Reg. # 483.25(l)<br>LSC | 12/17/2013 | ID Prefix F0371<br>Reg. # 483.35(i)<br>LSC | 12/17/2013 | ID Prefix F0456<br>Reg. # 483.70(c)(2)<br>LSC | 12/17/2013 |
| ID Prefix F0465<br>Reg. # 483.70(h)<br>LSC | 12/17/2013 | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

Followup to Survey Completed on:
11/7/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

Form Approved
OMB NO. 0938-0390

# Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245245 | A. Building<br>B. Wing | 12/20/2013 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| HERITAGE MANOR | 321 NORTHEAST SIXTH STREET<br>CHISHOLM, MN 55719 |

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

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix F0279<br>Reg. # 483.20(d), 483.20(k)(1)<br>LSC | 12/17/2013 | ID Prefix F0282<br>Reg. # 483.20(k)(3)(ii)<br>LSC | 12/17/2013 | ID Prefix F0315<br>Reg. # 483.25(d)<br>LSC | 12/17/2013 |
| ID Prefix F0329<br>Reg. # 483.25(l)<br>LSC | 12/17/2013 | ID Prefix F0371<br>Reg. # 483.35(i)<br>LSC | 12/17/2013 | ID Prefix F0456<br>Reg. # 483.70(c)(2)<br>LSC | 12/17/2013 |
| ID Prefix F0465<br>Reg. # 483.70(h)<br>LSC | 12/17/2013 | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| **Reviewed By CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |

**Followup to Survey Completed on:** 11/7/2013

**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WI5G
Facility ID: 00904

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **11/07/2013** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **06/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **78** (L18)
13.Total Certified Beds 78 (L17)

10.THE FACILITY IS CERTIFIED AS:
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: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 78 | | | |
| (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):
At the time of the Standard survey completed on November 7, 2013, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for health and life safety code along with the facility's plan of correction. PCR to follow.

17. SURVEYOR SIGNATURE Date :
Ann Hyrkas, HFE NEII 12/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/18/2013 (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 **09/01/1982** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)
27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

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

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS
Posted 12/26/2014 ML. WI5G

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)
DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7011 2000 0002 5143 7456

November 22, 2013

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

RE: Project Number S5245025

Dear Mr. Ryan:

On November 7, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

<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:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 302-6151
Fax: (218) 723-2359

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 17, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 17, 2013 the following remedy will be imposed:

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

**PLAN OF CORRECTION (PoC)**

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

**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 February 7, 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 May 7, 2014 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)
cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245245 | A. BUILDING ___ B. WING ___ | 11/07/2013 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HERITAGE MANOR | 321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719 |

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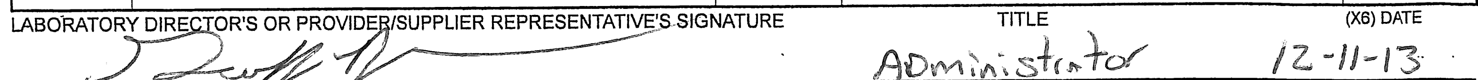
| F 000 | INITIAL COMMENTS<br><br>Ann Hyrkas<br>THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br>CENSUS = 72 | F 000 | OK 12-12-13 PLH | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment | F 279 | | |

