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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XREM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00904

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

13.Total Certified Beds **78** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Patricia Halverson, Unit Supervisor — 12/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 02/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/24/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245245
December 1, 2014

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

Dear Mr. Ryan:

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

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

Effective November 11, 2014 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

December 1, 2014

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

RE: Project Number S5245026

Dear Mr. Ryan:

On October 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 2, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On November 17, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 2, 2014, effective November 11, 2014 and therefore remedies outlined in our letter to you dated October 16, 2014, will not be imposed.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245245	A. Building B. Wing	11/17/2014

Name of Facility	Street Address, City, State, Zip Code
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **11/11/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/11/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/11/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/11/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/11/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PLH/mm	12/01/2014	00904	11/17/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/2/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XREM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00904

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(L1) **245245**

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Teresa Ament - HFE II — 11/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath Program Assurance — 11/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/24/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6986

October 16, 2014

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

RE: Project Number S5245026

Dear Mr. Ryan:

On October 2, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 11, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 2, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File 5245s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	10/02/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	ok 11-3-14 PLH	
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure preferences for bathing frequency were addressed for 4 of 4 residents (R18, R96, R49, R105) who were reviewed for choices. Findings include: R18 was not provided three baths per week	F 242		

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

Administrator | 10-29-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	10/02/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 1 according to his bathing preferences. On 9/30/14, at 1:17 p.m. R18 stated he was not given the opportunity to choose how often he received a bath, and preferred to have three baths a week. On 10/2/14, at 3:10 p.m. R18 stated he was scheduled for two baths a week; however, did not always receive two. R18 stated he preferred three baths a week, but, "Didn't want to step on anyone." R18 stated he used to take a bath daily prior to admission to the facility. R18 added, "If that's all you can get, that's all you can get. You can't have everything." The quarterly Minimum Data Set (MDS) dated 9/9/14, indicated R18's diagnoses included congestive heart failure (CHF), stroke (CVA), and hemiplegia (paralysis on one side of the body). The MDS identified R18 had no cognitive impairment; had no behaviors; and was dependent upon two staff for bathing. There was no evidence R18's preferences for bathing frequency of three times per week had been evaluated and addressed. R18's bathing care plan revised 10/1/14, indicated total assist of two staff for one bath per week. The Bath List dated 9/17/14, indicated R18 was scheduled for a regular bath/shower on Thursday, and an "Xtra" [sic] bath/shower on Monday. The documentation of bathing provided was reviewed from 7/28/14, to 10/2/14. There was no evidence of bathing for R18 on on Thursday 7/31/14, Monday 8/18/14, Thursday 8/21/14, Monday 8/25/14, Monday 9/8/14, and Thursday	F 242	**F242:** DON and/or designee will implement corrective action for residents (R18, R49, R96, and R105) affected by this practice by: • Residents (R18 and R96) were asked about their bathing schedule preferences and their bathing schedules were adjusted accordingly. • (R 49) was asked 3 different times about additional baths and she has declined any additional baths as she states, "One a week is just fine. I used to bathe 2 times a day when I was working in Chicago." • (R105) was discharged home on 10-16-2014. • Bath Aides were given individualized training on documenting baths correctly and timely. DON and/or designee will assess residents having the potential to be affected by this practice including: • All other cognitive residents are potentially affected by this practice and will be asked about their bathing schedule preferences and their bathing schedules will be adjusted accordingly. DON and/or designee will implement measures to ensure that this practice does not recur including: • All future residents will be asked about their bathing schedule preferences on admission. A new admission checklist was created to ensure residents preferences are discussed at admission.	

