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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XOPT

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 **01/27/2022** (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 **65** (L18)
13.Total Certified Beds **65** (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
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 02/18/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 02/18/2022 (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
02/17/2022
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 18, 2022

CMS Certification Number (CCN): 245245

Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, MN 55719

Dear Administrator:

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 February 24, 2022 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically Delivered
February 18, 2022

Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, MN 55719

RE: CCN: 245245
Cycle Start Date: December 16, 2021

Dear Administrator:

On January 27, 2022, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
December 29, 2021

Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, MN 55719

RE: CCN: 245245
Cycle Start Date: December 29, 2021

Dear Administrator:

On December 16, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 March 16, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by June 16, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	245245	A. BUILDING _____ B. WING _____	C 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 12/13/21, through 12/16/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/13/21, through 12/16/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED H5245051C (MN79165), and H5245052C (MN79171). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 01/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced	F 676		1/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 676	Continued From page 2 by: Based on observation, interview, and document review, the facility failed to ensure assistance with routine grooming was provided for 1 of 1 resident (R40) observed to have visible stubble on his cheeks, chin, and neck. Findings include: R40's admission Minimum Data Set (MDS) dated 11/29/21, identified R40 was cognitively intact and demonstrated no rejection of care behaviors. R40's MDS further indicated he required limited assistance with activities of daily living and required set up help with personal hygiene. R40's care plan dated 11/25/21, identified R40 was independent with grooming after set up. R40's goal was to be neatly groomed daily. The plan interventions listed were to set-up supplies for grooming/hygiene. In addition, to assist with completion of tasks as needed. On 12/13/21, at 1:41 p.m. R40 was observed to have white/gray stubble on his cheeks, chin, and neck. R40 stated he didn't like to have facial hair and stated it was hard to get a shower weekly. On 12/15/21, at 12:57 p.m. R40 was observed seated on the edge of his bed. R40 remained unshaven. On 12/16/21, at 8:54 a.m. nursing assistant (NA)-A stated R40 had his own razor and was able to shave himself. NA-A further stated residents "get a good shave on their bath day". On 12/16/21, at 2:46 p.m. registered nurse (RN)-C stated if a resident was alert staff should	F 676	F: 676 It is Heritage Manor's policy to provide grooming/hygiene to our residents per care plan. DON and/or designee will implement corrective action for resident R40 affected by this practice by: •R40 will be interviewed for grooming preferences related to shaving. Grooming care plan will be updated per resident preference. DON and/or designee will assess residents having the potential to be affected by this practice including: •All residents who require set up and/or assist with shaving have potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: •The Shave Male/Female policy will be reviewed and updated as needed. •All nursing staff will be educated on the Shave Male/Female policy in regards to shaving per resident preference following care plan. •All residents who need assistance with shaving will have their preferences reviewed and care plan updated as needed. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: •Random audits identifying shaving compliance per resident's care plan will	

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F 676	Continued From page 3 ask them daily if they want to be shaved. On 12/16/21, at 2:53 p.m. NA-C stated R40 did not get a bath/shower that day. NA-C stated he would get one "tomorrow". On 12/16/21, at 2:56 p.m. R40 verified he did not have a bath that morning and further stated he was not told anything about a plan for bathing/showering. R40 verified he was not asked if he wanted to be set up to shave that morning. R40 continued to have white/gray stubble on his cheeks, chin, and neck. On 12/16/21, at 3:15 p.m. the director of nursing (DON) verified he would expect staff to ask residents if they wanted to shave and to assist them accordingly. The facility policy titled Shave Male/Female Policy undated, indicated the nurse manager or designee would discuss the details of facial hair, its' grooming and removal on an individual basis. The resident's preference would be noted in the resident's individual care plan.	F 676	be completed by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of January 10th, 2022. •Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: January 24th, 2022	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine grooming was provided for 1 of 1 resident (R34) reviewed for personal care.	F 677	F: 677 It is Heritage Manor's policy to provide grooming/hygiene to our residents per care plan.	1/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 4 Findings include: R34's Face Sheet printed 12/16/21, identified diagnoses that included mild cognitive impairment. R34's significant change Minimum Data Set (MDS) dated 12/1/21, indicated R34 was severely cognitively impaired and demonstrated no rejection of care behaviors. R34's MDS indicated he required extensive assistance of one for activities of daily living including personal hygiene. R34's care plan dated 9/15/21, indicated R34 required assistance with grooming and personal hygiene. The care plan directed staff to encourage R34 to start grooming tasks, complete tasks he was unable to finish. On 12/13/21, at 2:02 p.m. R34 was observed to have white stubble on his face. R34 stated he "forgot" to shave. On 12/15/21, at 8:06 a.m. nursing assistant (NA)-D was observed helping R34 get ready for the day. NA-D brought R34 out of the bathroom using an mechanical lift and seated him in his wheelchair. No offer was made to set R34 up for shaving. On 12/15/21, at 1:03 p.m. R34 was watching television, when asked about shaving, he rubbed his jaw and said "maybe I should shave". On 12/16/21, NA-A stated residents should be shaved daily unless they refuse. NA-A stated R34 had his own electric razor but couldn't always get	F 677	DON and/or designee will implement corrective action for resident R34 affected by this practice by: •R34 will be interviewed for grooming preferences related to shaving. Grooming care plan will be updated per resident preference. DON and/or designee will assess residents having the potential to be affected by this practice including: •All residents who are dependent on staff for shaving needs have potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: •The Shave Male/Female policy will be reviewed and updated as needed. •All nursing staff will be educated on the Shave Male/Female policy in regards to shaving per resident preference following care plan. •All residents who need assistance with shaving will have their preferences reviewed and care plan updated as needed. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: •Random audits identifying shaving compliance per resident's care plan will be completed by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of January 10th, 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HERITAGE MANOR	**321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719**