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



Administrator | 12-11-13

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 279 | Continued From page 1<br>under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to develop a care plan to address post hospital care needs for 1 of 2 residents (R43) reviewed for hydration.<br><br>Findings include:<br><br>R43's diagnoses included post-hemorrhagic anemia, acute kidney failure, asthma, atrial fibrillation, congestive heart failure, hypertension, hypopotassemia, osteoarthrosis, pleural effusion, urinary tract infection, malignant neoplasm of small bowel, and pneumothorax.<br><br>The Interagency Transfer Form/Physician's Orders dated 6/24/13, revealed R43 had been hospitalized due to a small bowel obstruction secondary to a colonic mass. During the hospital stay, R43 suffered a dense hemispheric stroke with right sided paralysis. The 6/24/13, Transfer Form further noted R43's condition was terminal, and R43 was readmitted for hospice care.<br><br>Nursing progress notes at 10:09 p.m. on 6/24/13, indicated R43 was unresponsive with some movement of the right hand (likely autonomic responses), left side flaccid, and oral nutrition if able. R43 required hourly repositioning due to pressure ulcers on the coccyx, left inner heel and right ankle. | F 279 | **F279:** DON and/or designee will implement corrective action for resident (R43) affected by this practice by:<br>• Resident R43 received appropriate care after her hospitalization and passed away on 06-29-2013.<br><br>DON and/or designee will assess residents having the potential to be affected by this practice including:<br>• All other residents are potentially affected by this practice.<br>• All plans of care will be reviewed to ensure accuracy.<br><br>DON and/or designee will implement measures to ensure that this practice does not recur including:<br>• Nursing staff will be re-educated on updating plans of care beginning the week of 11-25-2013.<br><br>DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:<br>• 2 care plan audits will be performed weekly to ensure ongoing compliance beginning the week of 12-09-2013, until compliance is achieved, then two per quarter thereafter.<br>• The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring.<br><br>Completion Date: 12-17-2013 | |

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| F 279 | Continued From page 2<br><br>The care plan dated 6/28/13, indicated R43 ambulated with a walker, was independent in room, and required limited assist of 1 in corridor. The 6/28/13, care plan further indicated R43 was continent of bowel and bladder, fluid intake was to be 6 to 8 cups per day, and was independent after set up for elimination. The care plan described R43 as independent in grooming, with feeding after set up, with oral cares, with transferring, and self-propelled wheelchair off the unit independently.<br><br>On 11/7/13, at 12:00 p.m. registered nurse (RN)-A stated R43's care plan should have been updated to reflect the changes in condition upon return from the hospital with orders for hospice care.<br><br>On 11/7/13, at approximately 2:30 p.m. the director of nursing (DON) confirmed the care plan did not reflect the care needs of R43 upon hospital return.<br><br>A Nursing Care Plan Review policy revised 6/2009, directed each resident's care plan should be revised as needed to assure individualized, quality care. The policy further directed changes to the care plan should be made whenever a change is necessary, and the charge nurse should write a nurses note stating the care plan was reviewed and revised. | F 279 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN | F 282 | | |

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| F 282 | Continued From page 3<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility did not provided incontinence care as directed by the care plan for 1 of 4 residents (R44) reviewed for urinary incontinence.<br><br>Findings include:<br><br>R44 was not provided assistance with toileting or incontinence care from 4:49 a.m. to 10:08 a.m. (five hours and 19 minutes) on the morning of 11/6/13.<br><br>R44's diagnoses included chronic obstructive pulmonary disease, spinal stenosis, anxiety, type two diabetes and chronic pain.<br><br>The elimination care plan dated 2/19/13, indicated R44 was frequently incontinent of bowel and bladder. The goal indicated R44 would be clean and dry within one half hour of each incontinent episode. The care plan directed staff to offer toileting on rounds, every two hours and per request, and change the incontinent brief as needed during the day. | F 282 | **F282:** DON and/or designee will implement corrective action for resident (R44) affected by this practice by:<br>• Resident R44 plan of care is accurate.<br><br>DON and/or designee will assess residents having the potential to be affected by this practice including:<br>• All residents have plans of care, which must be followed by staff caring for residents.<br>• Care plans remain readily available for all staff providing direct care.<br><br>DON and/or designee will implement measures to ensure that this practice does not recur including:<br>• Nursing staff will be re-educated on availability of plans of care and the need to follow the resident specific plans of care beginning the week of 11-25-2013.<br><br>DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:<br>• 2 care plan audits, which will include toileting, will be performed weekly to ensure ongoing compliance beginning the week of 12-09-2013, until compliance is achieved, then two per quarter thereafter.<br>• The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring.<br><br>Completion Date: 12-17-2013 | |

