DEPARTMENT OF HEALT	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	-		-		AND TRANSMITTAL	ID: XOPT
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00904
1. MEDICARE/MEDICAID PROVID (L1) 245245	DER NO.	3. NAME AND AD (L3) HERITAGE		CILITY		4. TYPE OF ACTION: <u>7 (</u> L8)
2.STATE VENDOR OR MEDICAID	NO.	(L4) 321 NORTH	EAST SIXTH	I STREET		1. Initial2. Recertification3. Termination4. CHOW
(L2) 936651200		(L5) CHISHOLM	I, MN		(L6) 55719	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEO	GORY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 01/2	27/2022 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		06/30
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	00/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
					3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	65 (L18)	I. A	cceptable POC		4. 7-Day RN (Rural SN	
13. Total Certified Beds	65 (L17)	B. Not in Con	pliance with Pro	gram	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied	Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
65						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
	× ×			,		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Teresa Ament, Unit S	Supervisor	0	2/18/2022	(L19)	Joanne Simon, Enfo	rcement Specialist 02/18/2022
PA	RT II - TO BE	COMPLETED F	BY HCFA RI	. ,	OFFICE OR SINGLE S	(L20) TATE AGENCY
19. DETERMINATION OF ELIGIBI	LITY	20. COM	IPLIANCE WIT	H CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-2572)
X 1. Facility is Eligible to	Participate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligibl					5. Bour of the Above	
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
09/01/1982					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
	B. Rescind St	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	30	2. DETERMINATION		DATE		
no recent for emp-1557	52	02/17/2022				
	(L32)			(L33)	DETERMINATION APPI	ROVAL



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.

Heritage Manor December 29, 2021 Page 2

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: <u>susan.frericks@state.mn.us</u> 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

Heritage Manor December 29, 2021 Page 3

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

Heritage Manor December 29, 2021 Page 4 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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			· ·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	-	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY IPLETED
		245245	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HERITAG	E MANOR				21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
	compliance with Ap Preparedness Required a conducted during a	igh 12/16/21, a survey for pendix Z, Emergency uirements, §483.73(b)(6) was standard recertification was IN compliance.					
F 000	signature is not req page of the CMS-29 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents. TS	F0	000			
	recertification surve facility. A complaint conducted. Your fac compliance with the	igh 12/16/21, a standard ey was conducted at your investigation was also cility was found to be NOT in e requirements of 42 CFR 483, ments for Long Term Care					
		laints were found to be ED H5245051C (MN79165), IN79171).					
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	onsite revisit of you	acceptable electronic POC, an r facility may be conducted to intial compliance with the en attained.					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 01/28/2022

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/28/2022 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE SURVEY COMPLETED	
		245245	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR				321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 676 SS=D		ıg (ADLs)/Mntn Abilities 1)(b)(1)-(5)(i)-(iii)	F€	676			1/24/22
	assessment of a re- resident's needs an provide the necessa ensure that a reside daily living do not di of the individual's cl	on the comprehensive sident and consistent with the d choices, the facility must ary care and services to ent's abilities in activities of minish unless circumstances inical condition demonstrate n was unavoidable. This ensuring that:					
	treatment and servi or her ability to carr	ident is given the appropriate ces to maintain or improve his y out the activities of daily se specified in paragraph (b)					
		ovide care and services in ragraph (a) for the following					
	§483.24(b)(1) Hygie grooming, and oral	ene -bathing, dressing, care,					
	§483.24(b)(2) Mobi including walking,	lity-transfer and ambulation,					
	§483.24(b)(3) Elimi	nation-toileting,					
	§483.24(b)(4) Dinin snacks,	g-eating, including meals and					
	(i) Speech,(ii) Language,(iii) Other functional	munication, including communication systems. NT is not met as evidenced					

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		OMB NO.	0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	Сом	E SURVEY PLETED	
		245245	B. WING			C 16/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		10/2021	
HERITA	GE MANOR			321 NORTHEAST SIXTH STRE CHISHOLM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE	
F 676	Continued From pa	age 2	F 6	76			
	review, the facility f routine grooming w (R40) observed to l cheeks, chin, and r Findings include: R40's admission M 11/29/21, identified demonstrated no re R40's MDS further assistance with act required set up hell R40's care plan dat was independent w R40's goal was to b plan interventions l	tion, interview, and document ailed to ensure assistance with as provided for 1 of 1 resident have visible stubble on his neck. inimum Data Set (MDS) dated R40 was cognitively intact and ejection of care behaviors. indicated he required limited ivities of daily living and p with personal hygiene. ted 11/25/21, identified R40 vith grooming after set up. be neatly groomed daily. The isted were to set-up supplies ne. In addition, to assist with		 F: 676 It is Heritage M provide grooming/hygie per care plan. DON and/or designee corrective action for residents preferences by this practice by: •R40 will be intervie preferences related to care plan will be update preference. DON and/or designee residents having the position of the preference affected by this practice •All residents who mand/or assist with shave to be affected by deficition 	ene to our residents will implement sident R40 affected ewed for grooming shaving. Grooming ed per resident will assess otential to be e including: equire set up ring have potential ent practice.		
	completion of tasks On 12/13/21, at 1:4 have white/gray stu neck. R40 stated h and stated it was h On 12/15/21, at 12: seated on the edge unshaven. On 12/16/21, at 8:5 (NA)-A stated R40 able to shave hims residents "get a go On 12/16/21, at 2:4			 measures to ensure the does not recur includin The Shave Male/F reviewed and updated All nursing staff will the Shave Male/Femal to shaving per resident following care plan. All residents who ne with shaving will have the reviewed and care plan needed. DON and/or designee to corrective actions to ene effectiveness of these to an audits ide compliance per resider 	at this practice g: emale policy will be as needed. Il be educated on e policy in regards t preference need assistance their preferences n updated as will monitor nsure the actions including: entifying shaving		

Facility ID: 00904

If continuation sheet Page 3 of 17

TATEMENT	OF DEFICIENCIES	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) I	IO. 0938-039 DATE SURVEY OMPLETED	
		245245	A. BUILDING	2	C 2/16/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	2/10/2021	
HERITAC	E MANOR			321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			(X5) COMPLETIO DATE	
F 676	ask them daily if the On 12/16/21, at 2:5 not get a bath/show would get one "tom On 12/16/21, at 2:5 have a bath that me was not told anythin bathing/showering. if he wanted to be s R40 continued to h cheeks, chin, and r On 12/16/21, at 3:1 (DON) verified he w	ey want to be shaved. 3 p.m. NA-C stated R40 did ver that day. NA-C stated he orrow". 6 p.m. R40 verified he did not orning and further stated he ng about a plan for R40 verified he was not asked set up to shave that morning. ave white/gray stubble on his	F 676	 be completed by DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then oncome weekly x 2 weeks, and then monthly thereafter beginning the week of Januar 10th, 2022. •Audit results will be brought to the QAPI committee quarterly for review an further recommendation. Completion Date: January 24th, 2022 	y	
	Policy undated, ind designee would dis its' grooming and ro The resident's prefi- resident's individual ADL Care Provided CFR(s): 483.24(a)(§483.24(a)(2) A res- out activities of dail services to maintai personal and oral h	I for Dependent Residents 2) sident who is unable to carry y living receives the necessary n good nutrition, grooming, and	F 677	7	1/24/22	
	Based on observative review, the facility f	tion, interview, and document ailed to ensure routine ided for 1 of 1 resident (R34) nal care.		F: 677 It is Heritage Manor's policy to provide grooming/hygiene to our resider per care plan.	nts	

Facility ID: 00904

If continuation sheet Page 4 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/28/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245245	B. WING			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 .=.	
HERITAG	E MANOR			321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 4	F6			
	Findings include:			DON and/or designee will impleme corrective action for resident R34 by this practice by:		
	R34's Face Sheet printed 12/16/21, identified diagnoses that included mild cognitive impairment.					
	(MDS) dated 12/1/2 cognitively impaired rejection of care be he required extension	ange Minimum Data Set 1, indicated R34 was severely I and demonstrated no haviors. R34's MDS indicated ve assistance of one for ng including personal		preference. DON and/or designee will assess residents having the potential to be affected by this practice including: •All residents who are dependent staff for shaving needs have potent be affected by deficient practice.	nt on	
	required assistance hygiene. The care p encourage R34 to s tasks he was unable	tart grooming tasks, complete	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		ice y will be ed on	
	have white stubble "forgot" to shave. On 12/15/21, at 8:0	6 a.m. nursing assistant ed helping R34 get ready for		the Shave Male/Female policy in r to shaving per resident preference following care plan. •All residents who need assista with shaving will have their prefere reviewed and care plan updated a needed.	nce	
	NA-D brought R34 mechanical lift and No offer was made On 12/15/21, at 1:0 television, when ask his jaw and said "m On 12/16/21, NA-A	out of the bathroom using an seated him in his wheelchair. to set R34 up for shaving. 3 p.m. R34 was watching ked about shaving, he rubbed aybe I should shave". stated residents should be they refuse. NA-A stated R34		DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions inclu •Random audits identifying sha compliance per resident's care pla be completed by DON/designee 5 x 1 week, 3x/week x 2 weeks, the weekly x 2 weeks, and then month thereafter beginning the week of J	ving n will k/week n once ly	