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F 677	Continued From page 5 it all done, NA-A further stated staff should set R34 up and then finish shaving for him if he can't finish. On 12/16/21, NA-D stated residents should be assisted with shaving in the morning or later in the day but for sure on bath days. NA-D verified R34 had facial stubble and looked like he needed a shave, she verified she did not help him shave the day before. NA-D stated she had to leave early but NA-A took over for her. On 12/16/21, at 9:04 a.m. NA-A stated she was "pretty busy" and did not help R34 shave the day before. NA-A stated he would get shaved today "because it was his bath day". On 12/16/21, at 1:02 p.m. NA-E verified R34 had white stubble on his face and stated she would expect someone to help him shave. On 12/16/21, at 3:12 p.m. the director of nursing (DON) verified he would expect residents to be shaved base on their care plan. The facility policy titled Shave Male/Female Policy undated, indicated the nurse manager or designee would discuss the details of facial hair, its' grooming and removal on an individual basis. The resident's preference would be noted in the resident's individual care plan.	F 677	•Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: January 24th, 2022	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		1/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 6 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure restorative range of motion (ROM) programs were implemented as directed by the care plan for 2 of 2 residents (R1, R3). In addition, the facility failed to ensure palm protectors were appropriately in place for 2 of 2 residents (R1, R3) reviewed for splints. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/7/21, identified R1 had severe cognitive impairment and diagnoses which included dementia, spinal stenosis (a narrowing of the spinal canal in the lower back that may cause pain or numbness in the legs), and chronic fatigue. The MDS indicated R1 was non-ambulatory and was totally dependent on staff for all activities of daily living except personal hygiene, for which R1 required extensive assistance. The MDS also indicated R1 had functional limitation in range of motion (ROM) of	F 688	F: 688 It is Heritage Manor's policy to provide restorative services to those identified with limited range of motion and to assure that adaptive devices are applied properly per the care plan. DON and/or designee will implement corrective action for resident R1 and R3 affected by this practice by: •Care Plan and NAR Task List will be reviewed and updated as necessary to reflect Occupational Therapy recommendations for restorative services, including range of motion and use of palm protectors. •All nursing staff will be educated on following resident's plan of care regarding ROM practices and use of adaptive devices/splints to prevent decline of resident function. DON and/or designee will assess residents having the potential to be	

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F 688	Continued From page 7 the upper extremity (shoulder, elbow, wrist, hand) with impairment on one side and had not received physical therapy (PT), occupational therapy (OT) or restorative nursing services during the assessment period. The MDS further identified R1 exhibited no physical, verbal, or other behavioral symptoms or rejection of care during the look back period. R1's Current Care Plan dated 9/8/21, identified R1 required maintenance ROM with a goal to maintain current level of ROM and directed staff to provide passive range of motion (PROM) on bilateral upper extremities (BUE) and bilateral lower extremities (BLE) three times per week. The care plan also directed staff to provide gentle stretches and warm compresses to hands, left palm protector during the day and off at bedtime; put on palm protector with finger separator at bedtime and remove in the morning. During observation on 12/15/21, from 8:12 a.m. until 8:51 a.m. R1 was seated in a Broda chair (a tilt in space positioning chair) at a table in the dining room for the breakfast meal. She was covered from her neck to her feet with a clothing protector and lap blanket and her hands and arms were not visible. R1 was fed breakfast by a staff member and did not participate in any way with feeding herself. She was not observed to move her extremities during the meal. During observation on 12/15/21, at 1:57 p.m. R1 rested quietly in bed covered from her shoulders to her feet, with her eyes closed. Her hands and extremities were not visible. During observation on 12/16/21, at 7:14 a.m. R1 was seated in a Broda chair in the common area.	F 688	affected by this practice including: •All residents who receive range of motion services and/or utilize splints/braces have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: •The Restorative Nursing Program policy will be reviewed and updated as needed. •All residents who receive range of motion services and/or utilize splints/braces will have their care plans and NAR Task lists reviewed to assure that accurate information is in place to reflect recommendation of the occupational therapist. Updates will be made as needed. •All nursing staff will be educated on the Restorative Nursing Program policy, in regards to following resident's plan of care for range of motion practices and use of splints/braces to prevent decline of resident function. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: •Random audits will be conducted to ensure that range of motion and/or splint/brace utilization is being completed per resident plan of care 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of January 10th, 2022.	

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F 688	Continued From page 8 A padded palm protector was in her right hand with a strap secured around her knuckles. No device was observed in R1's left hand, which rested in a fist, the thumb tucked inside of the fingers. R1 did not respond when greeted. During interview on 12/16/21, at 7:25 a.m. licensed practical nurse (LPN)-A stated the facility had specific nursing assistant staff who were assigned to perform restorative duties for residents, however indicated they were often pulled to work on the floor. She walked to a room adjacent to the nursing station area and obtained two binders from a filing cabinet which she identified contained the residents' restorative programs and documentation of resident participation in the programs. Review of one binder revealed a form with columns across the top for room number, resident name, each day of the week with handwritten dates above the day, and restorative plan. The restorative plan for R1 included: gentle stretches, warm compress to hands, PROM 4x/wk (four times per week). No participation was documented for R1. The columns dated 12/14 through 12/20 were blank. During interview on 12/16/21, at 2:04 p.m. nursing assistant (NA)-G stated they had restorative aides who completed the restorative programs for residents so the NA's who worked on the floor did not do the programs as part of resident cares. She added if the restorative aides assisted with morning cares, they may get residents up and do their programs at that time. During interview on 12/16/21, at 2:06 p.m. NA-H stated she was the person who had assisted R1 to get up for the day and had completed her morning cares. R1 required full assistance and	F 688	•Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: January 24th, 2022	

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was totally dependent on staff for cares. She wore a splint in her right hand. Restorative aides completed the restorative programs for residents and it was not an expected tasks for NA's to do and she had not completed any ROM for R1. She had not noticed if R1's hands were stiffer or not but thought R1 was about the same over the last two months.

During interview on 12/16/21, at 2:11 p.m. NA-E stated she had worked as a restorative aide and provided services for R1 but had not done so since November. R1 required PROM to her upper extremities and needed a palm protector to her left hand. R1's right hand wasn't as contracted as the left one and she was able to open the hand all the way the last time she had provided care. R1 also required PROM to her lower extremities as well.