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	245245	A. BUILDING _____ B. WING _____	10/02/2014

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F 242	Continued From page 2 9/25/14. On 10/2/14, at 3:20 p.m. the registered nurse manager (RN)-A stated residents were not asked how often they would like a bath/shower. RN-A stated residents were given one bath per week, and, "Sometimes two if staff have time." On 10/2/14, at 3:30 p.m. RN-D confirmed R18's bath was not always documented even once a week. R96, interviewed on 9/29/14, at 5:15 p.m., stated she would prefer a bath twice a week, rather than weekly as she was receiving. R96's quarterly MDS dated 7/29/14, identified diagnoses that included anemia, hypertension, anxiety and depression. The MDS further indicated R96 was cognitively intact, and required limited assistance of one staff with bathing. The care plan dated 7/14/14, indicated R96 required limited physical assistance of one staff. The Resident Activity Assessment dated 4/25/14, indicated it was very important for R96 to choose between a tub bath, shower, bed bath or sponge bath, but did not address R96's choices for frequency of bathing. On 10/1/14, at 1:50 p.m. RN-A was interviewed and indicated R96 was bathed weekly, and staff was unaware she would like a bath twice a week. R49 was not given the opportunity to choose how often she received a bath. On 9/30/14, at 8:52 a.m. R49 stated she took a shower in the morning and the evening prior to being admitted to the facility. R49 stated she	F 242	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Care conference RN will address at initial and quarterly care conferences to determine if residents are receiving what they would like. Any discrepancies will be reported to the DON for further corrective action. Completion Date: 11-11-2014	

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F 242	Continued From page 3 received a shower once a week and would like a shower more often. R49 stated she thought about requesting a shower more often but did not want to, "rock the boat". "I can't upset everyone or everything." R49's Disease Diagnosis and Allergy list dated 10/2/14, included presenile dementia, congestive heart failure, chronic airway obstruction, osteoarthrosis, osteoarthritis, anemia, macular degeneration and depression. The Resident Activity Assessment dated 4/25/14, indicated it was very important to R49 to choose between a tub bath shower, bed bath or a sponge bath. The assessment did not include preferences of number of baths per week. The Bathing care plan dated 6/2/14, indicated R49 was independent with bathing and required limited assistance of one staff to transfer only. The Communications care plan dated 6/2/14, indicated R49 was able to express her needs. The quarterly Minimum Data Set (MDS) dated 9/23/14, indicated R49 had cognitive impairment, had no behaviors and had no refusal of cares. R49 required staff assistance with bathing for transferring only. On 10/1/14, at 9:45 a.m. nursing assistant (NA)-A verified R49 received a bath once a week on Wednesday. The NA stated she asked residents upon admission if they want a bath or a shower and marked their preference on the bath schedule. The NA stated residents were scheduled a bath once a week unless they needed a bath more than once a week or requested a bath more than once a week, "then	F 242		

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F 242	Continued From page 4 we try to fit them in the schedule". R105, interviewed on 9/10/14, at 9:55 a.m., stated preference for bathing three times per week; however, only weekly bathing was provided. R105's face sheet with admission information as of 10/2/14, included diagnoses of a knee joint replacement, peripheral neuropathy (nerve damage of legs), and shortness of breath. The care plan dated 9/26/14, indicated R105 required assistance with bathing, but lacked direction regarding preference for frequency or bath/shower. The care plan further indicated R105 was alert, oriented, and able to clearly express needs. The Resident Activity Assessment dated 9/18/14, indicated the choice of frequency and type of bathing was very important. The NAR assignment sheet indicated R105 required extensive assist of one staff for bathing. The bath list indicated one bath per week. During an interview on 10/02/14, at 9:00 a.m. RN-D, verified residents get one bath per week and are told on admission what day the bath will be provided. RN-D added that residents were asked what type of bath they want during their first bath, unless there were specific restrictions. On 10/02/14, at 1:45 p.m., the director of nursing (DON), stated that residents have a bath within the first 24 hours following admission. The bath aides ask residents if they prefer a shower or a bath, and the bath is assigned based on the resident room or bed number. If the resident wants an extra bath, they try to fit it into the schedule. A facility policy and procedure regarding bathing and choices was not provided.	F 242		

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F 279 SS=E	Continued From page 5 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to address interventions for anticoagulant use and/or psychotropic drug use for 4 of 5 residents (R65, R93, R96, R102) whose medications were reviewed. Findings include: R65's care plan did not address appropriate monitoring interventions for potential adverse effects related to the use of Coumadin	F 279 F 279	**F279:** DON and/or designee will implement corrective action for resident (R65, R93, R96, and R102) affected by this practice by: • Residents (R65, and R102) care plan was updated on 10-17-2014, to address specific interventions regarding anticoagulant use and psychotropic drug use • Residents (R96) care plan was updated on 10-17-2014 to address falls. • (R93) was discharged home on 10-14-2014. DON and/or designee will assess residents having the potential to be affected by this practice including: • All other residents with psychotropic and anticoagulation meds and also all residents at risk for falls are potentially affected. • All care plans will be reviewed for appropriate interventions related to falls, and side effect monitoring for psychotropic drugs and anticoagulation meds and they were updated to reflect any changes. DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be re-educated on updating plans of care beginning the week of 10-27-2014.	