Facility ID: 00904

If continuation sheet Page 5 of 17

		& MEDICAID SERVICES				. 0938-039
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		e survey IPleted
						С
		245245	B. WING		12/	16/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE MANOR			321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 677	Continued From pa	age 5	F 67	7		
	it all done, NA-A further stated staff should set R34 up and then finish shaving for him if he can't finish.				•Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	
	assisted with shavi the day but for sure R34 had facial stuk a shave, she verifie	o stated residents should be ng in the morning or later in e on bath days. NA-D verified oble and looked like he needed ed she did not help him shave -D stated she had to leave c over for her.		Completion Date: January 24th, 2022		
	"pretty busy" and d	04 a.m. NA-A stated she was id not help R34 shave the day d he would get shaved today s bath day".				
		02 p.m. NA-E verified R34 had s face and stated she would o help him shave.				
		2 p.m. the director of nursing would expect residents to be eir care plan.				
E 600	Policy undated, ind designee would dis its' grooming and r The resident's pref resident's individua		ГОО	0		1/04/00
F 688 SS=D	CFR(s): 483.25(c)	Decrease in ROM/Mobility 1)-(3)	F 68	Ø		1/24/22
	resident who enter	r. facility must ensure that a s the facility without limited es not experience reduction in				

Facility ID: 00904

If continuation sheet Page 6 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 01/28/2022 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (X3) DAT	E SURVEY IPLETED
		245245	B. WING	·		16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAG	E MANOR				21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 688	condition demonstr of motion is unavoid §483.25(c)(2) A res motion receives app services to increase prevent further dect §483.25(c)(3) A res receives appropriat assistance to maint the maximum pract reduction in mobility This REQUIREMEN by: Based on observat review, the facility fa range of motion (RC implemented as dir 2 residents (R1, R3 to ensure palm prot place for 2 of 2 resi splints. Findings include: R1's quarterly Minir 9/7/21, identified R2 impairment and dia dementia, spinal sta spinal canal in the I pain or numbness i fatigue. The MDS i non-ambulatory and staff for all activities hygiene, for which F assistance. The M	ess the resident's clinical ates that a reduction in range dable; and ident with limited range of propriate treatment and e range of motion and/or to rease in range of motion. ident with limited mobility e services, equipment, and ain or improve mobility with icable independence unless a y is demonstrably unavoidable. NT is not met as evidenced ion, interview, and document ailed to ensure restorative DM) programs were ected by the care plan for 2 of the addition, the facility failed ectors were appropriately in dents (R1, R3) reviewed for num Data Set (MDS) dated 1 had severe cognitive gnoses which included enosis (a narrowing of the ower back that may cause in the legs), and chronic ndicated R1 was d was totally dependent on s of daily living except personal R1 required extensive DS also indicated R1 had	F	588	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	
		in range of motion (ROM) of			residents having the potential to be	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í	IPLE CONSTRUCTION		E SURVEY IPLETED	
					С		
		245245	B. WING			16/2021	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
				321 NORTHEAST SIXTH STREET			
LINIAG				CHISHOLM, MN 55719			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 688	Continued From pa	ne 7	F 68	18			
	•	(shoulder, elbow, wrist, hand)	1 00	affected by this practice in	cludina:		
		one side and had not received		•All residents who rece			
		T), occupational therapy (OT)		motion services and/or util			
		ng services during the		splints/braces have the po			
		. The MDS further identified		affected by this deficient p			
		/sical, verbal, or other					
		ns or rejection of care during		DON and/or designee will	implement		
	the look back period	d.		measures to ensure that the	nis practice		
				does not recur including:			
		Plan dated 9/8/21, identified		•The Restorative Nursi			
		nance ROM with a goal to		policy will be reviewed and	updated as		
		vel of ROM and directed staff		needed.	in the second of		
		ange of motion (PROM) on emities (BUE) and bilateral		 All residents who rece motion services and/or util 			
		BLE) three times per week.		splints/braces will have their care plans			
		directed staff to provide gentle		and NAR Task lists review			
		compresses to hands, left		that accurate information is			
		ng the day and off at bedtime;		reflect recommendation of			
		or with finger separator at		occupational therapist. Up			
	bedtime and remov	e in the morning.		made as needed.			
				 All nursing staff will be 			
		on 12/15/21, from 8:12 a.m.		the Restorative Nursing Pr			
		vas seated in a Broda chair (a		regards to following reside			
		ning chair) at a table in the		for range of motion practic			
		breakfast meal. She was		splints/braces to prevent d	ecline of		
		eck to her feet with a clothing anket and her hands and		resident function.			
		le. R1 was fed breakfast by a		DON and/or designee will	monitor		
		lid not participate in any way		corrective actions to ensur			
		She was not observed to		effectiveness of these action			
	move her extremitie			•Random audits will be	-		
		č		ensure that range of motio			
	During observation	on 12/15/21, at 1:57 p.m. R1		splint/brace utilization is be			
	rested quietly in bed	d covered from her shoulders		per resident plan of care 5	x/week x 1		
		eyes closed. Her hands and		week, 3x/week x 2 weeks,			
	extremities were no	t visible.		weekly x 2 weeks, and the			
	D · · · · ·			thereafter beginning the w	eek of January		
	Luring obcorvation	on 12/16/21, at 7:14 a.m. R1		10th, 2022.		1	

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PRINTED: 01/28/2022

CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO.	APPROVE . 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	Сом	E SURVEY IPLETED		
		245245	B. WING		C 12/16/2021			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
HERITA	GE MANOR		321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 688	A padded palm pro with a strap secure device was observer rested in a fist, the fingers. R1 did not During interview on licensed practical in had specific nursing assigned to perform residents, however pulled to work on the adjacent to the nurse two binders from a identified contained programs and docu- participation in the binder revealed a fet top for room number the week with hand and restorative plan included: gentle st hands, PROM 4x/w participation was de columns dated 12/7 During interview on nursing assistant (N restorative aides wi programs for reside on the floor did not resident cares. Sh assisted with morni- residents up and do	tector was in her right hand d around her knuckles. No ed in R1's left hand, which thumb tucked inside of the respond when greeted. 12/16/21, at 7:25 a.m. hurse (LPN)-A stated the facility g assistant staff who were in restorative duties for indicated they were often he floor. She walked to a room sing station area and obtained filing cabinet which she d the residents' restorative umentation of resident programs. Review of one orm with columns across the er, resident name, each day of lwritten dates above the day, h. The restorative plan for R1 retches, warm compress to <i>kk</i> (four times per week). No occumented for R1. The 14 through 12/20 were blank. 12/16/21, at 2:04 p.m. NA)-G stated they had ho completed the restorative ents so the NA's who worked do the programs as part of e added if the restorative aides ing cares, they may get o their programs at that time.	F 688	 Audit results will be brou QAPI committee quarterly fo further recommendation. Completion Date: January 24 	r review and			

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		AND HUMAN SERVICES				FORM	01/28/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245245	B. WING				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HERITAC	GE MANOR			-	21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	was totally depende wore a splint in her completed the resto and it was not an ex and she had not co She had not noticed not but thought R1 last two months. During interview on stated she had worf provided services for since November. F upper extremities a her left hand. R1's contracted as the left open the hand all th provided care. R1 lower extremities as On 12/16/21 at 2:27 protector was place identified the toiletin which hand the pall NA-H asked LPN-A correct hand placer -At 2:24 p.m. LPN-A should be in R1's left should be updated wore the palm prote During a group inte p.m. LPN-A stated, agreed staffing for th had been difficult du NA-D added she ha scheduled restoratin	ent on staff for cares. She right hand. Restorative aides prative programs for residents xpected tasks for NA's to do impleted any ROM for R1. d if R1's hands were stiffer or was about the same over the 12/16/21, at 2:11 p.m. NA-E ked as a restorative aide and or R1 but had not done so R1 required PROM to her and needed a palm protector to right hand wasn't as eff one and she was able to ne way the last time she had also required PROM to her s well. 1 p.m. NA-H verified R1's palm ed in her right hand and ng sheet did not differentiate in m protector should be placed. A to check the computer for the ment for R1's palm protector. A stated the palm protector eff hand and the toileting sheet to include in which hand R1	F	588			