On 12/16/21 at 2:21 p.m. NA-H verified R1's palm protector was placed in her right hand and identified the toileting sheet did not differentiate in which hand the palm protector should be placed. NA-H asked LPN-A to check the computer for the correct hand placement for R1's palm protector. -At 2:24 p.m. LPN-A stated the palm protector should be in R1's left hand and the toileting sheet should be updated to include in which hand R1 wore the palm protector.

During a group interview on 12/16/21, at 2:24 p.m. LPN-A stated, and NA-D, NA-H and NA-I agreed staffing for the restorative aide position had been difficult due to needs on the floor. NA-D added she had only worked two of her scheduled restorative days in the last two weeks.

During interview on 12/16/21, at 2:34 p.m. NA-D

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stated she worked as a restorative aide, however, stated she had not completed R1's restorative program in a long time. To her knowledge, the last time she had done so, R1 was able to fully extend her right hand after application of warm compresses.

Review of R1's Therapy Detail Report for 9/16/21 to 12/16/21 revealed the following:
-Week of 9/19/21: PROM three times
-Week of 9/26/21: PROM one time
-Week of 10/3/21: PROM one time
-Week of 10/10/21: No services provided
-Week of 10/17/21: No services provided
-Week of 10/24/21: No services provided
-Week of 10/31/21: No services provided
-Week of 11/7/21: No services provided
-Week of 11/14/21: No services provided
-Week of 11/21/21: No services provided
-Week of 11/28/21: No services provided
-Week of 12/5/21: PROM one time
-Week of 12/12/21: No services provided

During observation on 12/16/21 at approximately 5:30 p.m. NA-G provided PROM for R1 after the application of warm compresses, while registered nurse RN-E observed. NA-G was able to fully extend both of R1's hands without difficulty. R1 tolerated the PROM well and without expression of pain or discomfort. RN-G indicated R1's ROM was at her baseline and stated the toileting sheets should be updated with all the required care information regarding R1's palm protectors so NA staff could apply them correctly.

During interview on 12/16/21, at 5:47 p.m. the director of nursing stated they had been having problems with staffing for restorative nursing. He reviewed R1's Therapy Detail Report and

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F 688	Continued From page 11	F 688		

indicated by the report, R1 had only received services twice since October.

The Restorative Nursing Program Policy dated 4/6/20, directed the facility would have a restorative nursing program that promoted a resident's ability to achieve and/or maintain their optimal function in accordance with the resident's comprehensive assessment and person-centered plan or care. The restorative staff would be responsible for providing the residents with restorative nursing programs and would document completion or resident refusal of restorative nursing services.

R3's Face Sheet printed 12/16/21, diagnoses which included Parkinson's Disease and dementia.

R3's quarterly Minimum Data Set (MDS) dated 12/7/21, identified R3 was severely cognitively impaired and had not rejected cares. R3 required extensive assistance with activities of daily living and was dependent on staff for dressing, transfers, toilet use, and eating. The MDS identified R3 had impairment on both sides of body, both upper and lower.

R3's care plan initiated 1/10/19, indicated R3 had contractures related to immobility. Interventions included ensuring palm protectors (provide support and protection to prevent finger contractures and skin breakdown in the palm) were donned in the morning and removed at night and replaced with a rolled wash cloth or finger separator (provides support between each digit and absorb any perspiration, provides support

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F 688	Continued From page 12	F 688		

between each digit). In addition maintenance ROM would be performed.

R3's Therapy Detail Report date range 9/16/21, to 12/16/21, indicated R3 was to receive passive range of motion (PROM) five times per week by restorative aides. The report indicated R3 received PROM on 9/20/21, 9/27/21, 10/18/21, 11/22/21, and 12/8/21, to hands, arms, legs, and feet.

On 12/14/21, at 11:03 a.m. R3 was observed to have a palm protector in her right hand, none in her left hand.

On 12/15/21, at 7:55 a.m. R3 was observed seated in her wheelchair dressed for the day, a palm protector was in her right hand, no palm protector in her left hand.

On 12/15/21, at 10:11 a.m. two staff entered R3's room and transferred from her wheelchair to her bed for a rest. R3's palm protector remained in her left hand, her right hand remained without a palm protector.

On 12/16/21, at 7:41 a.m. R3 was observed seated in her wheelchair in the dining room waiting for breakfast. R3 had a palm protector in her left hand, none in her right hand.

On 12/16/21, at 3:03 p.m. nursing assistant (NA)-F verified staff had been able to place a finger separator in R3's left hand.

On 12/16/21, at 1:04 p.m. NA-E stated R3 was supposed to have PROM three to five times a week. NA-E verified PROM was not done if the restorative aide was pulled to do cares. NA-E

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verified R3 was not currently wearing a palm protector in her left hand. NA-E looked in R3's dresser and found both a palm protector and a finger separator in her drawer. NA-E verified R3 should have been wearing one of them in her left hand.

On 12/16/21, at 2:19 p.m. registered nurse (RN)-D verified PROM does not get performed if the restorative aide was pulled to do cares. RN-D verified a resident could get more contracted if PROM was not performed as directed.

On 12/16/21, at 2:36 p.m. physical therapist (PT)-D stated R3 was discharged from occupational therapy on 3/11/21, related to refusals to participate.

On 12/16/21, RN-C said R3 was at baseline with her contractures for the past year.

On 12/16/21, at 3:16 p.m. the director of nursing (DON) stated restorative therapy should be performed as ordered. The DON stated the restorative aide had been pulled to do cares. The DON stated there were no reports that R3's contractures were worse related to missing PROM. The DON verified staff should be putting palm protectors in both of R3's hands as ordered.

On 12/16/21, at 3:36 p.m. the medical director verified R3's contractures were not worse from missing restorative therapy, he stated her contractures were disease progression. The medical director stated he would expect staff to put the palm protectors in daily as per the care plan.