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F 279	Continued From page 6 (anticoagulant - blood thinner). The signed physician's orders dated 9/23/14, included Coumadin 3 milligrams (mg) daily, starting on 3/31/14, for atrial fibrillation The annual Minimum Data Set (MDS) dated 9/2/14, identified R65 had severe cognitive impairment with short and long term memory problems; had a diagnosis of atrial fibrillation; and received an anticoagulant medication seven out of seven days during the assessment period. The anticoagulation therapy alert care plan dated 6/2/14, and the GI (gastrointestinal) disorder/GI bleed care plan dated 6/18/14, did not address monitoring for potential risks of anticoagulant medications. such as, but not limited to, excessive bleeding or bruising, blood in the urine or stool, coughing up blood, bleeding gums, and coffee ground emesis. R65 was periodically observed on 10/1/14, from 7:42 a.m. to 8:45 a.m., at 9:50 a.m., and at 1:03 p.m., and on 10/2/14, from 8:22 a.m. to 9:35 a.m. with no evidence of any bruising or bleeding noted. On 10/2/14, at 4:00 p.m. the director of nursing (DON) confirmed R65's care plan did not address monitoring for the potential risks or side effects of Coumadin. The DON verified risks and side effects should be addressed on the care plan, and stated there was no documentation in the medical records to indicate monitoring for side effects was being completed. The Anticoagulant Therapy Heparin and Oral Anticoagulants policy revised 6/09, indicated risks	F 279	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 2 care plan audits will be performed weekly to ensure ongoing compliance beginning the week of 11-3-14, until compliance is achieved, then two per quarter thereafter. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 11-11-2014	

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F 279	Continued From page 7 of anticoagulation therapy would be care planned. R96 received Zoloft (an antidepressant) and Xanax (an antianxiety) medications. The Physician's Order Sheet signed 9/23/14, directed Zoloft 25 mg by mouth daily for one week, then start Lexapro (an antidepressant) 10 mg by mouth daily for a diagnosis of anxiety, and Xanax 0.25 mg by mouth at bedtime, and 0.25 mg as needed once during the day for a diagnosis of anxiety. R96's quarterly Minimum Data Set (MDS) dated 7/29/14, indicated R96 was cognitively intact. The MDS also identified mood indicators of feeling down, trouble sleeping, being tired or having little energy, poor appetite, and feeling bad about yourself. The care plan dated 8/20/14, indicated addressed the problem of anxiety, but lacked monitoring of side effects for the use of Zoloft or Xanax. On 10/2/14, at 4:00 p.m. the director of nursing (DON) confirmed R96's care plans did not address monitoring interventions related to the potential risks or side effects of the Zoloft or Xanax. R102 received Ativan (an antianxiety) and Haldol (an antipsychotic) medications. The Physician's Order Sheet signed 9/10/14, directed Ativan solution 2 mg/milliliter (ml) intramuscularly (IM) three times per day at 8:00 a.m., 2:00 p.m. and 8:00 p.m. for a diagnosis of dementia (with indicators of anxiety/agitation, and twice per day as needed; and Haldol 2.5 mg IM every four hours as needed (with no indications for use). R102's Admission MDS dated 8/4/14, indicated	F 279		