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		AND HUMAN SERVICES				FORM	01/28/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245245	B. WING _				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
HERITAC	GE MANOR				1 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	stated she worked a stated she had not o program in a long ti last time she had do extend her right har compresses. Review of R1's The to 12/16/21 reveale -Week of 9/19/21: -Week of 9/26/21: -Week of 10/3/21: -Week of 10/17/21: -Week of 10/17/21: -Week of 10/24/21: -Week of 10/31/21: -Week of 11/21/21: -Week of 11/28/21: -Week of 11/28/21: -Week of 11/28/21: -Week of 12/5/21: -Week of 12/12/21: -Week of 12/12	as a restorative aide, however, completed R1's restorative ime. To her knowledge, the one so, R1 was able to fully nd after application of warm erapy Detail Report for 9/16/21 ed the following: PROM three times PROM one time PROM one time No services provided No services provided N	F 68	38	DEFICIENCY)		
		rapy Detail Report and					

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		AND HUMAN SERVICES				FORM	01/28/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245245	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HERITAG	GE MANOR				21 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	indicated by the rep services twice since The Restorative Nu 4/6/20, directed the restorative nursing resident's ability to optimal function in a comprehensive ass plan or care. The re- responsible for prov- restorative nursing document completion restorative nursing R3's Face Sheet pr which included Part dementia. R3's quarterly Minir	bort, R1 had only received e October. ursing Program Policy dated e facility would have a program that promoted a achieve and/or maintain their accordance with the resident's sessment and person-centered restorative staff would be viding the residents with programs and would on or resident refusal of services. rinted 12/16/21, diagnoses kinson's Disease and mum Data Set (MDS) dated	F	588			
	impaired and had n extensive assistance and was dependent transfers, toilet use	R3 was severely cognitively not rejected cares. R3 required ce with activities of daily living t on staff for dressing, e, and eating. The MDS npairment on both sides of nd lower.					
	contractures related included ensuring p support and protect contractures and sl were donned in the and replaced with a separator (provides	ated 1/10/19, indicated R3 had d to immobility. Interventions balm protectors (provide tion to prevent finger kin breakdown in the palm) e morning and removed at night a rolled wash cloth or finger s support between each digit rspiration, provides support					

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		AND HUMAN SERVICES				FORM	01/28/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DAT COM	E SURVEY IPLETED
		245245	B. WING	i			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	BE MANOR				21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 688	between each digit) ROM would be perf R3's Therapy Detai 12/16/21, indicated range of motion (PF restorative aides. T received PROM on 11/22/21, and 12/8/ feet. On 12/14/21, at 11: have a palm protect her left hand. On 12/15/21, at 7:5 seated in her wheel palm protector was protector in her left On 12/15/21, at 10: room and transferre bed for a rest. R3's	 In addition maintenance formed. I Report date range 9/16/21, to R3 was to receive passive ROM) five times per week by 'he report indicated R3 9/20/21, 9/27/21, 10/18/21, '21, to hands, arms, legs, and 03 a.m. R3 was observed to otor in her right hand, none in 55 a.m. R3 was observed lchair dressed for the day, a in her right hand, no palm 	1	588	,		
	palm protector. On 12/16/21, at 7:4 seated in her wheel waiting for breakfas her left hand, none	1 a.m. R3 was observed Ichair in the dining room st. R3 had a palm protector in in her right hand.					
		l3 p.m. nursing assistant f had been able to place a R3's left hand.					
	supposed to have F week. NA-E verified	4 p.m. NA-E stated R3 was PROM three to five times a d PROM was not done if the s pulled to do cares. NA-E					

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		AND HUMAN SERVICES				FORM	01/28/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245245	B. WING _				C 16/2021
NAME OF F	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
HERITAG	E MANOR				NORTHEAST SIXTH STREET ISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	protector in her left dresser and found & finger separator in & should have been w hand. On 12/16/21, at 2:1 (RN)-D verified PRO the restorative aide verified a resident of PROM was not perf On 12/16/21, at 2:3 (PT)-D stated R3 w occupational therap refusals to participal On 12/16/21, RN-C her contractures for On 12/16/21, at 3:1 (DON) stated restor performed as order restorative aide had DON stated there w contractures were w PROM. The DON v palm protectors in the On 12/16/21, at 3:3 verified R3's contra missing restorative contractures were of medical director sta put the palm protector plan.	 currently wearing a palm hand. NA-E looked in R3's both a palm protector and a her drawer. NA-E verified R3 vearing one of them in her left 9 p.m. registered nurse OM does not get performed if was pulled to do cares. RN-D could get more contracted if formed as directed. 6 p.m. physical therapist as discharged from by on 3/11/21, related to ate. said R3 was at baseline with the past year. 6 p.m. the director of nursing rative therapy should be red. The DON stated the d been pulled to do cares. The vere no reports that R3's worse related to missing rerified staff should be putting both of R3's hands as ordered. 6 p.m. the medical director ctures were not worse from therapy, he stated her disease progression. The ated he would expect staff to stors in daily as per the care 	F 68	38			
	The facility policy tit	led Restorative Nursing					

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI		<u>). 0938-039</u> TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		MPLETED	
			_		С	
		245245	B. WING	12	/16/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE MANOR			321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 688	Program reviewed restorative nursing resident's ability to optimal function, in	ge 14 4/6/20, indicated the program would promote a achieve and/or maintain there accordance with the resident's sessment and person-centered	F 68	8		
F 698 SS=D	Dialysis		F 69	8	1/24/22	
	require dialysis reco with professional st comprehensive per the residents' goals This REQUIREMEN by: Based on observat review, the facility fi consistent assessm access site for 1 of dialysis. Findings include: R27's significant ch (MDS) dated 12/10 cognitively intact an resident at the facili end stage renal dis dialysis, and diabet chronic kidney dise R27's care plan rev had renal failure wit included staff to ass of infection. The ca	asure that residents who eive such services, consistent andards of practice, the son-centered care plan, and a and preferences. NT is not met as evidenced tion, interview and record ailed to ensure a system for nent or monitoring of a dialysis 1 resident (R27) reviewed for hange Minimum Data Set /21, indicated R27 was not received dialysis while a ity. R27's diagnoses included ease, dependence on renal es mellitus with diabetic		 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 	3	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/28/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245245	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR				21 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	dialysis access site bleeding. Review of R27's De medication and treat (MAR/TAR) failed to documentation relat R27's access site for On 12/15/21, at 3:1 shunt in the upper r On 12/16/21, at 12: coordinator (HUC) a nurses checked R2 sound of blood flow site when listening of (the feel of blood flow when palpated) and include directions for On 12/16/21, at 12: (RN)-B stated she of access site, did not and did not check for On 12/16/21, at 1:0 are responsible for R27's access site for and feeling for thrill	 (access site) for patency or ecember 2021, electronic atment administration record o include directions or ted to assessing or monitoring or patency or bleeding. 5 p.m. R27 stated he had a ight arm used for dialysis. 47 p.m. the health unit stated she was uncertain if the 7's access site for bruit (the ting through a dialysis access with a stethoscope) or thrill owing though a dialysis access at R27's MAR/TAR did not or assessing the access site. 53 p.m. registered nurse did not do anything with R27's monitor the site for bleeding, or bruit or thrill. 3 p.m. RN-A stated the nurses monitoring and assessing or bleeding, listening for bruit . RN-A further stated the include directions to monitor 	F 6	\$98	 policy will be reviewed and updated needed. All residents who receive dialys have their care plans reviewed to e monitoring of dialysis access site for bleeding and patency, and will updated. All nursing staff will be educate the monitoring of dialysis access sit the Dialysis Management policy. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions inclu. Random care plan audits will be completed on those receiving dialyse ensure care plans reflect proper monitoring of dialysis access sites I DON/designee 5x/week x 1 week, 3x/week x 2 weeks, then once wee weeks, and then monthly thereafter beginning the week of January 10th 2022. Audit results will be brought to a QAPI committee quarterly for review further recommendation. Completion Date: January 24th, 202 	ated as d on tes per ding: e sis to by kly x 2 n, the w and	
	(DON) stated the ca assessing R27's dia returned from dialyi assess the access	0 p.m. the director of nursing art nurses are responsible for alysis access site. When R27 sis, the cart nurses should site, check for bruit and thrill, r infection or bleeding.					