The facility policy titled Restorative Nursing

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F 688	Continued From page 14 Program reviewed 4/6/20, indicated the restorative nursing program would promote a resident's ability to achieve and/or maintain there optimal function, in accordance with the resident's comprehensive assessment and person-centered care plan.	F 688		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a system for consistent assessment or monitoring of a dialysis access site for 1 of 1 resident (R27) reviewed for dialysis. Findings include: R27's significant change Minimum Data Set (MDS) dated 12/10/21, indicated R27 was cognitively intact and received dialysis while a resident at the facility. R27's diagnoses included end stage renal disease, dependence on renal dialysis, and diabetes mellitus with diabetic chronic kidney disease. R27's care plan revised on 11/8/21, indicated R27 had renal failure with dialysis and interventions included staff to assess for signs and symptoms of infection. The care plan failed to include directions for staff to assess or monitor R27's	F 698	F: 698 It is Heritage Manor's policy to provide monitoring of resident's dialysis access site. DON and/or designee will implement corrective action for resident R27 affected by this practice by: •R27 no longer resides are this care center. DON and/or designee will assess residents having the potential to be affected by this practice including: •All residents receiving dialysis have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: •The facility's dialysis management	1/24/22

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F 698	Continued From page 15 dialysis access site (access site) for patency or bleeding. Review of R27's December 2021, electronic medication and treatment administration record (MAR/TAR) failed to include directions or documentation related to assessing or monitoring R27's access site for patency or bleeding. On 12/15/21, at 3:15 p.m. R27 stated he had a shunt in the upper right arm used for dialysis. On 12/16/21, at 12:47 p.m. the health unit coordinator (HUC) stated she was uncertain if the nurses checked R27's access site for bruit (the sound of blood flowing through a dialysis access site when listening with a stethoscope) or thrill (the feel of blood flowing though a dialysis access when palpated) and R27's MAR/TAR did not include directions for assessing the access site. On 12/16/21, at 12:53 p.m. registered nurse (RN)-B stated she did not do anything with R27's access site, did not monitor the site for bleeding, and did not check for bruit or thrill. On 12/16/21, at 1:03 p.m. RN-A stated the nurses are responsible for monitoring and assessing R27's access site for bleeding, listening for bruit and feeling for thrill. RN-A further stated the MAR/TAR failed to include directions to monitor or assess R27's access site. On 12/16/21, at 2:00 p.m. the director of nursing (DON) stated the cart nurses are responsible for assessing R27's dialysis access site. When R27 returned from dialyisis, the cart nurses should assess the access site, check for bruit and thrill, as well as check for infection or bleeding.	F 698	policy will be reviewed and updated as needed. •All residents who receive dialysis will have their care plans reviewed to ensure monitoring of dialysis access site for bleeding and patency, and will updated as needed. •All nursing staff will be educated on the monitoring of dialysis access sites per the Dialysis Management policy. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: •Random care plan audits will be completed on those receiving dialysis to ensure care plans reflect proper monitoring of dialysis access sites by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of January 10th, 2022. •Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: January 24th, 2022	

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F 698	Continued From page 16 Directions for daily monitoring and assessment of the access site should have been included on R27's MAR/TAR. The facility's undated Dialysis policy identified end-stage renal disease as an irreversible and permanent stage of renal impairment that required a regular course of dialysis or kidney transplantation to maintain life. The policy further identified the facalities care plan should include instructions for access assessment and care. The facility's Dialysis Management policy revised 2/19/18, identified bruit as the sound of blood going through the access site when listening through a stethoscope and thrill as the feel of blood flowing though the access when palpated. The policy identified the dialysis access site should be assessed daily for bleeding and patency via palpation (thrill) and auscultation (bruit).	F 698		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2021

Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, MN 55719

Re: State Nursing Home Licensing Orders
Event ID: XOPT11

Dear Administrator:

The above facility was surveyed on December 13, 2021 through December 16, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	00904	A. BUILDING: _____ B. WING _____	C 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/13/21, through 12/16/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES	2 000		

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2 000	Continued From page 2 In addition, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be UNSUBSTANTIATED: H5245051C (MN79165). H5245052C (MN79171). The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by:	2 890		1/24/22

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2 890	Continued From page 3 Based on observation, interview, and document review, the facility failed to ensure restorative range of motion (ROM) programs were implemented as directed by the care plan for 2 of 2 residents (R1, R3). In addition, the facility failed to ensure palm protectors were appropriately in place for 2 of 2 residents (R1, R3) reviewed for splints. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/7/21, identified R1 had severe cognitive impairment and diagnoses which included dementia, spinal stenosis (a narrowing of the spinal canal in the lower back that may cause pain or numbness in the legs), and chronic fatigue. The MDS indicated R1 was non-ambulatory and was totally dependent on staff for all activities of daily living except personal hygiene, for which R1 required extensive assistance. The MDS also indicated R1 had functional limitation in range of motion (ROM) of the upper extremity (shoulder, elbow, wrist, hand) with impairment on one side and had not received physical therapy (PT), occupational therapy (OT) or restorative nursing services during the assessment period. The MDS further identified R1 exhibited no physical, verbal, or other behavioral symptoms or rejection of care during the look back period. R1's Current Care Plan dated 9/8/21, identified R1 required maintenance ROM with a goal to maintain current level of ROM and directed staff to provide passive range of motion (PROM) on bilateral upper extremities (BUE) and bilateral lower extremities (BLE) three times per week. The care plan also directed staff to provide gentle stretches and warm compresses to hands, left	2 890	F: 688 It is Heritage Manor's policy to provide restorative services to those identified with limited range of motion and to assure that adaptive devices are applied properly per the care plan. DON and/or designee will implement corrective action for resident R1 and R3 affected by this practice by: •Care Plan and NAR Task List will be reviewed and updated as necessary to reflect Occupational Therapy recommendations for restorative services, including range of motion and use of palm protectors. •All nursing staff will be educated on following resident's plan of care regarding ROM practices and use of adaptive devices/splints to prevent decline of resident function. DON and/or designee will assess residents having the potential to be affected by this practice including: •All residents who receive range of motion services and/or utilize splints/braces have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: •The Restorative Nursing Program policy will be reviewed and updated as needed. •All residents who receive range of motion services and/or utilize splints/braces will have their care plans and NAR Task lists reviewed to assure that accurate information is in place to	