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F 279	Continued From page 8 R102 had severe cognitive impairment. The MDS also identified R102 had mood indicators of feeling tired or having little energy, and behaviors that included verbal behaviors, other behaviors that did not affect others, rejection of care and wandering. The care plan dated 7/28/14, lacked monitoring interventions related to the potential risks or side effects of the Ativan or Haldol. On 10/2/14, at 4:00 p.m. the director of nursing (DON) confirmed R102's care plan did not address monitoring interventions related to the potential risks or side effects of the Ativan or Haldol. R93 received Zoloft (an antidepressant), Seroquel (an antipsychotic), Ativan and Klonopin (antianxiety) medications and the medical record lacked evidence of side effect monitoring was completed to identify possible adverse reactions of the medications. In addition the care plan lacked indications for use of Seroquel for shortness of breath instead of psychosis. The Disease Diagnosis and Allergy sheet dated 10/3/14, indicated R93's diagnoses included tissue/lung transplant with complications, muscle weakness, osteoporosis, diabetes, renal failure, shortness of breath, anxiety, pathological fractures and respiratory failure. The significant change Minimum Data Set (MDS) dated 8/1/14, identified R93 had moderate	F 279		

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F 279	Continued From page 9 cognitive impairment. The MDS indicated R93 had no symptoms of delirium or depression; had no behavior problems. The MDS further indicated R93 received an antipsychotic and antidepressant on seven out of seven days; an antianxiety medication four out of seven days during the seven day assessment period. The signed physician orders dated 9/23/14, directed staff to administer Seroquel 25 milligrams(mg) daily at 8:00 p.m. with an indication for use of anxiety (order started 9/9/14); Klonopin 0.5 mg daily at 8:00 a.m. and 0.5 mg one time a pay as needed (PRN) for anxiety (order started 9/10/14); Zoloft 100 mg daily for depression (order started 9/10/14) and Ativan 0.5 mg every six hours as needed for anxiety (order started 9/9/14). The PRN Medication Administration Report from 7/2/14 to 10/2/14 indicated R93 received Ativan 29 times (7/16/14, twice on 7/17/14, 7/18/14, 7/19/14, 7/20/14, 7/21/14, 7/24/14, 7/25/14, twice on 7/26/14, 7/27/14, 7/28/14, 7/29/14, 7/30/14, 7/31/14, 8/4/14, 8/5/14, twice on 8/6/14, 8/7/14, 8/8/14, 8/9/14, 8/10/14, 8/11/14, 8/14/14, 8/19/14, 8/20/14 and 10/1/14). The report further indicated R93 did not receive any PRN Klonopin. R93 was interviewed and observed on 9/29/14, at 5:45 p.m. and was observed periodically through 10/2/14. R93 did not display any signs or symptoms of possible psychotropic medication side effects. The anxiety care plan dated 8/20/14, directed staff to administer medications as ordered and reduce stimuli. The care plan did not include the antianxiety, antidepressant or the antipsychotic	F 279		

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F 279	Continued From page 10 medications. The care plan also did not address monitoring interventions for the potential risks or side effects of the medications. Further, the medical record lacked evidence of any type of monitoring for side effects of the medications was completed. The bronchopulmonary care plan dated 7/30/14, did not include indications for use of an antipsychotic medication (Seroquel) when used for breathlessness. On 10/02/2014, at 3:39 p.m. registered nurse (RN)-D stated the seroquel's indication for use was for anxiety with R93's shortness of breath from the lung transplant. The RN stated she spoke with R93's transplant coordinator regarding the use of seroquel for anxiety from shortness of breath. The coordinator stated R93's current medication regimen was less sedating. The RN stated she did not document the conversation because it was not a doctor's order. The RN verified the Zoloft, Seroquel, Ativan and Klonopin were not on the care plan and the care plan lacked monitoring for risks and side effects and should have been included. The RN then stated the indication for use of the Seroquel was for anxiety and should be included in the anxiety care plan.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure coordination of care and information between hospice and facility staff for 1 of 1 residents (R104) reviewed for hospice. Findings include: R104's face sheet printed 10/2/14, included diagnoses of multiple myeloma, diabetes type II, anxiety state, depressive disorder, hypertension (high blood pressure), coronary atheroslerosis, and dementia. The admission Minimum Data Set (MDS) dated 9/19/14, indicated R104 had severe cognitive deficit, mood indicators with moderate depression, and no behaviors. The MDS further indicated R104 had dementia and required assistance with all activities of daily living (ADL)s. R104's nursing facility care plan dated 9/30/14, indicated the hospice start of care was 9/12/14. The hospice care plan, initiated prior to admission and revised on 9/15/14, directed documentation of each visit and a review of the calendar and hospice aid care plan. The schedule and care plan would be kept inside the resident's closet door. Each visit would be documented in the journal in the resident's room. Hospice services incuded weekly skilled nursing visits, social services and twice weekly home health aid services. Home health aid services were not specified.	F 309	**F309:** DON and/or designee will implement corrective action for resident (R55) affected by this practice by: • Resident's hospice schedule will be discussed with all nursing staff via small group in-service beginning the week of 10-27-2014 and it was added to her NA/R assignment sheet on 10-20-2014. DON and/or designee will assess residents having the potential to be affected by this practice including: • All hospice residents are potentially affected, currently 2 others. All hospice residents hospice schedule will be discussed with all nursing staff via small group in-services beginning the week of 10-27-2014 and their NA/R assignment sheets were updated on 10-20-2014. DON and/or designee will implement measures to ensure that this practice does not recur including: • During small group in-services staff will be informed how hospice communicates their schedule. Any future residents receiving hospice treatment will have that information on the NA/R assignment sheets. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Interdisciplinary team will audit and review any new hospice residents to ensure compliance. Completion Date: 11-11-2014	