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		AND HUMAN SERVICES					FORM	01/28/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED C
		245245	B. WING	i				_ 16/2021
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIF	2 CODE		
HERITAC	GE MANOR				321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
F 698	Directions for daily the access site sho R27's MAR/TAR. The facility's undate end-stage renal dis permanent stage of required a regular of transplantation to m identified the facalit instructions for acco The facility's Dialys 2/19/18, identified to going through the a through a stethosco blood flowing thoug The policy identified should be assessed	ge 16 monitoring and assessment of uld have been included on ed Dialysis policy identified ease as an irreversible and f renal impairment that course of dialysis or kidney haintain life. The policy further ies care plan should include ess assessment and care. is Management policy revised oruit as the sound of blood access site when listening ope and thrill as the feel of the access when palpated. d the dialysis access site d daily for bleeding and on (thrill) and auscultation	F	698		,		

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Electronically delivered December 29, 2021

Administrator Heritage Manor 321 Northeast Sixth Street Chisholm, MN 55719

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

Re: State Nursing Home Licensing Orders Event ID: XOPT11

Heritage Manor December 29, 2021 Page 2

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: <u>susan.frericks@state.mn.us</u> 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

Minneso	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00904	B. WING		12/1	C 6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HERITAG	E MANOR		HEAST SIXT M, MN 5571			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of f lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	was conducted at y the Minnesota Depa facility was found N State Licensure and orders are issued. F electronic plan of co	S: b 12/16/21, a licensing survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN the following correction Please indicate in your prrection you have reviewed				
ABORATOR	epartment of Health 7 DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 01/05/22

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 17

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00004	B. WING			C
		00904			12/	16/2021
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IERITAC	GE MANOR		THEAST SIXT LM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	these orders and id be completed.	entify the date when they will				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." Fo are the Suggested Time period for Cor					
	receipt of State lice the Minnesota Depa Informational Bullet https://www.health.s n/infobulletins/ib14_ orders are delineate	in state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota				
	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proo completion date, the	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
	PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA	RD THE HEADING OF THE				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00904	B. WING			C 16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HERITAC	GE MANOR		RTHEAST SIXT LM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	your facility by surv Department of Hea	laint survey was conducted at eyors from the Minnesota Ith (MDH). Your facility was e with the MN State				
	UNSUBSTANTIATE H5245051C (MN79 H5245052C (MN79 The facility is enroll signature is not req page of state form. is required, it is req	165).	ו			
2 890	MN Rule 4658.052 Motion	5 Subp. 2 A Rehab - Range of	2 890			1/24/22
	that is directed towa through positioning implemented and n comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without a limited rai experience reduction	ho enters the nursing home nge of motion does not on in range of motion unless al condition demonstrates range of motion is				
	This MN Requiremo	ent is not met as evidenced				

If continuation sheet 3 of 17

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
		00904	B. WING	12	2/16/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
HERITAG	GE MANOR		THEAST SIX M, MN 557	(TH STREET 19	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 890	Continued From pa	ge 3	2 890		
2 890	Based on observati review, the facility farange of motion (RG implemented as dir 2 residents (R1, R3 to ensure palm proti- place for 2 of 2 resi- splints. Findings include: R1's quarterly Minir 9/7/21, identified R impairment and dia dementia, spinal sta- spinal canal in the I pain or numbness i fatigue. The MDS in non-ambulatory and staff for all activities hygiene, for which I assistance. The M functional limitation the upper extremity with impairment on physical therapy (P or restorative nursin assessment period R1 exhibited no phy behavioral symptom the look back perior R1's Current Care I R1 required mainter maintain current lev	on, interview, and document ailed to ensure restorative OM) programs were ected by the care plan for 2 of b). In addition, the facility failed tectors were appropriately in dents (R1, R3) reviewed for num Data Set (MDS) dated 1 had severe cognitive gnoses which included enosis (a narrowing of the ower back that may cause n the legs), and chronic ndicated R1 was d was totally dependent on s of daily living except personal R1 required extensive DS also indicated R1 had in range of motion (ROM) of (shoulder, elbow, wrist, hand) one side and had not received T), occupational therapy (OT) ng services during the . The MDS further identified ysical, verbal, or other ns or rejection of care during d. Plan dated 9/8/21, identified nance ROM with a goal to vel of ROM and directed staff	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 paltr 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 doe not recur including: The Restorative Nursing Program policy will be reviewed and updated as neceded. All residents who receive range of not recur including: 	s, n g
	bilateral upper extre lower extremities (E The care plan also	range of motion (PROM) on emities (BUE) and bilateral BLE) three times per week. directed staff to provide gentle n compresses to hands, left		•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	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00904	B. WING			<i>,</i> 6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
HERITAG	SE MANOR		THEAST SIX	TH STREET 19		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COP	RRECTION	(X5)
PRÉFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
2 890	Continued From pa	ge 4	2 890			
	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.			reflect recommendation of the occupational therapist. Update made as needed. •All nursing staff will be each the Restorative Nursing Pro	ates will be educated on	
	until 8:51 a.m. R1 was seated in tilt in space positioning chair) at a dining room for the breakfast me covered from her neck to her fee protector and lap blanket and her arms were not visible. R1 was fe staff member and did not particip with feeding herself. She was not move her extremities during the r	vas seated in a Broda chair (a ning chair) at a table in the breakfast meal. She was eck to her feet with a clothing anket and her hands and		regards to following resident for range of motion practices splints/braces to prevent de resident function.	t's plan of care s and use of cline of	
		lid not participate in any way f. She was not observed to		DON and/or designee will m corrective actions to ensure effectiveness of these action •Random audits will be c ensure that range of motion	the ns including: conducted to	
	rested quietly in bee to her feet, with her extremities were no			splint/brace utilization is bein per resident plan of care 5x/ week, 3x/week x 2 weeks, th weekly x 2 weeks, and then thereafter beginning the week	week x 1 hen once monthly	
	was seated in a Bro A padded palm pro with a strap secure device was observe	on 12/16/21, at 7:14 a.m. R1 oda chair in the common area. tector was in her right hand d around her knuckles. No ed in R1's left hand, which thumb tucked inside of the		 10th, 2022. Audit results will be brou QAPI committee quarterly for further recommendation. 		
		respond when greeted.		Completion Date: January 2	4th, 2022	
licensed pr had specific assigned to residents, h	licensed practical n had specific nursing assigned to perform residents, however	12/16/21, at 7:25 a.m. urse (LPN)-A stated the facility g assistant staff who were n restorative duties for indicated they were often				
	adjacent to the nurs two binders from a identified contained programs and docu	ne floor. She walked to a room sing station area and obtained filing cabinet which she I the residents' restorative imentation of resident				
		programs. Review of one orm with columns across the				

If continuation sheet 5 of 17

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00904	B. WING			16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HERITA	GE MANOR		THEAST SIXT			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 890	top for room number the week with hand and restorative plar included: gentle str hands, PROM 4x/w participation was do columns dated 12/1 During interview on nursing assistant (N restorative aides wh programs for reside on the floor did not resident cares. She assisted with morni residents up and do During interview on stated she was the to get up for the day morning cares. R1 was totally depende wore a splint in her completed the resto and it was not an ey and she had not co She had not noticed not but thought R1 last two months. During interview on stated she had worl provided services for since November. F upper extremities a her left hand. R1's contracted as the left open the hand all the	ge 5 er, resident name, each day of written dates above the day, n. The restorative plan for R1 retches, warm compress to k (four times per week). No ocumented for R1. The 4 through 12/20 were blank. 12/16/21, at 2:04 p.m. VA)-G stated they had no completed the restorative ents so the NA's who worked do the programs as part of e added if the restorative aides ing cares, they may get their programs at that time. 12/16/21, at 2:06 p.m. NA-H person who had assisted R1 y and had completed her required full assistance and ent on staff for cares. She right hand. Restorative aides prative programs for residents opected tasks for NA's to do mpleted any ROM for R1. d if R1's hands were stiffer or was about the same over the 12/16/21, at 2:11 p.m. NA-E ked as a restorative aide and or R1 but had not done so R1 required PROM to her nd needed a palm protector to right hand wasn't as aft one and she was able to be way the last time she had also required PROM to her				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00904		B. WING			C 16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXT _M, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 890	Continued From pa	ge 6	2 890			
	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.					
	stated she worked a stated she had not program in a long ti last time she had do	12/16/21, at 2:34 p.m. NA-D as a restorative aide, however, completed R1's restorative ime. To her knowledge, the one so, R1 was able to fully nd after application of warm				
	to 12/16/21 reveale -Week of 9/19/21: -Week of 9/26/21: -Week of 10/3/21: -Week of 10/10/21: -Week of 10/17/21: -Week of 10/24/21: -Week of 10/31/21:	PROM three times PROM one time				
	-Week of 11/14/21: -Week of 11/21/21:	No services provided No services provided No services provided				

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
					COMPLETED		
	00904		B. WING			C 12/16/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
HERITAG	GE MANOR		THEAST SIXT LM, MN 55719				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE	
2 890	Continued From page 7		2 890				
	-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.						
	director of nursing s problems with staffi reviewed R1's Ther	12/16/21, at 5:47 p.m. the stated they had been having ing for restorative nursing. He apy Detail Report and bort, R1 had only received e October.					
	4/6/20, directed the restorative nursing resident's ability to optimal function in a comprehensive ass plan or care. The r responsible for prov restorative nursing	Irsing Program Policy dated facility would have a program that promoted a achieve and/or maintain their accordance with the resident's sessment and person-centered estorative staff would be viding the residents with programs and would on or resident refusal of services.					
		inted 12/16/21, diagnoses kinson's Disease and					
	R3's quarterly Minir	num Data Set (MDS) dated					