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| F 282 | Continued From page 4<br>During continuous observation on 11/6/13, from 7:25 a.m. to 10:08 a.m. R44 was not offered or provided toileting or incontinence care. On 11/6/13, at 10:08 a.m. NA-A provided incontinence care but did not offer the toilet. R44's incontinent brief was heavily saturated with urine. At 10:30 a.m. the shift repositioning/toileting sheet was reviewed and NA-A stated R44 was last provided toileting/incontinence care at 5:00 a.m..<br><br>On 11/6/13, at 1:45 p.m., the director of nursing (DON) was interviewed and verified the care plan directed every two hour toileting/incontinence care. | F 282 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility did not provide toileting and incontinence care as directed by the care plan for 1 of 4 residents (R44) reviewed for urinary incontinence. | F 315 | | |

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| F 315 | Continued From page 5<br><br>Findings include:<br><br>R44 was not provided assistance with toileting or incontinence care from 4:49 a.m. to 10:08 a.m. (five hours and 19 minutes) on the morning of 11/6/13.<br><br>R44's diagnoses included chronic obstructive pulmonary disease, spinal stenosis, anxiety, type two diabetes and chronic pain.<br><br>The quarterly minimum data set (MDS) dated 7/31/13, indicated R44 had severe cognitive impairment. R44 required the extensive assistance of one staff with bed mobility and toileting and the extensive assistance of two staff with transferring.<br><br>The quarterly bowel and bladder assessment dated 10/20/13, indicated R44 was frequently incontinent of bowel and bladder. R44's current toileting plan was every two hours and per resident request, change as needed (PRN) during the day.<br><br>The elimination care plan dated 2/19/13, indicated R44 was frequently incontinent of bowel and bladder. The goal was for R44 to be clean and dry within one half hour of each incontinent episode. The care plan directed staff to offer toileting every two hours and per request, and to change the incontinent brief as needed during the | F 315 | **F315:** DON and/or designee will implement corrective action for resident (R44) affected by this practice by:<br>• Resident R44 is toileted according to her plan of care. Staff continues to follow the plan of care.<br><br>DON and/or designee will assess residents having the potential to be affected by this practice including:<br>• All other residents that need assistance with toileting are potentially affected by this practice.<br><br>DON and/or designee will implement measures to ensure that this practice does not recur including:<br>• Individualized training will be given to the nursing assistant and LPN working on 11-06-2013.<br>• Nursing assistants were given instruction on providing timely toileting and the importance of following the care plans beginning the week of 11-25-2013. | |

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| F 315 | Continued From page 6<br>day.<br><br>During continuous observation on 11/6/13, from 7:25 a.m. to 10:08 a.m. R44 was not offered or provided toileting/incontinence care. During this time R44 had breakfast and was given medications. At 9:52 a.m. nursing assistant (NA)-A entered R44's room to do morning cares, but another resident was in the bathroom. NA-A left the room, saying she would return when the bathroom was available.<br><br>On 11/6/13, at 10:08 a.m. NA-A provided incontinence care, but did not offer R44 an opportunity to use the toilet. R44's incontinent brief was heavily saturated with urine as verified by NA-A. At 10:30 a.m. the shift repositioning/toileting sheet was reviewed and NA-A stated R44 was last provided toileting/incontinence care at 5:00 a.m.. The shift repositioning/toileting sheet indicated 4:49 a.m. NA-A added that R44 should have been offered toileting and provided incontinence care every two hours.<br><br>On 11/6/13, at 1:45 p.m., the director of nursing (DON) was interviewed and was aware of the lack of toileting/incontinence care for R44. | F 315 | DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:<br>• 2 observational audits, which will include toileting, will be performed weekly at various times to ensure ongoing compliance beginning the week of 12-09-2013, until compliance is achieved, then 2 per quarter thereafter.<br>• The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance committee will make recommendations for ongoing monitoring.<br><br>Completion Date: 12-17-2013 | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>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 | F 329 | | |