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F 309	Continued From page 12	F 309		

Home health aid visit notes indicated services provided included back rubs, hair brushing, companionship, food and fluids.During an observation on 10/1/14, at 8:35 a.m., R104 was watching television in the bedroom. The hospice schedule was observed inside the closet door.

During an interview on 10/2/14, at 12:52 p.m. licensed practical nurse (LPN)-E, verified hospice came once or twice a week, but was not sure when, and stated she knows it was written somewhere but did not know where. LPN-E did ask and found out the schedule was located in the closet.

During an interview on 10/01/2014, at 1:31:54 p.m. NA-D stated hospice should come two to three times weekly. NA-D stated hospice might take R104 to the bathroom if she needs to go and keep her company. NA-D stated she does not really know what they are supposed to do.

During an interview on 10/02/2014, at 1:50 p.m. the director of nursing (DON) stated hospice assesses, care plans, does routine visits, and documents in progress notes what they did. The DON stated what hospice does and when they come should be on the care plan and communicated to the NAs. The DON verified the nurse manager was to communicate this to the NAs.

During an interview on 10/02/2014, at 2:44 p.m. hospice RN stated information is communicated to the nursing home staff through a journal in R104's room, a calendar inside the closet door that indicates when different disciplines will visit from hospice, the nursing care plan in the paper

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 chart, progress notes, and a communication sent every Friday. The hospice RN verified the home health aide (HHA) and the nurse visits twice weekly, and the social worker visits every other week. The hospice RN listed some of the things the HHA offers to do when visiting, including giving a bath or shower, brushing or combing hair, giving a back rub, trimming nails, deodorant, massage, hair, washing face and hands, transfers, bring to the bathroom, personal cares, encourage food and fluids, nail care, brushing teeth, and provide companionship. The hospice RN verified that care was not coordinated prior to the visit and the HHA was to check with the staff when arriving at the facility . During an interview on 10/02/2014, at 3:27 p.m. NA-E was unaware that R104 received hospice services. During an interview on 10/02/2014, at 3:31 p.m., RN-A and RN-B verified the HHA sets up the schedule and gets a routine going, and then the NAs get used to the routine and to the HHA coming. RN-A and RN-B verified the facility does not put the special services information on the NA sheets. They also stated the communication in the journal is for the family and the facility does not put care information in the journal. The facility did not provide a policy and procedure for hospice services.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

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F 329	Continued From page 14 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure side effects of anticoagulant and/or psychotropic medications were monitored for 4 of 5 residents (R65, R96, R102, R93) whose medications were reviewed. Findings include: R65 received Coumadin (anticoagulant - blood thinner), Risperdal (antipsychotic), and Ativan (antianxiety) medications, and the medical records lacked evidence side effect monitoring was being completed to identify possible adverse reactions of the medications.	F 329	**F329:** DON and/or designee will implement corrective action for resident (R65, R93, R96, R102, and R104) affected by this practice by: • Resident (R65, R93, R96, R102, and R104) had side effect monitoring set up on 10-27-2014. • Resident R102 had indications for use added on 10-17-2014. DON and/or designee will assess residents having the potential to be affected by this practice including: • All other residents are potentially affected by this practice. • All resident medications will be reviewed for side effect monitoring and parameters of use. DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be re-educated on monitoring side effects of medications and getting parameters for use beginning the week of 10-27-2014.	