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2 890	Continued From page 4 palm protector during the day and off at bedtime; put on palm protector with finger separator at bedtime and remove in the morning. During observation on 12/15/21, from 8:12 a.m. until 8:51 a.m. R1 was seated in a Broda chair (a tilt in space positioning chair) at a table in the dining room for the breakfast meal. She was covered from her neck to her feet with a clothing protector and lap blanket and her hands and arms were not visible. R1 was fed breakfast by a staff member and did not participate in any way with feeding herself. She was not observed to move her extremities during the meal. During observation on 12/15/21, at 1:57 p.m. R1 rested quietly in bed covered from her shoulders to her feet, with her eyes closed. Her hands and extremities were not visible. During observation on 12/16/21, at 7:14 a.m. R1 was seated in a Broda chair in the common area. A padded palm protector was in her right hand with a strap secured around her knuckles. No device was observed in R1's left hand, which rested in a fist, the thumb tucked inside of the fingers. R1 did not respond when greeted. During interview on 12/16/21, at 7:25 a.m. licensed practical nurse (LPN)-A stated the facility had specific nursing assistant staff who were assigned to perform restorative duties for residents, however indicated they were often pulled to work on the floor. She walked to a room adjacent to the nursing station area and obtained two binders from a filing cabinet which she identified contained the residents' restorative programs and documentation of resident participation in the programs. Review of one binder revealed a form with columns across the	2 890	reflect recommendation of the occupational therapist. Updates will be made as needed. •All nursing staff will be educated on the Restorative Nursing Program policy, in regards to following resident's plan of care for range of motion practices and use of splints/braces to prevent decline of resident function. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: •Random audits will be conducted to ensure that range of motion and/or splint/brace utilization is being completed per resident plan of care 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of January 10th, 2022. •Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: January 24th, 2022	

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2 890	Continued From page 5 top for room number, resident name, each day of the week with handwritten dates above the day, and restorative plan. The restorative plan for R1 included: gentle stretches, warm compress to hands, PROM 4x/wk (four times per week). No participation was documented for R1. The columns dated 12/14 through 12/20 were blank. During interview on 12/16/21, at 2:04 p.m. nursing assistant (NA)-G stated they had restorative aides who completed the restorative programs for residents so the NA's who worked on the floor did not do the programs as part of resident cares. She added if the restorative aides assisted with morning cares, they may get residents up and do their programs at that time. During interview on 12/16/21, at 2:06 p.m. NA-H stated she was the person who had assisted R1 to get up for the day and had completed her morning cares. R1 required full assistance and was totally dependent on staff for cares. She wore a splint in her right hand. Restorative aides completed the restorative programs for residents and it was not an expected tasks for NA's to do and she had not completed any ROM for R1. She had not noticed if R1's hands were stiffer or not but thought R1 was about the same over the last two months. During interview on 12/16/21, at 2:11 p.m. NA-E stated she had worked as a restorative aide and provided services for R1 but had not done so since November. R1 required PROM to her upper extremities and needed a palm protector to her left hand. R1's right hand wasn't as contracted as the left one and she was able to open the hand all the way the last time she had provided care. R1 also required PROM to her lower extremities as well.	2 890		

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2 890	Continued From page 6 On 12/16/21 at 2:21 p.m. NA-H verified R1's palm protector was placed in her right hand and identified the toileting sheet did not differentiate in which hand the palm protector should be placed. NA-H asked LPN-A to check the computer for the correct hand placement for R1's palm protector. -At 2:24 p.m. LPN-A stated the palm protector should be in R1's left hand and the toileting sheet should be updated to include in which hand R1 wore the palm protector. During a group interview on 12/16/21, at 2:24 p.m. LPN-A stated, and NA-D, NA-H and NA-I agreed staffing for the restorative aide position had been difficult due to needs on the floor. NA-D added she had only worked two of her scheduled restorative days in the last two weeks. During interview on 12/16/21, at 2:34 p.m. NA-D stated she worked as a restorative aide, however, stated she had not completed R1's restorative program in a long time. To her knowledge, the last time she had done so, R1 was able to fully extend her right hand after application of warm compresses. Review of R1's Therapy Detail Report for 9/16/21 to 12/16/21 revealed the following: -Week of 9/19/21: PROM three times -Week of 9/26/21: PROM one time -Week of 10/3/21: PROM one time -Week of 10/10/21: No services provided -Week of 10/17/21: No services provided -Week of 10/24/21: No services provided -Week of 10/31/21: No services provided -Week of 11/7/21: No services provided -Week of 11/14/21: No services provided -Week of 11/21/21: No services provided -Week of 11/28/21: No services provided	2 890		

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2 890	Continued From page 7 -Week of 12/5/21: PROM one time -Week of 12/12/21: No services provided During observation on 12/16/21 at approximately 5:30 p.m. NA-G provided PROM for R1 after the application of warm compresses, while registered nurse RN-E observed. NA-G was able to fully extend both of R1's hands without difficulty. R1 tolerated the PROM well and without expression of pain or discomfort. RN-G indicated R1's ROM was at her baseline and stated the toileting sheets should be updated with all the required care information regarding R1's palm protectors so NA staff could apply them correctly. During interview on 12/16/21, at 5:47 p.m. the director of nursing stated they had been having problems with staffing for restorative nursing. He reviewed R1's Therapy Detail Report and indicated by the report, R1 had only received services twice since October. The Restorative Nursing Program Policy dated 4/6/20, directed the facility would have a restorative nursing program that promoted a resident's ability to achieve and/or maintain their optimal function in accordance with the resident's comprehensive assessment and person-centered plan or care. The restorative staff would be responsible for providing the residents with restorative nursing programs and would document completion or resident refusal of restorative nursing services. R3's Face Sheet printed 12/16/21, diagnoses which included Parkinson's Disease and dementia. R3's quarterly Minimum Data Set (MDS) dated	2 890		