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING:			
	00904		B. WING			C 16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXT LM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 890	Continued From page 8		2 890			
	 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. 					
	12/16/21, indicated range of motion (Pf restorative aides. T received PROM on	I Report date range 9/16/21, to R3 was to receive passive ROM) five times per week by he report indicated R3 9/20/21, 9/27/21, 10/18/21, 21, to hands, arms, legs, and				
	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.					
	seated in her wheel	5 a.m. R3 was observed lchair dressed for the day, a in her right hand, no palm hand.				
	room and transferre	11 a.m. two staff entered R3's ed from her wheelchair to her palm protector remained in				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00904		B. WING			C 12/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
HERITAC	GE MANOR		THEAST SIXT LM, MN 55719	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	TION SHOULD BE COMP THE APPROPRIATE DAT		
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.						
	supposed to have F week. NA-E verified restorative aide was verified R3 was not protector in her left dresser and found I finger separator in I	4 p.m. NA-E stated R3 was PROM three to five times a d PROM was not done if the s pulled to do cares. NA-E currently wearing a palm hand. NA-E looked in R3's both a palm protector and a her drawer. NA-E verified R3 wearing one of them in her left					
	(RN)-D verified PR the restorative aide verified a resident of	9 p.m. registered nurse OM does not get performed if was pulled to do cares. RN-D could get more contracted if formed as directed.					
	(PT)-D stated R3 w	6 p.m. physical therapist vas discharged from by on 3/11/21, related to ate.					
	On 12/16/21, RN-C her contractures for	said R3 was at baseline with r the past year.					
	(DON) stated resto	6 p.m. the director of nursing rative therapy should be red. The DON stated the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00904	B. WING			C 12/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
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IERIIA	GE MANOR	CHISHO	LM, MN 55719				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 890	Continued From pa	ge 10	2 890				
	DON stated there w contractures were v PROM. The DON v palm protectors in b On 12/16/21, at 3:3 verified R3's contra- missing restorative contractures were c medical director sta put the palm protec plan. The facility policy tit Program reviewed 4 restorative nursing resident's ability to a optimal function, in	I been pulled to do cares. The vere no reports that R3's vorse related to missing erified staff should be putting both of R3's hands as ordered. 6 p.m. the medical director ctures were not worse from therapy, he stated her lisease progression. The ted he would expect staff to tors in daily as per the care led Restorative Nursing 4/6/20, indicated the program would promote a achieve and/or maintain there accordance with the resident's essment and person-centered	5				
	SUGGESTED MET	HOD OF CORRECTION:					
	develop, review, an procedures to ensu restorative therapy finger separators ar The Director of Nur- educate all appropr procedures. The Director of Nur-	sing or designee could d/or revise policies and re resident's receive as directed and splints and re in place as directed. sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing					
	compliance.	R CORRECTION: Twenty-one					
	(21) days.	CONTROLOTION. Twenty-Olle					

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		L` ´com	E SURVEY PLETED
00904	B. WING		C 16/2021
STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
		-	
		PROVIDER'S PLAN OF CORRECTION	(X5)
	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE
age 11	2 915		
5 Subp. 6 A Rehab - ADLs	2 915		1/24/22
sident assessment, a nursing that: s given the appropriate vices to maintain or improve s of daily living unless ormal or characteristic part of lition. For purposes of this aily living includes the ss, and groom; nd ambulate; ilet; th, language, or other			
tion, interview, and document failed to ensure assistance with vas provided for 1 of 1 resident have visible stubble on his neck. Inimum Data Set (MDS) dated I R40 was cognitively intact and ejection of care behaviors. indicated he required limited		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	
	00904 STREET AD 321 NORT	00904 B. WING STREET ADDRESS, CITY, 321 NORTHEAST SIX CHISHOLM, MN 5571 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 11 2 915 25 Subp. 6 A Rehab - ADLs 2 915 of daily living. Based on the sident assessment, a nursing e that: 2 915 s given the appropriate vices to maintain or improve is of daily living unless ormal or characteristic part of lition. For purposes of this aily living includes the the time includes the time is not met as evidenced tim, interview, and document failed to ensure assistance with vas provided for 1 of 1 resident have visible stubble on his neck. timimum Data Set (MDS) dated I R40 was cognitively intact and ejection of care behaviors. indicated he required limited tivities of daily living and	00904 B. WING 12/ STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719 ATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) SIDENTIFYING INFORMATION) age 11 2 915 STREET ADDRESS, CITY, STATE, ZIP CODE CHISHOLM, MN 55719 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) age 11 2 915 STREET ADDRESS of daily living unless ormal or characteristic part of lititon. For purposes of this aigly living includes the : ss, and groom; d ambulate; ilet; 2 915 Add groom; d ambulate; ilet; h, language, or other incation systems; and 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. INIMUM Data Set (MDS) dated by this practice by: "R40 will be interviewed for grooming preferenc

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	ETED		
		00904	B. WING		C 12/16/2021			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY,	STATE, ZIP CODE				
HERITAC	GE MANOR		RTHEAST SIXTH STREET DLM, MN 55719					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLE ⁻ DATE		
2 915	Continued From pa	ige 12	2 915					
	R40's care plan dat was independent w R40's goal was to b plan interventions li for grooming/hygier completion of tasks On 12/13/21, at 1:4 have white/gray stu neck. R40 stated he and stated it was ha On 12/15/21, at 12: seated on the edge unshaven. On 12/16/21, at 8:5 (NA)-A stated R40 b able to shave himse residents "get a goo On 12/16/21, at 2:4 (RN)-C stated if a re ask them daily if the On 12/16/21, at 2:5 not get a bath/show would get one "tom On 12/16/21, at 2:5 have a bath that mo was not told anythir bathing/showering. if he wanted to be s	 ted 11/25/21, identified R40 tith grooming after set up. be neatly groomed daily. The isted were to set-up supplies ine. In addition, to assist with a sa needed. as needed. as needed. as needed. and to get a shower weekly. 57 p.m. R40 was observed to oble on his cheeks, chin, and e didn't like to have facial hair and to get a shower weekly. 57 p.m. R40 was observed to of his bed. R40 remained a a.m. nursing assistant had his own razor and was elf. NA-A further stated od shave on their bath day". 6 p.m. registered nurse esident was alert staff should ey want to be shaved. a p.m. NA-C stated R40 did ver that day. NA-C stated he orrow". 6 p.m. R40 verified he did not orning and further stated he ng about a plan for R40 verified he was not asked set up to shave that morning. ave white/gray stubble on his 		affected by this practice incl •All residents who requir assist with shaving have point affected by deficient practical DON and/or designee will in measures to ensure that this not recur including: •The Shave Male/Female reviewed and updated as ne •All nursing staff will be en- the Shave Male/Female polities to shaving per resident prefer following care plan. •All residents who need as shaving will have their prefer reviewed and care plan upd needed. DON and/or designee will me corrective actions to ensure effectiveness of these action •Random audits identifyic compliance per resident's care completed by DON/designer week, 3x/week x 2 weeks, the weekly x 2 weeks, and then thereafter beginning the weat 10th, 2022. •Audit results will be brow QAPI committee quarterly for further recommendation. Completion Date: January 2	e set up and/or tential to be e. nplement s practice does e policy will be eeded. educated on icy in regards erence assistance with rences ated as nonitor the ns including: ng shaving are plan will be e 5x/week x 1 hen once monthly ek of January			
		5 p.m. the director of nursing vould expect staff to ask						

If continuation sheet 13 of 17

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00904	B. WING		C 12/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXT LM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 13	2 915			
	residents if they wa them accordingly.	inted to shave and to assist				
	Policy undated, ind designee would dis its' grooming and re	tled Shave Male/Female icated the nurse manager or icuss the details of facial hair, emoval on an individual basis. erence would be noted in the I care plan.				
	SUGGESTED MET	THOD OF CORRECTION:				
	develop, review, ar procedures to ensu- restorative therapy The Director of Nur educate all appropri procedures. The Director of Nur	rsing or designee could nd/or revise policies and ure a residents receive as directed. rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			1/24/22
	comprehensive res home must ensure B. a resident who activities of daily liv) is unable to carry out ring receives the necessary n good nutrition, grooming,				
	This MN Requirem	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/16/2021	
		00904	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HERITAG	E MANOR		THEAST SIX	(TH STREET 19		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ige 14	2 920			
	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 It is Heritage Manor's provide grooming/hygiene to per care plan.	our residents	
	Findings include: R34's Face Sheet p diagnoses that inclu impairment.	printed 12/16/21, identified uded mild cognitive		DON and/or designee will im corrective action for resident by this practice by: •R34 will be interviewed to preferences related to shavin care plan will be updated pe	r R34 affected for grooming ng. Grooming	
	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.		/	preference. DON and/or designee will as residents having the potentia affected by this practice inclu •All residents who are de staff for shaving needs have be affected by deficient prac	al to be uding: pendent on potential to	
	required assistance hygiene. The care p encourage R34 to s tasks he was unabl On 12/13/21, at 2:0	ted 9/15/21, indicated R34 e with grooming and personal olan directed staff to start grooming tasks, complete le to finish. 12 p.m. R34 was observed to on his face. R34 stated he		DON and/or designee will im measures to ensure that this not recur including: •The Shave Male/Female reviewed and updated as ne •All nursing staff will be e the Shave Male/Female poli to shaving per resident prefe following care plan.	e policy will be eded. ducated on cy in regards	
	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			 All residents who need a shaving will have their prefer reviewed and care plan upda needed. DON and/or designee will m corrective actions to ensure effectiveness of these action Random audits identifyir compliance per resident's care 	rences ated as onitor the is including: ng shaving	