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F 329	Continued From page 15 The quarterly Minimum Data Set (MDS) dated 9/9/14, identified R65 had severe cognitive impairment with short and long term memory problems. The MDS indicated R65 had no symptoms of delirium or depression; had no behaviors; had diagnoses of atrial fibrillation, dementia, and psychotic disorder; and received an anticoagulant and antipsychotic medication seven out of seven days during the assessment period. The MDS further indicated R65 had not received an antianxiety medication in the seven day assessment period. The signed physician's orders dated 9/23/14, directed staff to administer Coumadin 3 milligrams (mg) daily at bedtime for a diagnosis of atrial fibrillation (order started 3/31/14); Risperdal 0.25 mg once daily for a diagnosis of delusional disorder (order started 4/1/14); and Ativan 0.5 mg PRN (as needed) for a diagnosis of delusional disorder (order started 5/21/14). The electronic medication administration records (EMAR's) for July, August, and September 2014, indicated R65 had received Coumadin 3 mg daily, Risperdal 0.25 mg daily, and PRN Ativan seven times (7/6/14, 7/16/14, 7/31/14, 8/6/14, 8/21/14, 9/16/14, and 9/27/14). R65 was periodically observed on 10/1/14, from 7:42 a.m. to 8:45 a.m., at 9:50 a.m., and at 1:03 p.m., and on 10/2/14, from 8:22 a.m. to 9:35 a.m. with no evidence of any bruising, bleeding, or possible psychotropic medication side effects noted. The anticoagulation therapy alert care plan dated 6/2/14; the GI (gastrointestinal) disorder / GI	F 329	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 2 Medication audits, which will include side effect monitoring and parameters for use, will be performed weekly to ensure ongoing compliance beginning the week of 11-03-14, until compliance is achieved, then two per quarter thereafter. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 11-11-2014	

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F 329	Continued From page 16 bleed care plan dated 6/18/14, and the delusion/agitation-restlessness/resistive during cares care plans all dated 5/29/14, did not address monitoring interventions for the potential risks or side effects of the medications. Further, the medical records lacked evidence any type of monitoring for side effects of the medications was being completed. On 10/2/14, at 4:00 p.m. the director of nursing (DON) confirmed R65's care plans did not address monitoring interventions related to the potential risks or side effects of the Coumadin, Risperdal, or Ativan. The DON verified risks and side effects of the medications should be addressed on the care plan. The DON further stated the side effect monitoring was supposed to be in the EMAR, but the facility had switched over to a new computer system within the past several months, and the medication side effect monitoring had never been entered into the new system. The Anticoagulant Therapy Heparin and Oral Anticoagulants policy revised 6/09, indicated risks of anticoagulation therapy would be care planned. The Psychotropic Drug Policy/Procedure revised 5/14, indicated all residents who received routine and PRN medications prescribed for a specific behavior or manifestation of a disordered thought process would be monitored for medication effectiveness and side effects. The policy directed staff to observe and document the occurrence of medication side effects as needed. Neither of the policies addressed how routine monitoring for side effects of the medications would be completed. R96 received Zoloft (an antidepressant) and Xanax (an antianxiety) medications. The	F 329		