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| F 329 | Continued From page 7<br>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.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to identify, assess and monitor indications for use of medications for 2 of 5 residents (R12, R28) reviewed for unnecessary medications. In addition, non-pharmacological interventions were not attempted prior to routine use of as needed (PRN) hypnotic medications for R12.<br><br>Findings include:<br><br>R12 diagnoses included Parkinson Disease, generalized weakness secondary to cerebral | F 329 | **F329:** DON and/or designee will implement corrective action for resident (R12, R28) affected by this practice by:<br>• Resident R12 had monitoring for effectiveness set up on 11-07-2013. Resident R28 PRN antipsychotic was discontinued on 11-08-2013.<br><br>DON and/or designee will assess residents having the potential to be affected by this practice including:<br>• All other residents are potentially affected by this practice.<br>• All resident medications will be reviewed for appropriate monitoring and parameters of use.<br><br>DON and/or designee will implement measures to ensure that this practice does not recur including:<br>• Nursing staff will be re-educated on monitoring effectiveness of medications and getting parameters for use of PRN medications and documenting non-pharmacological interventions beginning the week of 11-25-2013. | |

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| F 329 | Continued From page 8<br>vascular accident (stroke), mental disorder, depression and insomnia.<br><br>The current physician's order indicated R12 was prescribed Ambien (hypnotic medication) 5 mg (milligrams) one tablet every evening as needed (PRN) with a start date of 8/23/13. A physician progress note dated 8/23/13, indicated R12 had difficulty sleeping, had previously done well with low dose of Ambien, and was interested in trying that again. The physician ordered Ambien 5 mg PRN and advised R12 to try to use Ambien only 2 or 3 times a week.<br><br>The medication administration record (MAR) from September 2013 indicated R12 had requested and received the PRN Ambien 26 out of 30 days with good effect. The October 2013 MAR indicated R12 had received the PRN Ambien 29 of 31 days with sporadic documentation of good effect. The November 2013 MAR indicated R12 received the PRN Ambien on 5 of 6 days.<br><br>The care plan dated 11/7/13, did not address insomnia, non-pharmacological interventions to improve sleep, or use of Ambien. Physician's notes dated 10/22/13, indicated Ambien seemed to be effective for insomnia.<br><br>On 11/7/13, at 9:05 a.m. registered nurse (RN) -A confirmed R12's Ambien was not being monitored. RN-A stated when a resident begins any kind of psychotropic medication the facility has a form that is to be completed to make sure the proper monitoring is in place, but this must | F 329 | DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:<br>• 2 Medication audits, which will include appropriate monitoring and parameters for use, will be performed weekly to ensure ongoing compliance beginning the week of 12-09-2013, until compliance is achieved, then two per quarter thereafter.<br>• The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring.<br><br>Completion Date: 12-17-2013 | |

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| F 329 | Continued From page 9<br>have been missed. RN-A added usually the licensed practical nurses (LPNs) document on the use of the medication and the behavior weekly and the RN reviews monthly to determine effectiveness. RN-A also verified the record lacked any documentation of non-pharmacological interventions before the PRN medication was administered.<br><br>On 11/7/13, at 10:40 a.m. the pharmacist was interviewed by phone and stated that medications are reviewed for dosage reduction on a quarterly basis and R12's Ambien would have been evaluated on the next visit. The pharmacist stated Ambien should be used for short period of time and during evaluation of the medication they would want to know what non-pharmacological interventions would have been attempted instead of just giving the PRN medication.<br><br>On 11/7/13 at approximately 10:45 a.m. the director of nursing (DON) confirmed R12's Ambien was not being monitored according to the facility policy.<br><br>The Psychotropic Drug Policy/Procedure revised on 1/06 indicated all residents receiving routine and PRN medication prescribed for control of a specific behavior are monitored for medication effectiveness. The procedure indicated staff would monitor and record the occurrence of behavior and the interventions attempted every shift and the effectiveness of the interventions. The policy also noted RN staff would summarize the weekly LPN reviews for the incidence of behaviors and interventions and effectiveness of | F 329 | | |