If continuation sheet 15 of 17

Minnesc	ta Department of He	alth			FORM APPROVE	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00904	B. WING		C 12/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIX M, MN 557 [,]	TH STREET 19		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETE	
2 920	Continued From pa	ge 15	2 920			
2 920	On 12/16/21, NA-A shaved daily unless had his own electric it all done, NA-A fur R34 up and then fir finish. On 12/16/21, NA-D assisted with shavir the day but for sure R34 had facial stub a shave, she verifie the day before. NA- early but NA-A took On 12/16/21, at 9:0 "pretty busy" and di before. NA-A stated "because it was his On 12/16/21, at 1:0 white stubble on his expect someone to On 12/16/21, at 3:1 (DON) verified he w shaved base on the	 stated residents should be stated residents should be a razor but couldn't always get ther stated staff should set a stated residents should be a g in the morning or later in a on bath days. NA-D verified b be and looked like he needed d she did not help him shave D stated she had to leave a over for her. 4 a.m. NA-A stated she was d not help R34 shave the day a he would get shaved today b bath day". 2 p.m. NA-E verified R34 had a face and stated she would a help him shave. 2 p.m. the director of nursing yould expect residents to be 	2 920	week, 3x/week x 2 weeks, then or weekly x 2 weeks, and then mont thereafter beginning the week of x 10th, 2022. •Audit results will be brought to QAPI committee quarterly for revi further recommendation. Completion Date: January 24th, 2	hly January o the ew and	
	Policy undated, indi designee would dis its' grooming and re	cated the nurse manager or cuss the details of facial hair, emoval on an individual basis. erence would be noted in the				
		HOD OF CORRECTION:				
	develop, review, an	sing or designee could d/or revise policies and				
linnesota D TATE FOR	epartment of Health M		6899	XOPT11	If continuation sheet 16 of	

		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		00904	B. WING		C 12/16/2021	
IAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
IERITA	GE MANOR		THEAST SIXT _M, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 16	2 920			
	completed for resid The Director of Nur educate all appropri- procedures. The Director of Nur develop monitoring compliance.	ure personal hygiene/shaving is dents who are dependent. rsing or designee could rsing or designee could rsystems to ensure ongoing R CORRECTION: Twenty-one				

		AND HUMAN SERVICES & MEDICAID SERVICES	F5245	03	3		FORM	01/05/2022 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - HERITAGE MANOR		(X3) DATE SURVEY COMPLETED	
		245245	B. WING				12/	20/2021
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZI	P CODE		
	E MANOR			3	321 NORTHEAST SIXTH STREET	•		
HERITAG				0	CHISHOLM, MN 55719			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF ((X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T			COMPLÉTION DATE
					DEFICIENC			
K 000	INITIAL COMMENT	ſS	K	000				
	FIRE SAFETY							
		ety Code survey was linnesota Department of						
		Fire Marshal Division. At the						
		Heritage Manor was found not						
		the requirements for						
		licare/Medicaid at 42 CFR, Life Safety from Fire, and the						
		onal Fire Protection						
		101, Life Safety Code (LSC),						
	Chapter 19 Existing	Health Care and the 2012						
	edition of NFPA 99,	Health Care Facilities Code.						
	THE FACILITY'S P	OC WILL SERVE AS YOUR						
		COMPLIANCE UPON THE						
		CCEPTANCE. YOUR						
		IE BOTTOM OF THE FIRST S-2567 FORM WILL BE						
		ATION OF COMPLIANCE.						
		F AN ACCEPTABLE POC, AN						
	CONDUCTED TO	OF YOUR FACILITY MAY BE						
		MPLIANCE WITH THE						
		AS BEEN ATTAINED IN						
	ACCORDANCE W	TH YOUR VERIFICATION.						
	PLEASE RETURN	ΤΗΕ ΡΙ ΔΝΙ ΟΕ						
		R THE FIRE SAFETY						
	DEFICIENCIES (K-							
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION						
	IS NOT REQUIRED							
	Healthcare Fire Ins	pections						
		ER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE			(X6) DATE
	ically 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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/05/2022 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE MANOR			(X3) DATE	0938-0391 E SURVEY PLETED
		245245	B. WING			12/:	20/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE MANOR				21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
К 000	 State Fire Marshal 445 Minnesota St., St. Paul, MN 55101 By email to: FM.HC.Inspections THE PLAN OF COIDEFICIENCY MUS FOLLOWING INFO 1. A detailed descentation of planned to 2. Address the metaplace to ensure the 3. Indicate how the future performance sustained. 4. Identify who is machined. 4. Identify who is machined. 5. The actual or performance sustained. Heritage Manor, is a basement. The origin 1953 and was deconstruction. In 1980 constructed to the be of Type II(111) coriginal building and construction type all this facility was survival. 	Division Suite 145 -5145, OR @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: ription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are responsible for the corrective ring of compliance. roposed date for completion of a 1-story building with a full inal building was constructed termined to be of Type II(111) at & 2001 additions were building that was determined to construction. Because the d its additions meet the lowed for existing buildings, veyed as a single building. as an apartment complex	κo	000			

If continuation sheet Page 2 of 15

		AND HUMAN SERVICES		FOR	D: 01/05/2022 M APPROVEI <u>D. 0938-039</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ATE SURVEY DMPLETED	
		245245	B. WING	1	12/20/2021	
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR			321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From pa	ge 2	K 00	0		
	facility has a fire ala detection in the cor- corridors that is mo- department notifical have either heat de that are on the fire with the Minnesota The facility has a ca- census of 48 at the The requirement at NOT MET as evide Means of Egress - CFR(s): NFPA 101 Means of Egress - Aisles, passageway exit locations, and a with Chapter 7, and continuously mainta full use in case of e 18/19.2.2 through 1 18.2.1, 19.2.1, 7.1.7 This REQUIREMEN by: Based on observat facility failed to mai the means of egress edition), Life Safety 7.1.10.1. These de	Apacity of 70 beds and had a time of the survey. 42 CFR, Subpart 483.70(a) is nced by: General General ys, corridors, exit discharges, accesses are in accordance the means of egress is ained free of all obstructions to emergency, unless modified by 18/19.2.11.	K 21	K211 CHC will have maintained means of egress In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.2.2	1/24/22	
	Findings include:			and 7.1.10.1:	-	

Event ID: XOPT21

Facility ID: 00904

If continuation sheet Page 3 of 15

		AND HUMAN SERVICES			F	TED: 01/05/2022 ORM APPROVED NO: 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE MANOR			(X3) DATE SURVEY COMPLETED	
		245245	B. WING			12/20/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY	Y, STATE, ZIP CODE		
HERITAG	E MANOR			321 NORTHEAST SIXT CHISHOLM, MN 55	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K 211	 PM, it was revealed addition exit by roo maintenance room egress. 2. On 12/20/2021, I PM, it was revealed banquet table was in the dining room. An interview with the second secon	age 3 between 10:30 AM and 1:30 d by observation that the Park m 405, dining area, and had snow blocking the path of between 10:30 AM and 1:30 d by observation that a in front of the emergency exit he Environmental Services ese deficient findings at the	К 2	 The Par 405 was cleared table was moved emergency exit 12/22/2021. The Env Director (ESD) of and checked all ensure complian The ESD and m were educated of exits free from of snow). ESD will ensure future con 4. The Env Director is respon monitoring to pro- deficiency. 	vironmental Service onsible for correction a event reoccurrence of	cility ess. / to	
K 321 SS=F	CFR(s): NFPA 101 Hazardous Areas - Hazardous areas a having 1-hour fire r fire rated doors) or system in accordar When the approved system option is us separated from oth partitions and doors Doors shall be self-		К 3	-	tion Date: 01/24/2022	1/24/22	

Facility ID: 00904

If continuation sheet Page 4 of 15

		AND HUMAN SERVICES			FC	RM APF	/05/2022 PROVED 38-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE MANOR			(X3) DATE SURVEY COMPLETED	
		245245	B. WING	i		12/20/2021	
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	SE MANOR			-	21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) DMPLETION DATE
К 321	from the bottom of Describe the floor a hazardous areas th 19.3.2.1, 19.3.5.9 Area Separation N// a. Boiler and Fuel-F b. Laundries (larger c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee g. Laboratories (if of Hazard - see K322) This REQUIREMEN by: Based on observat facility failed to mai storage rooms per Safety Code, section 19.3.2.1.5. These d widespread impact facility. Findings include: 1. On 12/20/2021 b PM, it was revealed following areas had door closers. Room Sandbox Storage A	at do not exceed 48 inches the door. and zone locations of lat are deficient in REMARKS. Automatic Sprinkler A Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces et) classified as Severe	K	321	K321 CHC will have appropriate enclosures a smoke barriers for hazardous areas. In order to comply with NFPA 101 (201) 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 the fully closed and latched on 01/03/2022. Records room in sandbox storage area and 4-inch pipe had penetrations	2 , hey	
	2. On 12/20/2021 b	etween 10:30 AM and 2:00			filled with appropriate material.		