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F 329	Continued From page 17 Physician's Order Sheet signed 9/23/14, directed Zoloft 25 mg by mouth daily for one week, then start Lexapro (an antidepressant) 10 mg by mouth daily for a diagnosis of anxiety, and Xanax 0.25 mg by mouth at bedtime, and 0.25 mg as needed once during the day for a diagnosis of anxiety. R96's quarterly Minimum Data Set (MDS) dated 7/29/14, indicated R96 was cognitively intact. The MDS also identified mood indicators of feeling down, trouble sleeping, being tired or having little energy, poor appetite, and feeling bad about yourself. The care plan dated 8/20/14, indicated addressed the problem of anxiety, but lacked monitoring of side effects for the use of Zoloft or Xanax. On 10/2/14, at 4:00 p.m. the director of nursing (DON) confirmed R96's care plan did not address monitoring interventions related to the potential risks or side effects of the Zoloft or Xanax. R102 received Ativan (an antianxiety) and Haldol (an antipsychotic) medications. The Physician's Order Sheet signed 9/10/14, directed Ativan solution 2 mg/milliliter (ml) intramuscularly (IM) three times per day at 8:00 a.m., 2:00 p.m. and 8:00 p.m. for a diagnosis of dementia (with indicators of anxiety/agitation, and twice per day as needed; and Haldol 2.5 mg IM every four hours as needed (with no indications for use). R102's Admission MDS dated 8/4/14, indicated R102 had severe cognitive impairment. The MDS also identified R102 had mood indicators of feeling tired or having little energy, and behaviors that included verbal behaviors, other behaviors	F 329		

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F 329	Continued From page 18 that did not affect others, rejection of care and wandering. The care plan dated 7/28/14, lacked monitoring interventions related to the potential risks or side effects of the Ativan or Haldol. On 10/2/14, at 4:00 p.m. the director of nursing (DON) confirmed R102's care plan did not address monitoring interventions related to the potential risks or side effects of the Ativan or Haldol. R93 received Zoloft (an antidepressant), Seroquel (an antipsychotic), Ativan and Klonopin (antianxiety) medications and the medical record lacked evidence of side effect monitoring was completed to identify possible adverse reactions of the medications. The Disease Diagnosis and Allergy sheet dated 10/3/14, indicated R93's diagnoses included tissue/lung transplant with complications, muscle weakness, osteoporosis, diabetes, renal failure, shortness of breath, anxiety, pathological fractures and respiratory failure. The significant change Minimum Data Set (MDS) dated 8/1/14, identified R93 had moderate cognitive impairment. The MDS indicated R93 had no symptoms of delirium or depression; had no behavior problems. The MDS further indicated R93 received an antipsychotic and antidepressant on seven out of seven days; an antianxiety medication four out of seven days during the seven day assessment period. The signed physician orders dated 9/23/14, directed staff to administer Seroquel 25	F 329		

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F 329	Continued From page 19 milligrams(mg) daily at 8:00 p.m. for anxiety (started 9/9/14); Klonopin 0.5 mg daily at 8:00 a.m. and 0.5 mg one time a pay as needed (PRN) for anxiety (order started 9/10/14); Zoloft 100 mg daily for depression (order started 9/10/14) and Ativan 0.5 mg every six hours as needed for anxiety (order started 9/9/14). The PRN Medication Administration Report from 7/2/14 to 10/2/14 indicated R93 received Ativan 29 times (7/16/14, twice on 7/17/14, 7/18/14, 7/19/14, 7/20/14, 7/21/14, 7/24/14, 7/25/14, twice on 7/26/14, 7/27/14, 7/28/14, 7/29/14, 7/30/14, 7/31/14, 8/4/14, 8/5/14, twice on 8/6/14, 8/7/14, 8/8/14, 8/9/14, 8/10/14, 8/11/14, 8/14/14, 8/19/14, 8/20/14 and 10/1/14). The report further indicated R93 did not receive any PRN Klonopin. R93 was interviewed and observed on 9/29/14, at 5:45 p.m. and was observed periodically through 10/2/14. R93 did not display any signs or symptoms of possible psychotropic medication side effects. The anxiety care plan dated 8/20/14, directed staff to administer medications as ordered and reduce stimuli. The care plan did not include the antianxiety, antidepressant or the antipsychotic medications. The care plan also did not address monitoring interventions for the potential risks or side effects of the medications. On 10/02/2014, at 3:39 p.m. registered nurse (RN)-D stated the seroquel's indication for use was for anxiety with R93's shortness of breath from the lung transplant. The RN verified the Zoloft, Seroquel, Ativan and Klonopin were not on the care plan and the care plan lacked monitoring for risks and side effects and should have been	F 329		