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| F 329 | Continued From page 10<br>the interventions monthly.<br><br>R28's physician's orders dated 10/28/13, included Risperdal (antipsychotic medication) 0.5 mg po (by mouth) bid (twice daily) for psychosis, and x1/day PRN for psychosis. The order did not identify symptoms of psychosis to be monitored and lacked parameters for use of the PRN dose.<br><br>R28's diagnoses included senile delirium, dementia without behavior disturbance and anxiety state.<br><br>A significant change minimum data set (MDS) dated 10/1/13, indicated R28 had severe cognitive impairment, no signs/symptoms of delirium, no hallucinations or delusions, less than daily behaviors not directed towards others, that did not interfere with care or participation in activities or social interactions and did not place others at risk of injury. The MDS indicated R28 occasionally rejected care and the behaviors significantly disrupted care or living environment.<br><br>The October 2013 MAR dated 10/2013, indicated R28 had received 1 dose of PRN Risperdal on 10/28/13, at 11:30 a.m. On 11/7/13, at 9:40 a.m. RN-B verified the lack of indications for use of PRN Risperdal, as well as results of the dose administered on 10/28/13.<br><br>On 11/7/13, at approximately 2:30 p.m. the DON verified R28's physician orders lacked parameters for use of PRN Risperdal. The DON added the reason for administration and | F 329 | | |

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|---|---|---|---|
| | 245245 | A. BUILDING ______ B. WING ______ | 11/07/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HERITAGE MANOR | 321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719 |

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| F 329 | Continued From page 11<br>effectiveness of the medication should be documented on the MAR as well.<br><br>A Medication Administration Record policy revised 6/2009, indicated PRN medication will be documented with the date, time, medication name, reason, the result, and nurses signature on the back of the MAR's. | F 329 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure staff did not handle food with bare hands or with contaminated gloves for 5 of 13 (R63, R31, R49, R65, R100) residents during 2 meal observations.<br><br>Findings include:<br><br>On 11/4/13, during the evening meal the following was observed: | F 371 | | |

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| F 371 | Continued From page 12<br>At 4:42 p.m. while assisting R63, nursing assistant (NA)-D picked up a slice of bread with bare hands, buttered it and placed it back on the plate. At 5:15 p.m. NA-D stated she usually did it that way because she had sanitized her hands before picking up the bread.<br><br>At 4:57 p.m. NA-B picked up a half of a slice of bread with bare hands and gave R31 three bites of the bread until it was gone. At 5:45 p.m. NA-B stated she always did it that way and never thought about doing it any other way as long as her hands are clean or sanitized.<br><br>On 11/5/13, during the brunch meal the following was observed:<br><br>At 10:42 a.m. R49 was served brunch. NA-E held the sandwich with bare hands when she cut it and touched the french toast when buttering it. At 11:05 a.m. NA-E picked up one quarter of the sandwich with bare hands and handed it to R49.<br><br>I AM NOT SURE THIS IS DEFICIENT<br><br>At 10:55 a.m. while assisting R65 with brunch, NA-C sanitized her hands with hand sanitizer and donned gloves from the pocket of her scrub top. NA-C picked up half of a sandwich and handed it to R65. At 11:05 a.m. NA-C removed the gloves, sanitized her hands, and pulled another glove from the pocket of her scrub top for the right hand. NA-C handled R65's sandwich two more times. At 11:25 a.m. NA-C indicated she usually carries the gloves in her pockets and uses them | F 371 | **F371:** DON and/or designee will implement corrective action for residents affected by this practice by:<br>• Residents currently are served meals in a sanitary manor.<br><br>DON and/or designee will assess residents having the potential to be affected by this practice including:<br>• All other residents that are served meals could be affected by this practice.<br><br>DON and/or designee will implement measures to ensure that this practice does not recur including:<br>• All servers in the Dining Room (NA/R's RN's, LPN's, Activies and Dietary) were given training on glove usage and infection control practices beginning the week of 11-25-2013.<br><br>DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:<br>• Two meal delivery observational audits will be completed beginning the week of 12-09-2013, until compliance is achieved, then 2 per quarter thereafter.<br>• The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance committee will make recommendations for ongoing monitoring.<br><br>Completion Date: 12-17-2013 | |

