DEPARTMENT OF HEALTH AND HUMAN SERVICES	DEPARTMENT	OF HEAL	TH AND HU	MAN SERV	ICES
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#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

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

						IND TRANSMITTAL	ID: KH8E Facility ID: 00904
1. MEDICARE/MEDICA (L1) 245245 2.STATE VENDOR OR M (L2) 936651200			<ol> <li>NAME AND AL</li> <li>(L3) HERITAGE</li> <li>(L4) 321 NORTH</li> <li>(L5) CHISHOLM</li> </ol>	MANOR EAST SIXTH		(L6) <b>55719</b>	4. TYPE OF ACTION:     7 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint
5. EFFECTIVE DATE CI (L9)	HANGE OF OWNER	SHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
<ol> <li>DATE OF SURVEY</li> <li>ACCREDITATION ST         <ul> <li>0 Unaccredited</li> <li>2 AOA</li> </ul> </li> </ol>	<b>02/05/201</b> ATUS: 1 TJC 3 Other	<b>9</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CEF From (a) : To (b) : 12.Total Facility Beds 13.Total Certified Beds	RTIFICATION	<ul><li>70 (L18)</li><li>70 (L17)</li></ul>	Complian			And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code	Cope of Services Limit     . Medical Director
			Requirements	and/or Applied W	aivers:	* Code: A*	(L12)
<ol> <li>LTC CERTIFIED BE</li> <li>18 SNF</li> </ol>	18/19 SNF 70	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37)	(L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNA	as, Unit Sup			06//2019	(L19)	Alison Helm, Enforc	ement Specialist 02/06//2019
	PAR	Г II - ТО ВІ	COMPLETED	BY HCFA R	EGIONAI	OFFICE OR SINGLE ST	ATE AGENCY
-	DF ELIGIBILITY is Eligible to Particip y is not Eligible	te (L21)		IPLIANCE WITH GHTS ACT:	I CIVIL	<ol> <li>Statement of Finan</li> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23	LTC AGREEM	ENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>09/01/1982</b>	N	BEGINNING	DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION I	DATE: 27.		VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
	(L27)	<ul><li>A. Suspension</li><li>B. Rescind Sus</li></ul>	n of Admissions:	(L44) (L45)			00-Active
28. TERMINATION DAT	ГЕ:	29	. INTERMEDIARY/			30. REMARKS	
		(L28)	03001		(L31)		
31. RO RECEIPT OF CM		32 L32)	. DETERMINATION ( 01/23/2019	OF APPROVAL I	DATE (L33)	DETERMINATION APPR	OVAL
		-				DETERMINATION ATTR	····



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered February 6, 2019

Administrator Heritage Manor 321 Northeast Sixth Street Chisholm, MN 55719

RE: Project Numbers S5245031 and H5245026

Dear Administrator:

On February 5, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 28, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Feel free to contact me if you have questions.

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 6, 2019

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 January 21, 2019 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,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

DEFACIMENT OF HEALTH AND	MEDIC	ARE/MEDICAI - TO BE COMPI			ND TRANS	SMITTAL		D: KH8E Facility ID: 00904
1. MEDICARE/MEDICAID PROVIDER NO.           (L1)         245245           2.STATE VENDOR OR MEDICAID NO.         (L2)           936651200		<ul> <li>3. NAME AND AD</li> <li>(L3) HERITAGE</li> <li>(L4) 321 NORTHI</li> <li>(L5) CHISHOLM</li> </ul>	MANOR EAST SIXTH S		(L6	5) <b>55719</b>	<ol> <li>TYPE OF ACTION</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	: <u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSH (L9)         6. DATE OF SURVEY       12/13/2018         8. ACCREDITATION STATUS:	(L34) _ (L10)	Complianc	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 14 CORF 15 ASC 16 HOSPICE And/Or App 2. T 3. 2	.7) 22 CLIA roved Waivers Of The Cechnical Personnel 4 Hour RN '-Day RN (Rural SNF)	7. On-Site Visit      8. Full Survey After Co  FISCAL YEAR ENDINC  06/30  Following Requirements:     6. Scope of Serv.     7. Medical Dire     8. Patient Room	i DATE: (L35)
	(L18) (L17)	X B. Not in Con Requirements a	npliance with Prog and/or Applied Wa		5. L * Code:	ife Safety Code <b>B</b> *	9. Beds/Room (L12)	
14.       LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF         70       70         (L37)       (L38)         16.       STATE SURVEY AGENCY REMARKS (IF	19 SNF (L39) APPLICABLE	ICF (L42) E SHOW LTC CANCE	IID (L43) ELLATION DATE	):	15. FACILIT 1861 (e) (1)	Y MEETS or 1861 (j) (1):	(L15)	
17. SURVEYOR SIGNATURE	E 11	Date : 0	01/07/2019	(L19)		URVEY AGENCY A	PPROVAL	Date: <u>t</u> 01/14/2019 (L20)
PART I	I - TO BE	COMPLETED	BY HCFA RI	. ,	OFFICE O	R SINGLE STA	ATE AGENCY	(120)
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li><u>X</u></li> <li>1. Facility is Eligible to Participate</li> <li><u>2</u>. Facility is not Eligible</li> </ol>	(L21)		IPLIANCE WITH GHTS ACT:	CIVIL	2		cial Solvency (HCFA-2572) Interest Disclosure Stmt (He	CFA-1513)
OF PARTICIPATION E 09/01/1982	IC AGREEMI BEGINNING I L41)		<ol> <li>LTC AGREEM ENDING DAT (L25)</li> </ol>		<u>VOLUNTARY</u> 01-Merger, Clo		<u>INVOLUN</u> 05-Fail to M	L30) <u>"ARY</u> leet Health/Safety leet Agreement
25. LTC EXTENSION DATE: 27. A A.	LTERNATIV	TE SANCTIONS of Admissions: pension Date:	(L44) (L45)			oluntary Termination on for Withdrawal	<u>OTHER</u> 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29.	INTERMEDIARY/C	CARRIER NO.		30. REMARK	S		
(L2	8)	03001		(L31)				