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2 890	Continued From page 8 12/7/21, identified R3 was severely cognitively impaired and had not rejected cares. R3 required extensive assistance with activities of daily living and was dependent on staff for dressing, transfers, toilet use, and eating. The MDS identified R3 had impairment on both sides of body, both upper and lower. R3's care plan initiated 1/10/19, indicated R3 had contractures related to immobility. Interventions included ensuring palm protectors (provide support and protection to prevent finger contractures and skin breakdown in the palm) were donned in the morning and removed at night and replaced with a rolled wash cloth or finger separator (provides support between each digit and absorb any perspiration, provides support between each digit). In addition maintenance ROM would be performed. R3's Therapy Detail Report date range 9/16/21, to 12/16/21, indicated R3 was to receive passive range of motion (PROM) five times per week by restorative aides. The report indicated R3 received PROM on 9/20/21, 9/27/21, 10/18/21, 11/22/21, and 12/8/21, to hands, arms, legs, and feet. On 12/14/21, at 11:03 a.m. R3 was observed to have a palm protector in her right hand, none in her left hand. On 12/15/21, at 7:55 a.m. R3 was observed seated in her wheelchair dressed for the day, a palm protector was in her right hand, no palm protector in her left hand. On 12/15/21, at 10:11 a.m. two staff entered R3's room and transferred from her wheelchair to her bed for a rest. R3's palm protector remained in	2 890		

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2 890	Continued From page 9	2 890		

her left hand, her right hand remained without a palm protector.

On 12/16/21, at 7:41 a.m. R3 was observed seated in her wheelchair in the dining room waiting for breakfast. R3 had a palm protector in her left hand, none in her right hand.

On 12/16/21, at 3:03 p.m. nursing assistant (NA)-F verified staff had been able to place a finger separator in R3's left hand.

On 12/16/21, at 1:04 p.m. NA-E stated R3 was supposed to have PROM three to five times a week. NA-E verified PROM was not done if the restorative aide was pulled to do cares. NA-E verified R3 was not currently wearing a palm protector in her left hand. NA-E looked in R3's dresser and found both a palm protector and a finger separator in her drawer. NA-E verified R3 should have been wearing one of them in her left hand.

On 12/16/21, at 2:19 p.m. registered nurse (RN)-D verified PROM does not get performed if the restorative aide was pulled to do cares. RN-D verified a resident could get more contracted if PROM was not performed as directed.

On 12/16/21, at 2:36 p.m. physical therapist (PT)-D stated R3 was discharged from occupational therapy on 3/11/21, related to refusals to participate.

On 12/16/21, RN-C said R3 was at baseline with her contractures for the past year.

On 12/16/21, at 3:16 p.m. the director of nursing (DON) stated restorative therapy should be performed as ordered. The DON stated the

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2 890	Continued From page 10 restorative aide had been pulled to do cares. The DON stated there were no reports that R3's contractures were worse related to missing PROM. The DON verified staff should be putting palm protectors in both of R3's hands as ordered. On 12/16/21, at 3:36 p.m. the medical director verified R3's contractures were not worse from missing restorative therapy, he stated her contractures were disease progression. The medical director stated he would expect staff to put the palm protectors in daily as per the care plan. The facility policy titled Restorative Nursing Program reviewed 4/6/20, indicated the restorative nursing program would promote a resident's ability to achieve and/or maintain there optimal function, in accordance with the resident's comprehensive assessment and person-centered care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's receive restorative therapy as directed and splints and finger separators are in place as directed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		

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2 915	Continued From page 11	2 915		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance with routine grooming was provided for 1 of 1 resident (R40) observed to have visible stubble on his cheeks, chin, and neck. Findings include: R40's admission Minimum Data Set (MDS) dated 11/29/21, identified R40 was cognitively intact and demonstrated no rejection of care behaviors. R40's MDS further indicated he required limited assistance with activities of daily living and required set up help with personal hygiene.	2 915	F: 676 It is Heritage Manor's policy to provide grooming/hygiene to our residents per care plan. DON and/or designee will implement corrective action for resident R40 affected by this practice by: •R40 will be interviewed for grooming preferences related to shaving. Grooming care plan will be updated per resident preference. DON and/or designee will assess residents having the potential to be	1/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00904	A. BUILDING: _____ B. WING _____	C 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 12 R40's care plan dated 11/25/21, identified R40 was independent with grooming after set up. R40's goal was to be neatly groomed daily. The plan interventions listed were to set-up supplies for grooming/hygiene. In addition, to assist with completion of tasks as needed. On 12/13/21, at 1:41 p.m. R40 was observed to have white/gray stubble on his cheeks, chin, and neck. R40 stated he didn't like to have facial hair and stated it was hard to get a shower weekly. On 12/15/21, at 12:57 p.m. R40 was observed seated on the edge of his bed. R40 remained unshaven. On 12/16/21, at 8:54 a.m. nursing assistant (NA)-A stated R40 had his own razor and was able to shave himself. NA-A further stated residents "get a good shave on their bath day". On 12/16/21, at 2:46 p.m. registered nurse (RN)-C stated if a resident was alert staff should ask them daily if they want to be shaved. On 12/16/21, at 2:53 p.m. NA-C stated R40 did not get a bath/shower that day. NA-C stated he would get one "tomorrow". On 12/16/21, at 2:56 p.m. R40 verified he did not have a bath that morning and further stated he was not told anything about a plan for bathing/showering. R40 verified he was not asked if he wanted to be set up to shave that morning. R40 continued to have white/gray stubble on his cheeks, chin, and neck. On 12/16/21, at 3:15 p.m. the director of nursing (DON) verified he would expect staff to ask	2 915	affected by this practice including: •All residents who require set up and/or assist with shaving have potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: •The Shave Male/Female policy will be reviewed and updated as needed. •All nursing staff will be educated on the Shave Male/Female policy in regards to shaving per resident preference following care plan. •All residents who need assistance with shaving will have their preferences reviewed and care plan updated as needed. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: •Random audits identifying shaving compliance per resident's care plan will be completed by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of January 10th, 2022. •Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: January 24th, 2022	