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|---|---|---|---|
| | 245245 | A. BUILDING ______ B. WING ______ | 11/07/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 371 | Continued From page 13 to touch the food.<br><br>On 11/5/13, at 10:40 a.m. NA-F wheeled R100 into the dining room and positioned the wheelchair by the table. At 10:45 a.m. NA-F handed R100 a bologna sandwich with bare hands. At 10:53 a.m. NA-F palmed one half of R100's sandwich with her bare left hand and used the knife in the right hand to cut the sandwich into quarters. At no time during this dining observation on 11/5/13, from 10:30 a.m. through 11:16 am. was NA-F observed to wash or sanitize hands, nor wear gloves. On 11/5/13, at 11:16 a.m. NA-F stated she was a home health aide who worked with hospice and visited R100 twice a week. NA-F confirmed she normally washed her hands when she arrived at the facility and before she leaves. She confirmed she touched the food with bare hands when assisting R100 with lunch.<br><br>On 11/6/13, at 7:30 a.m. registered nurse (RN)-B verified the hospice home health aides were held to the same infection control standards as facility staff.<br><br>On 11/6/13, at 1:45 p.m. the director of nursing (DON) was interviewed and stated staff should not be touching food with bare hands, clean gloves should be worn, and gloves should not be taken from staff pockets. | F 371 | | |
| F 456 SS=F | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br><br>The facility must maintain all essential | F 456 | | |

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| F 456 | Continued From page 14<br>mechanical, electrical, and patient care equipment in safe operating condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, observation, and document review, the facility failed to ensure the stove in the main kitchen was in safe operating order. This had the potential to affect all 72 residents in the facility.<br><br>Findings include:<br><br>On 11/4/13, from 2:10 p.m. to 2:41 p.m. the initial kitchen tour was conducted with the dietary director (DD). During this tour, cook (C)-B shared that not all the burners on the six burner stove where in working order and that he needed to use a match to light them.<br><br>On 11/6/13, at 9:30 a.m. C-A attempted to turn on the six burners of the kitchen stove. The following burners did not produce a flame when the knobs were turned: back right burner, front right and left burner. C-A verified the kitchen staff used matches to light the other burners. She gestured towards the window sill in the kitchen which had a box of matches sitting on the ledge. C-A confirmed all six burners are used for cooking.<br><br>On 11/6/13, at 1:28 p.m. environmental service director stated he had not received a request to fix the burners on the kitchen stove, however, he | F 456 | **F456:** ESD and/or designee will implement corrective action by:<br>• New Stove was ordered in November, arrived at the facility on December 3rd, and is scheduled for install on December 10th, 2013.<br><br>ESD and/or designee will assess residents having the potential to be affected by this practice including:<br>• All residents are potentially affected by this practice.<br><br>ESD and/or designee will implement measures to ensure that this practice does not recur including<br>• Facility Administration and Environmental Services were aware of the need to replace the stove and was scheduled for replacement in the upcoming Major Addition project.<br><br>ESD and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:<br>• Environmental Services will monitor the operation of the stove as well as other equipment that potentially could become a safety issue and facility will repair or replace.<br><br>Completion Date: 12-17-2013 | |

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| | 245245 | A. BUILDING ______ B. WING ______ | 11/07/2013 |

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| F 456 | Continued From page 15<br>knew the stove was old and needed to be replaced.<br><br>On 11/6/13, at 3:00 p.m. DD provided a copy of a page out of the maintenance log book. Entry date 4/8 indicated the stove in the kitchen was old and not working. DD confirmed the stove was old and worn out. | F 456 | | |
| F 465 SS=F | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility did not ensure doors/woodwork, radiator covers and walls were clean and in good repair for 8 of 40 resident rooms (R14, R22, R84, R90, R7, R29, R109); for soiled and worn carpet in the main entrance area and into resident care units; and for unclean resident care equipment. This had the potential to affect all residents/families/staff passing through utilizing the main entrance and hallways to the resident care areas.<br><br>Findings include:<br><br>During the environmental tour with the environmental services director (ESD) on 11/7/13, at 9:00 a.m., the following was observed: | F 465 | | |