Facility ID: 00904

If continuation sheet Page 5 of 15

		& MEDICAID SERVICES			1	0938-039 E SURVEY
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	01 - HERITAGE MANOR		PLETED
		245245	B. WING		12/2	20/2021
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE MANOR		-	21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 321	PM, it was revealed Level Soiled Linen have a working doc 3. On 12/20/2021 b PM, it was revealed were multiple penel located in the Sand Maintenance Office stuffed with a stuffe An interview with th	by observation that the Lower in the Laundry Room does not or closer. etween 10:30 AM and 2:00 by observation that there trations in the Records Room Box Storage Area and the e, which had a 4-inch pipe	K 321	 The Environmental Service Director (ESD) completed a tour of and checked all hazardous areas f closures and areas of penetrations ensure compliance. The ESD and maintenance employee were educ self-closures and penetrations throus smoke barriers. ESD will tour facility rando ensure future compliance. The Environmental Service Director is responsible for correction monitoring to prevent reoccurrence deficiency. 	f facility for door to ated on bugh mly to e on and	
	CFR(s): NFPA 101 Fire Alarm System A fire alarm system accordance with an with the requirement Electric Code, and and Signaling Code acceptance, mainter available. 9.6.1.3, 9.6.1.5, NF This REQUIREMENT by: Based on a review documentation and failed to inspect the 101 (2012 edition),	NT is not met as evidenced	K 345	 Completion Date: 01/24/20 K345 CHC will have appropriate testing a maintenance of the fire alarm systematic systematic content of the fire alarm systemala sy	and	1/24/22

Facility ID: 00904

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		AND HUMAN SERVICES				FORM	01/05/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE MANOR				E SURVEY PLETED
		245245	B. WING			12/2	20/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	BE MANOR				1 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 345	This deficient findin impact on the resid Findings include: On 12/20/2021 at 1 review of available semi-annual fire ala not available at the An interview with th	ig could have a widespread ents within the facility. :00 PM, it was revealed by a documentation that the arm testing documentation was	К 3	445	 Edition), Life Safety Code sections and NFPA 72 (2010 edition), The N Fire Alarm and Signaling Code, sections and NFPA 72 (2010 edition), The N Fire Alarm and Signaling Code, section 14.3.1: 1. Semi Annual fire alarm test was completed on 01/05/2022. 2. The Environmental Service Director (ESD) and maintenance employee were trained on requirem semiannual fire alarm testing on 01/05/2022. 3. Administrator will audit to effuture compliance. 4. The Environmental Service Director is responsible for correction monitoring to prevent reoccurrence deficiency. 	ational ction ting nents of nsure n and	
	construction type, a approved automatic accordance with NI Installation of Sprin In Type I and II con measures are perm sprinkler protection or local regulations	nstallation d hospitals where required by are protected throughout by an c sprinkler system in PA 13, Standard for the kler Systems. struction, alternative protection nitted to be substituted for in specific areas where state	К 3	51	5. Completion Date: 01/24/20	22	1/24/22

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		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 01/05/2022 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X3) DA . BUILDING 01 - HERITAGE MANOR		
	245245		B. WING			12/20/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
HERITAC	BE MANOR			321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 351	closets of patient sl of the closet does n sprinkler coverage required by NFPA 1 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 1 19.4.2, 19.3.5.10, 9 This REQUIREMEN by: Based on observat facility failed to insta 101 (2012 edition), 19.3.5.1 and 9.7.1.1 The Standard for th Systems, section 8. could have an isola within the facility. Findings include: On 12/20/2021 at 1 observation that the Room appeared no coverage to the ceil An interview with th	eeping rooms where the area tot exceed 6 square feet and covers the closet footprint as 3, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5, .7, 9.7.1.1(1) NT is not met as evidenced ion and staff interview, the all sprinkler heads per NFPA Life Safety Code, sections 1 and NFPA 13 (2010 edition), e Installation of Sprinkler 1.1. This deficient condition ted impact on the residents 2:00 PM, it was revealed by a Lower Lever Room 20 Pump t to have adequate sprinkler	К 3	 K351 K351 CHC will have proper sprinted in order to comply with NFFE Edition), Life Safety Code is 19.3.5.1 and 9.7.1.1 and NEE Edition) The Standard for the of Sprinkler Systems, section 1. Room LL20 Pump scheduled to have a sprink installed to provide proper of ceiling on 01/06/2022. 2. The Environmental Director (ESD) completed a and checked sprinkler head compliance. 3. ESD will tour facilitiens future compliance. 4. The Environmental Director is responsible for of monitoring to prevent record deficiency. 5. Completion Date: 0 	PA 101 (2012 sections FPA 13 (201 he Installatio ons 8.1.1: Room is ler head coverage to I Service a tour of faci ds to ensure y randomly t I Service correction an currence of t	0 n the ity o

Facility ID: 00904

		AND HUMAN SERVICES			FOR	D: 01/05/2022 MAPPROVED D. 0938-0391
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245			TIPLE CONSTRUCTION ING 01 - HERITAGE MANOR		ATE SURVEY OMPLETED
			B. WING		1 ;	2/20/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 321 NORTHEAST SIXTH S CHISHOLM, MN 55719	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	Sprinkler System - CFR(s): NFPA 101 Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMARI any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMEN by: Based on observat facility failed to mai NFPA 101 (2012 ec sections 9.7.5 and Standard for Inspec Maintenance of Wa Systems, sections 4	Maintenance and Testing Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire 5. Records of system design, action and testing are sure location and readily system last checked system test supply source KS information on coverage for r partial automatic sprinkler and NFPA 25 NT is not met as evidenced tion and staff interview, the ntain the sprinkler system per lition), Life Safety Code, NFPA 25 (2011 edition), ction, Testing, and ter-Based Fire Protection 4.1.5 through 4.1.5.2. This uld have a patterned impact on	K 3 K 3	K353 K353 CHC will have a pro sprinkler system. In order to comply w Edition), Life Safety and NFPA 25 (2011		1/24/22
	Findings include: On 12/20/2021 betw it was revealed by c	ween 10:30 AM and 12:30 PM, observation that there were in the Kitchen, LL26 Janitor		Water-Based Fire P sections 4.1.5 throu 1. Ceiling tiles	rotection Systems, gh 4.1.5.2: were replaced in the or Closet, and nurse's	

Facility ID: 00904

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		AND HUMAN SERVICES				FORM	01/05/2022 APPROVED 0938-0391
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE MANOR			(X3) DATE SUR COMPLETE	
		245245	B. WING	i		12/2	20/2021
NAME OF F	PROVIDER OR SUPPLIER	l		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR				1 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	Continued From pa	ige 9	K3	353			
	Closet, and nurses	station by the main entrance.			12/21/2021.		
		e Environmental Services ese deficient findings at the			2. The ESD and maintenance employee were trained on making s replace any ceiling tiles during routin walk-throughs. The Environmental Service Director (ESD) completed a of facility and checked all ceiling are ensure compliance.	ne i tour	
					3. ESD will tour facility random ensure future compliance.	nly to	
					4. The Environmental Service Director is responsible for correction monitoring to prevent reoccurrence deficiency.		
	Portable Fire Exting CFR(s): NFPA 101	guishers	KS	355	5. Completion Date: 01/24/202	22	1/24/22
	inspected, and mai NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.12	uishers are selected, installed, ntained in accordance with I for Portable Fire					
	Based on observat facility failed to mai extinguishers per N Safety Code, section edition), Standard f sections 6.1.3.1 and	tion and staff interview, the ntain access to portable fire IFPA 101 (2012 edition), Life on 9.7.4.1, and NFPA 10 (2010 for Portable Fire Extinguishers, d 6.1.3.3.1. These deficient a patterned impact on the facility.			K355 CHC will have appropriate access to portable fire extinguishers. In order to comply with NFPA 101 (2 Edition), Life Safety Code, section 9 and NFPA 10 (2010 Edition), Standa	2012 9.7.4.1	