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HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719

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2 915	Continued From page 13 residents if they wanted to shave and to assist them accordingly. The facility policy titled Shave Male/Female Policy undated, indicated the nurse manager or designee would discuss the details of facial hair, its' grooming and removal on an individual basis. The resident's preference would be noted in the resident's individual care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure a residents receive restorative therapy as directed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced	2 920		1/24/22

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2 920	Continued From page 14 by: Based on observation, interview, and document review, the facility failed to ensure routine grooming was provided for 1 of 1 resident (R34) reviewed for personal care. Findings include: R34's Face Sheet printed 12/16/21, identified diagnoses that included mild cognitive impairment. R34's significant change Minimum Data Set (MDS) dated 12/1/21, indicated R34 was severely cognitively impaired and demonstrated no rejection of care behaviors. R34's MDS indicated he required extensive assistance of one for activities of daily living including personal hygiene. R34's care plan dated 9/15/21, indicated R34 required assistance with grooming and personal hygiene. The care plan directed staff to encourage R34 to start grooming tasks, complete tasks he was unable to finish. On 12/13/21, at 2:02 p.m. R34 was observed to have white stubble on his face. R34 stated he "forgot" to shave. On 12/15/21, at 8:06 a.m. nursing assistant (NA)-D was observed helping R34 get ready for the day. NA-D brought R34 out of the bathroom using an mechanical lift and seated him in his wheelchair. No offer was made to set R34 up for shaving. On 12/15/21, at 1:03 p.m. R34 was watching television, when asked about shaving, he rubbed his jaw and said "maybe I should shave".	2 920	F: 677 It is Heritage Manor's policy to provide grooming/hygiene to our residents per care plan. DON and/or designee will implement corrective action for resident R34 affected by this practice by: •R34 will be interviewed for grooming preferences related to shaving. Grooming care plan will be updated per resident preference. DON and/or designee will assess residents having the potential to be affected by this practice including: •All residents who are dependent on staff for shaving needs have potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: •The Shave Male/Female policy will be reviewed and updated as needed. •All nursing staff will be educated on the Shave Male/Female policy in regards to shaving per resident preference following care plan. •All residents who need assistance with shaving will have their preferences reviewed and care plan updated as needed. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: •Random audits identifying shaving compliance per resident's care plan will be completed by DON/designee 5x/week x 1	

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2 920	Continued From page 15 On 12/16/21, NA-A stated residents should be shaved daily unless they refuse. NA-A stated R34 had his own electric razor but couldn't always get it all done, NA-A further stated staff should set R34 up and then finish shaving for him if he can't finish. On 12/16/21, NA-D stated residents should be assisted with shaving in the morning or later in the day but for sure on bath days. NA-D verified R34 had facial stubble and looked like he needed a shave, she verified she did not help him shave the day before. NA-D stated she had to leave early but NA-A took over for her. On 12/16/21, at 9:04 a.m. NA-A stated she was "pretty busy" and did not help R34 shave the day before. NA-A stated he would get shaved today "because it was his bath day". On 12/16/21, at 1:02 p.m. NA-E verified R34 had white stubble on his face and stated she would expect someone to help him shave. On 12/16/21, at 3:12 p.m. the director of nursing (DON) verified he would expect residents to be shaved base on their care plan. The facility policy titled Shave Male/Female Policy undated, indicated the nurse manager or designee would discuss the details of facial hair, its' grooming and removal on an individual basis. The resident's preference would be noted in the resident's individual care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and	2 920	week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of January 10th, 2022. •Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: January 24th, 2022	

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2 920	Continued From page 16 procedures to ensure personal hygiene/shaving is completed for residents who are dependent. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		

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	245245	A. BUILDING **01 - HERITAGE MANOR** B. WING _____	**12/20/2021**

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

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/05/2022

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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.	K 000		

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K 000	Continued From page 2 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 70 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain unobstructed access to the means of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2 and 7.1.10.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 211	K211 CHC will have maintained means of egress In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.2.2 and 7.1.10.1:	1/24/22

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K 211	Continued From page 3 1. On 12/20/2021 between 10:30 AM and 1:30 PM, it was revealed by observation that the Park addition exit by room 405, dining area, and maintenance room had snow blocking the path of egress. 2. On 12/20/2021, between 10:30 AM and 1:30 PM, it was revealed by observation that a banquet table was in front of the emergency exit in the dining room. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 211	1. The Park addition exit by room 405 was cleared of snow and the banquet table was moved from in front of the emergency exit in the dining room on 12/22/2021. 2. The Environmental Service Director (ESD) completed a tour of facility and checked all emergency exits to ensure compliance with means of egress. The ESD and maintenance employee were educated on keeping emergency exits free from obstruction (including snow). 3. ESD will tour facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 01/24/2022	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321		1/24/22

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K 321	Continued From page 4 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain several hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, and 19.3.2.1.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/20/2021 between 10:30 AM and 2:00 PM, it was revealed by observation that the following areas had combustible storage with no door closers. Room LL15 Kitchen Storage, the Sandbox Storage Area, and the Utility Room 11, a central bath converted into a combustible storage room. 2. On 12/20/2021 between 10:30 AM and 2:00	K 321	K321 CHC will have appropriate enclosures and smoke barriers for hazardous areas. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.3.2.1.2, 19.3.2.1.3, and 19.3.2.1.5: 1. Room LL15 Kitchen Storage, Sandbox Storage Area, Utility Room 11, Lower Level Soiled Linen and Laundry Room self-closures were adjusted so they fully closed and latched on 01/03/2022. Records room in sandbox storage area and 4-inch pipe had penetrations filled with appropriate material.	