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| F 465 | Continued From page 16<br><br>R14's shared bathroom had scratches along the front of the gray metal radiator.<br><br>R22's bath room wall had gouges on the lower third portion of the wall.<br><br>R84's room door had gouges with missing pieces of wood on the inside and outside edges near the handle. The area was rough and sharp.<br><br>In R54's and R90's shared room, the vent was covered with a smoke colored plastic sleeve with a towel stuffed into it. The ceiling tile around the sleeve was soiled with a black substance.<br><br>R7's bathroom door had a piece missing near the door handle approximately 1 by 1 inches. The bedroom door had a piece missing on the inside near the door jam. The ceiling tile near the vent above the bed was soiled with a dark substance.<br><br>In R29's room there was a smoke colored plastic sleeve with a towel stuffed into it over the ceiling vent. The ceiling tile around the sleeve was soiled with a black substance. There were also numerous scratches on the bathroom door.<br><br>In R109's room, the wall board next to the bathroom had a couple of deep gauges in the wall. | F 465 | **F465:** ESD and/or designee will implement corrective action by:<br>• The ESD is making repairs to the Items noted for R14,R22, R84, R54, R90, R7, R29 and R109,<br>• Carpet in the hallway from the main entrance to wings A and B is scheduled to be replaced by tile in the upcoming Major Addition Project. The carpet is being cleaned with a commercial floor scrubber twice a week until replacement.<br>• All pal lifts and hoyer lifts were cleaned A policy was written in regard to the regular cleaning and maintaining of the patient lifts<br><br>ESD and/or designee will assess residents having the potential to be affected by this practice including:<br>• All residents are potentially affected by this practice.<br><br>ESD and/or designee will implement measures to ensure that this practice does not recur including:<br>• Nursing staff were re-educated on the importance of noting issues of cleanliness and other resident equipment issues in the maintenance logs beginning the week of 12-02-13. The ESD did a complete inspection of the resident rooms and common areas, and has developed a plan for the repair of others areas/items noted in his inspection. New air deflectors were fabricated to direct the air away from the residents while in bed without the use of a towel. Maintenance staff were educated to not alter the air deflectors as designed. | |

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| | 245245 | A. BUILDING ______ B. WING ______ | 11/07/2013 |

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

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| F 465 | Continued From page 17<br><br>Carpet in the hallway from the main entrance to the main dining room, around the wing A and B nursing station, and near the entrance to wings A and B was soiled and had several holes in it.<br><br>All seven of the PAL lifts (mechanical stand aids) was observed to have loose dirt and crumbs on the foot platform from 11/4/13 through 11/7/13.<br><br>The ESD stated he does a "walk through" of the facility every two weeks to check light bulbs and make note of other areas needing repair. Staff had a maintenance book at each nursing station to report anything in need of repair. The books were checked daily Monday through Friday. The soiled area around the ceiling vents was from dust escaping around the vent. The sleeves were placed around the vents to direct the air away from the residents and towels were stuffed into the vents sleeve when residents complained the air was blowing on them. The PAL lift cleaning was to be done with the wheelchair washing schedule on each unit. Review of the wheelchair and PAL lift cleaning schedule with the ESD indicated the PAL lifts had not been cleaned as that section was blank.<br><br>There was no policy regarding PAL lift cleaning and building/res room maintenance. | F 465 | ESD and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:<br>• ESD will complete two building inspections per week, to look for other items that may need repair, check carpet and lifts for cleanliness, and ensure air vents are kept clear. This will continue until compliance is maintained, then monthly thereafter.<br><br>Completion Date: 12-17-2013 | |

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|---|---|---|---|
| | 245245 | A. BUILDING **01 - HERITAGE MANOR**<br>B. WING ___ | 11/05/2013 |

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| **HERITAGE MANOR** | **321 NORTHEAST SIXTH STREET**<br>**CHISHOLM, MN 55719** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Heritage Manor 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.<br><br>Heritage Manor, is a 1-story building with a full basement. The original building was constructed in 1953 and was determined to be of Type II(111) construction. In 1981 & 2001 additions were constructed to the building that was determined to be of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building also has an apartment complex attached that is properly separated.<br><br>The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 78 beds and had a census of 72 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is MET. | 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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| | 245245 | A. BUILDING **01 - HERITAGE MANOR**<br>B. WING ______ | **11/05/2013** |

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*Protecting, Maintaining and Improving the Health of Minnesotans*

November 22, 2013

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

Re: Project Number S5245025

Dear Mr. Ryan:

The above facility survey was completed on November 7, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File