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		AND HUMAN SERVICES				FORM	01/05/2022 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE MANOR			(X3) DATE SURVE COMPLETED	
	245245		B. WING			12/2	20/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR				21 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 355	Continued From pa	ige 10	К 3	55			
	Findings include:				Portable Fire Extinguishers sections 6.1.31 and 6.1.3.3.1:	6	
	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.				1. The carts were removed fro LL18 and by room 411 to allow acce fire extinguishers on 12/20/2021.		
		e Environmental Services ase deficient findings at the			2. Staff will be trained on locat fire extinguishers and the importance keeping them free from obstruction. Environmental Service Director (ESI completed a tour of facility and check access to all fire extinguishers to en- compliance.	e of The D) ked	
					3. ESD will tour facility random ensure future compliance.	nly to	
					4. The Environmental Service Director is responsible for correction monitoring to prevent reoccurrence deficiency.		
	Corridor - Doors CFR(s): NFPA 101		КЗ	63	5. Completion Date: 01/24/202	22	1/24/22
	required enclosures hazardous areas re and are made of 1 wood or other mate at least 20 minutes smoke compartment the passage of smo to rooms containing	prridor openings in other than s of vertical openings, exits, or esist the passage of smoke 3/4 inch solid-bonded core erial capable of resisting fire for . Doors in fully sprinklered nts are only required to resist oke. Corridor doors and doors g flammable or combustible itive latching hardware. Roller					

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		AND HUMAN SERVICES				FORM	01/05/2022 APPROVED 0938-0391
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE MANOR			E SURVEY PLETED
			B. WING	i		12/2	20/2021
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR				21 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 363	requirements do not do not contain flam Clearance between covering is not exce complying with 7.2. with a device capat when a force of 5 lk impediment to the of devices that release pulled are permitted of unlimited height meeting 19.3.6.3.6 shall be labeled and materials in complia smoke compartment window assemblies sprinklered compar restrictions in area frames in window a 19.3.6.3, 42 CFR P and 485 Show in REMARKS protection ratings, a etc. This REQUIREMEN by: Based on observat facility failed to mai 101 (2012 edition), 19.3.6.3.10. These a patterned impact facility. Findings include: On 12/20/2021 betw	ed by CMS regulation. These of apply to auxiliary spaces that mable or combustible material. a bottom of door and floor eeding 1 inch. Powered doors 1.9 are permissible if provided ole of keeping the door closed of is applied. There is no closing of the doors. Hold open e when the door is pushed or d. Nonrated protective plates are permitted. Dutch doors are permitted. Door frames d made of steel or other ance with 8.3, unless the nt is sprinklered. Fixed fire are allowed per 8.3. In tments there are no or fire resistance of glass or issemblies. arts 403, 418, 460, 482, 483, 6 details of doors such as fire automatics closing devices, NT is not met as evidenced tion and staff interview, the ntain corridor doors per NFPA Life Safety Code, section e deficient findings could have on the residents within the	K	363	K363 CHC will have maintained corridor for hazardous areas. In order to comply with NFPA 101 (Edition), Life Safety Code sections 19.3.6.3.10: 1. Room LL26 janitor Closet,	2012	
		ween 10:30 AM and 2:00 PM, observation that the LL26			1. Room LL26 janitor Closet, Medication Room, and Storage Clo	set at	

Facility ID: 00904

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		AND HUMAN SERVICES				APPROVE . 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - HERITAGE MANOR		e survey IPleted
		245245	B. WING		12/	20/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
K 363	Janitor closet, Mec Closet at the nurse door stops. An interview with th	age 12 lication Room, and Storage es' station were held open by ne Environmental Services ese deficient findings at the	K 36	 nurses station had door as Self-closures were adjust closed and latched on 12 2. The Environmen Director (ESD) completed and checked all hazardoor closures to ensure comp be educated on not propy with door stops or other i 3. ESD will tour fac ensure future compliance 4. The Environmen Director is responsible for monitoring to prevent recordeficiency. 5. Completion Date 	ted so they fully 2/22/2021. tal Service d a tour of facility us area door liance. Staff will ping doors open tems. ility randomly to e. tal Service or correction and occurrence of the	
-	complies with NFP electrical wiring an NFPA 70, National	Electric las or related gas piping A 54, National Fuel Gas Code, d equipment complies with Electric Code. Existing ontinue in service provided no	K 51	-	0 1/24/2022	1/24/22
	by:	NT is not met as evidenced tion and staff interview, the		K511		

Facility ID: 00904

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(EACH DEFICIENCY REGULATORY OR LE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245 TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		IPLE CONSTRUCTION IG 01 - HERITAGE MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719 PROVIDER'S PLAN OF CORRECTION	(X3) DATE S COMPLE 12/20 /	ETED
E MANOR SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719	12/20/	/2021
E MANOR SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa	MUST BE PRECEDED BY FULL	PREFIX	321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL	PREFIX	CHISHOLM, MN 55719		
(EACH DEFICIENCY REGULATORY OR LE	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION		
			(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETION DATE
99 (2012 edition), H section 6.3.2.2.1.3. have a widespread the facility. Findings include: On 12/20/2021 betw it was revealed by o locked breaker pan boxes allowing acco These panels were An interview with th Director verified the time of discovery. Fundamentals - Bu CFR(s): NFPA 101 Fundamentals - Bu Building systems ar	ure electrical panels per NFPA dealth Care Facilities Code, These deficient findings could impact on the residents within ween 10:30 AM and 2:00 PM, observation there were no els on the circuit breaker ess by unqualified persons. located throughout the facility. e Environmental Services ese deficient findings at the ilding System Categories re designed to meet Category	K 51	 CHC will have appropriate secured electrical panels. In order to comply with NFPA 99 (20 Edition), Health Care Facilities Cod section 6.3.2.2.1.3: 1. All circuit breaker panels w fixed and locked on 01/05/2022. 2. The Environmental Service Director (ESD) completed a tour of and checked all circuit breaker panels locked maintenance employee were educate keeping circuit breaker panels locked. 3. ESD will tour facility randomensure future compliance. 4. The Environmental Service Director is responsible for correctio monitoring to prevent reoccurrence deficiency. 5. Completion Date: 01/24/20 	e, ere facility els to ated on ed. nly to n and of the 22	24/22
F Citikby Acti FC FE1Cdp	Fundamentals - Bu Crategories are dete building systems an chrough 4 require Categories are dete boundamented risk as content of the content	Findings include: On 12/20/2021 between 10:30 AM and 2:00 PM, was revealed by observation there were no bocked breaker panels on the circuit breaker boxes allowing access by unqualified persons. These panels were located throughout the facility. These panels were located throughout the facility. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	Fundamentals - Building System Categories CPR(s): NFPA 101 Sundamentals - Building System Categories CPR(s): NFPA 101 Councerted risk assessment procedure weight and the set of	 Edition), Health Care Facilities Cod section 6.3.2.2.1.3: Edition), Health Care Facilities Cod section 6.3.2.2.1.3: All circuit breaker panels were located throughout the facility. In All circuit breaker panels were located throughout the facility. In the Environmental Services Director verified these deficient findings at the me of discovery. ESD will tour facility random ensure future compliance. The Environmental Services Director verified these deficient findings at the me of discovery. ESD will tour facility random ensure future compliance. The Environmental Services ESD will tour facility random ensure future compliance. The Environmental Services Director is responsible for correction monitoring to prevent reoccurrence deficiency. Completion Date: 01/24/20. Completion Date: 01/24/20. Completion Date: 01/24/20. Completion Date: 01/24/20. 	 Edition), Health Care Facilities Code, section 6.3.2.2.1.3: Edition), Health Care Facilities Code, section 6.3.2.2.1.3: Edition), Health Care Facilities Code, section 6.3.2.2.1.3: All circuit breaker panels were fixed and locked on 01/05/2022. 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. ESD will tour facility randomly to ensure compliance. The ESD and maintenance employee were educated on keeping circuit breaker panels locked. ESD will tour facility randomly to ensure future compliance. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. Completion Date: 01/24/2022 Undamentals - Building System Categories Suliding systems are designed to meet Category through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and locumented risk assessment procedure information.

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	MENT OF HEALTH		FORM	01/05/2022 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING 01 - HERITAGE MANOR (X3) DAT		
		245245	B. WING 12			20/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE MANOR			321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 901	Continued From pa	ge 14	K 90)1		
	by: Based on a review and staff interview, the building system Category 1 through NFPA 99 (2012 Edit Code, Chapter 4. T have a widespread the facility. Findings include: On 12/20/2021 at 1 review of available of was undergoing con not made to the NF Assessment dated An interview with th	, , , , , , , , , , , , , , , , , , ,		 K901 CHC will have appropriate risk assessment completed. In order to comply with NFPA 99 (20 Edition), Health Care Facilities Code Chapter 4: 1. The facility risk assessment updated to include construction in progress on 01/05/2022. 2. The ESD will monitor for chata need to be included on the faciliassessment. 3. The facility Administrator withe risk assessment periodically to a future compliance. 4. The Environmental Service Director is responsible for correction monitoring to prevent reoccurrence deficiency. 5. Completion Date: 01/24/202 	e, t was anges lity risk III audit ensure n and of the	