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K 321	Continued From page 5 PM, it was revealed by observation that the Lower Level Soiled Linen in the Laundry Room does not have a working door closer. 3. On 12/20/2021 between 10:30 AM and 2:00 PM, it was revealed by observation that there were multiple penetrations in the Records Room located in the Sand Box Storage Area and the Maintenance Office, which had a 4-inch pipe stuffed with a stuffed animal. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 321	2. The Environmental Service Director (ESD) completed a tour of facility and checked all hazardous areas for door closures and areas of penetrations to ensure compliance. The ESD and maintenance employee were educated on self-closures and penetrations through smoke barriers. 3. ESD will tour facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 01/24/2022	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1.	K 345	K345 CHC will have appropriate testing and maintenance of the fire alarm system. In order to comply with NFPA 101 (2012	1/24/22

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

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K 345	Continued From page 6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/20/2021 at 1:00 PM, it was revealed by a review of available documentation that the semi-annual fire alarm testing documentation was not available at the time of the survey. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 345	Edition), Life Safety Code sections 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1: 1. Semi Annual fire alarm testing was completed on 01/05/2022. 2. The Environmental Service Director (ESD) and maintenance employee were trained on requirements of semiannual fire alarm testing on 01/05/2022. 3. Administrator will audit to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 01/24/2022	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes	K 351		1/24/22

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	245245	A. BUILDING **01 - HERITAGE MANOR** B. WING _____	**12/20/2021**

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K 351	Continued From page 7 closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, section 8.1.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 12/20/2021 at 12:00 PM, it was revealed by observation that the Lower Lever Room 20 Pump Room appeared not to have adequate sprinkler coverage to the ceiling. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 351	K351 CHC will have proper sprinkler system. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 Edition) The Standard for the Installation of Sprinkler Systems, sections 8.1.1: 1. Room LL20 Pump Room is scheduled to have a sprinkler head installed to provide proper coverage to the ceiling on 01/06/2022. 2. The Environmental Service Director (ESD) completed a tour of facility and checked sprinkler heads to ensure compliance. 3. ESD will tour facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 01/24/2022	

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K 353	Continued From page 8	K 353		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5 and NFPA 25 (2011 edition), Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5 through 4.1.5.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/20/2021 between 10:30 AM and 12:30 PM, it was revealed by observation that there were missing ceiling tiles in the Kitchen, LL26 Janitor	K 353	K353 CHC will have a properly maintained sprinkler system. In order to comply with NFPA 101(2012 Edition), Life Safety Code sections 9.7.5 and NFPA 25 (2011 edition), Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5 through 4.1.5.2: 1. Ceiling tiles were replaced in the kitchen, LL26 Janitor Closet, and nurse's station by the main entrance on	1/24/22

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K 353	Continued From page 9 Closet, and nurses station by the main entrance. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 353	12/21/2021. 2. The ESD and maintenance employee were trained on making sure to replace any ceiling tiles during routine walk-throughs. The Environmental Service Director (ESD) completed a tour of facility and checked all ceiling areas to ensure compliance. 3. ESD will tour facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 01/24/2022	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.1 and 6.1.3.3.1. These deficient findings could have a patterned impact on the residents within the facility.	K 355	K355 CHC will have appropriate access to portable fire extinguishers. In order to comply with NFPA 101 (2012 Edition), Life Safety Code, section 9.7.4.1 and NFPA 10 (2010 Edition), Standard for	1/24/22

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K 355	Continued From page 10 Findings include: On 12/20/2021, between 10:30 AM to 2:00 PM, it was revealed by observation the fire extinguishers by Room LL18 and Room 411 were blocked by equipment. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 355	Portable Fire Extinguishers sections 6.1.31 and 6.1.3.3.1: 1. The carts were removed from LL18 and by room 411 to allow access to fire extinguishers on 12/20/2021. 2. Staff will be trained on location of fire extinguishers and the importance of keeping them free from obstruction. The Environmental Service Director (ESD) completed a tour of facility and checked access to all fire extinguishers to ensure compliance. 3. ESD will tour facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 01/24/2022	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller	K 363		1/24/22

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K 363	Continued From page 11 latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 12/20/2021 between 10:30 AM and 2:00 PM, it was revealed by observation that the LL26	K 363	K363 CHC will have maintained corridor doors for hazardous areas. In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.3.6.3.10: 1. Room LL26 janitor Closet, Medication Room, and Storage Closet at	

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K 363	Continued From page 12 Janitor closet, Medication Room, and Storage Closet at the nurses' station were held open by door stops. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 363	nurses station had door stops removed. Self-closures were adjusted so they fully closed and latched on 12/22/2021. 2. The Environmental Service Director (ESD) completed a tour of facility and checked all hazardous area door closures to ensure compliance. Staff will be educated on not propping doors open with door stops or other items. 3. ESD will tour facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 01/24/2022	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 511	K511	1/24/22

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K 511	Continued From page 13 facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/20/2021 between 10:30 AM and 2:00 PM, it was revealed by observation there were no locked breaker panels on the circuit breaker boxes allowing access by unqualified persons. These panels were located throughout the facility. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 511	CHC will have appropriate secured electrical panels. In order to comply with NFPA 99 (2012 Edition), Health Care Facilities Code, section 6.3.2.2.1.3: 1. All circuit breaker panels were fixed and locked on 01/05/2022. 2. The Environmental Service Director (ESD) completed a tour of facility and checked all circuit breaker panels to ensure compliance. The ESD and maintenance employee were educated on keeping circuit breaker panels locked. 3. ESD will tour facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 01/24/2022	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		1/24/22

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K 901	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99 (2012 Edition), Health Care Facilities Code, Chapter 4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/20/2021 at 12:30 PM, it was revealed by a review of available documentation that the facility was undergoing construction, and changes were not made to the NFPA 99 Facility Risk Assessment dated 10/19/2018. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 901	K901 CHC will have appropriate risk assessment completed. In order to comply with NFPA 99 (2012 Edition), Health Care Facilities Code, Chapter 4: 1. The facility risk assessment was updated to include construction in progress on 01/05/2022. 2. The ESD will monitor for changes that need to be included on the facility risk assessment. 3. The facility Administrator will audit the risk assessment periodically to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 01/24/2022	