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F 329	Continued From page 20 included.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F441:** DON and/or designee will implement corrective action for this practice by: • Individualized training was provided to the employee who performed the medication pass and blood glucose check on 10-15-2014. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents are potentially affected by this practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be educated on the new procedure and the importance of hand washing use beginning the week of 10-27-2014. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 2 observational medication pass audits of 3 residents per audit will be performed weekly at various times to ensure ongoing compliance beginning the week of 11-03-14, until compliance is achieved, then 2 per quarter thereafter. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance will make recommendations for ongoing monitoring. Completion Date: 11-11-2014	

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F 441	Continued From page 21	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure hand hygiene was completed after a blood glucose check for 1 of 1 resident (R62) prior to touching the Electronic Medication Administration Record (EMAR) keyboard on the A-B unit medication cart. This practice had the potential to affect all 26 residents who received medications from the cart.
In addition, the facility failed to ensure medications were dispensed without bare hand contact to maintain infection control standards for 1 of 5 residents (R61) who were observed for medication administration.

Findings include:

On 10/1/14, at 10:00 a.m. licensed practical nurse (LPN)-C was observed to complete a blood glucose check for R62. LPN-C washed her hands with an alcohol based hand sanitizer (ABHS); obtained a new lancet from the medication cart; and entered R62's room. LPN-C obtained R62's supplies/blood glucose meter from within the room; donned gloves; and appropriately obtained a blood sample with a blood glucose result of 167. LPN-C provided R62 with gauze to hold pressure on the finger to stop the bleeding, and put away the supplies/blood glucose meter. LPN-C exited the room with the gloves on; discarded the used lancet in the sharps container on the A-B unit medication cart; and removed/discarded the dirty gloves. Without washing her hands, LPN-C typed data using a keyboard on the medication cart into the EMAR.

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F 441	Continued From page 22 After the data had been entered, LPN-C washed her hands with an ABHS. On 10/2/14, at 8:28 a.m. LPN-C was observed during a medication pass for R61. LPN-C washed her hands with ABHS; opened the medication cart drawer; obtained two bottled medications (Senna Plus, Ocuvite), and one cartridge which contained four medications in blister packs (Dilantin, Lisinopril, Vesicare, Toprol XL); and closed the drawer on the medication cart. The two bottled medications were appropriately dispensed into a souffle' cup, and then LPN-C punched the medications from the four blister packs directly into her bare hand and picked each of the four medications out of her hand with her fingers to place them into the souffle' cup. The medications were immediately administered to R61. LPN-C was questioned regarding bare hand touching of the medications and stated she touched medications often because they were hard to punch out of the blister packs, and didn't always drop into the souffle' cup. LPN-C added, she usually used a glove, and verified she had not used a glove during R61's medication administration. LPN-C was also questioned regarding hand hygiene after completing the blood glucose check for R62 on 10/1/14. LPN-C confirmed she had not washed her hands after obtaining the blood glucose prior to touching the EMAR keyboard. LPN-C confirmed she should have washed her hands after discarding the gloves. On 10/2/14, at approximately 10:00 a.m. the director of nursing (DON) stated the staff should wash their hands when going from dirty to clean, and should never place resident medications in their bare hands.	F 441		

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F 441	Continued From page 23 The Handwashing policy dated 6/09, indicated all nursing personnel shall wash their hands correctly between patient cares and before handling food to prevent spread of infection. The Medication Administration policy revised 1/11, indicated no medications shall be handled with bare hands.	F 441		

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

F5245024

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	245245	A. BUILDING **01 - HERITAGE MANOR** B. WING _____	**10/01/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Heritage Manor was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Heritage Manor, is a 1-story building with a full basement. The original building was constructed in 1953 and was determined to be of Type II(111) construction. In 1981 & 2001 additions were constructed to the building that was determined to be of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building also has an apartment complex attached that is properly separated. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 78 beds and had a census of 71 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6986

October 16, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5245026

Dear Mr. Ryan:

The above facility was surveyed on September 29, 2014 through October 2, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

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

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 Patricia Halverson at the number detailed above.

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.

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

Sincerely,

Mark Meath

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

Enclosure(s)

cc: Licensing and Certification File 5245s15lic