(L33)

DETERMINATION APPROVAL

32. DETERMINATION OF APPROVAL DATE

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 27, 2018

Administrator Heritage Manor 321 Northeast Sixth Street Chisholm, MN 55719

RE: Project Numbers S5245031 and H5245026

Dear Administrator:

On December 13, 2018, a standard survey was completed at your facility by the Minnesota Department 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. In addition, at the time of the December 13, 2018 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5245026 that was found to be substantiated.

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

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 22, 2019.

### ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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

Heritage Manor December 27, 2018 Page 2

practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor St. Cloud B Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: kathleen.lucas@state.mn.us Phone: (320) 223-7343 Fax: (320) 223-7348

### 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

Heritage Manor December 27, 2018 Page 3 Marshal Division staff if your ePoC for the respective deficiencies (if any) is acceptable.

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by March 13, 2019 (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 13, 2019 (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

Heritage Manor December 27, 2018 Page 4

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

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.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

		AND HUMAN SERVICES						APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	T			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					Сом	PLETED
		245245	B. WING_					-
NAME OF F	PROVIDER OR SUPPLIER			STREE	FADDRESS, CITY, STATE, ZI	P CODE		
HERITAG	E MANOR					г		
				CHISH	IOLM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00				
F 000	Emergency Prepare conducted on 12/10 a recertification sur		F 0(	00				
	was completed at y Department of Hea was in compliance	gh 12/13/18, a standard survey our facility by the Minnesota Ith to determine if your facility with the requirements of 42 part B, and Requirements for acilities.						
		complaint H5245026 was nplaint was substantiated at						
	as your allegation of Department's 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 first page of the CMS-2567 ic submission of the POC will tion of compliance.						
	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with						
F 550 SS=D			F 5	<b>U</b> C				1/21/19
	§483.10(a) Resider The resident has a	nt Rights. right to a dignified existence,						
LABORATORY	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	STREET ADDRESS, CITY, STATE, ZIP CODE           321 NORTHEAST SIXTH STREET           CHISHOLM, MN 55719           PREFIX           (EACH CORRECTIVE ACTION SHOULD BE           CROSS-REFERENCED TO THE APPROPRIATE           DEFICIENCY)   E 000           F 000   F 000           F 000   I 1/21/19					
Electron	ically Signed							01/04/2019

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: 01/08/2019

		AND HUMAN SERVICES				FORM	01/08/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE COM	E SURVEY PLETED
		245245	B. WING				C 13/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	SE 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 PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	self-determination, access to persons a outside the facility, this section. §483.10(a)(1) A fac with respect and dig resident in a manner promotes maintenather quality of life, resident in a manner individuality. The fa promote the rights of §483.10(a)(2) The fa access to quality caseverity of condition must establish and practices regarding provision of service residents regardless §483.10(b) Exercises The resident has thrights as a resident or resident of the U §483.10(b)(1) The faresident can exercise interference, coerci from the facility. §483.10(b)(2) The faresident can exercise interference for the facility.	and communication with and and services inside and including those specified in ility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident. facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source. e of Rights. e right to exercise his or her of the facility and as a citizen	F 5	50			

If continuation sheet Page 2 of 31

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· /	E SURVEY PLETED
			A. BUILD	ING _			
		245245	B. WING				
NAME OF F	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	, . <u> </u>	
HERITAG	E MANOR				21 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 550	Continued From pa	age 2	F 5	50			
	Based on observatively, the facility for catheter bag was permaintain dignity for reviewed for dignity. Findings include: R11's Face Sheet of diagnoses included (a structural or funduring flow). R11 was cognitively he was rarely or new service of the structure	tion, interview, and document ailed to ensure a urinary laced in a privacy bag to 1 of 2 residents (R11) dated 6/28/18, indicated l obstructive & reflux uropathy ctional hindrance of normal			<ul> <li>F550: It's Heritage Manor's policy provide privacy to our residents.</li> <li>DON and/or designee will implement corrective action for resident R11 at by this practice by: <ul> <li>Providing R11 with privacy bag plastic basin to be used for his catt bag when R11 is sitting in his reclint</li> <li>R11's catheter privacy bag strated adjusted on his wheelchair by NA-A prevent the bag from touching the 12-12-2018.</li> <li>NA-A was re-educated on 12-4 to ensure that R11's catheter bag in a privacy bag when in recliner at in a plastic basin to prevent bag from the p</li></ul></li></ul>	ent affected g and a heter ner. ap was A to floor on 12-2018 s kept nd kept	
	R11 was at risk for tract infection (UTI) and directed nursin catheter bag using catheter bag below catheter bag in a pu wheelchair (w/c) or	plan dated 10/27/18, indicated complications such as urinary prelated to a Foley catheter ag assistants (NA) to empty aseptic technique, keep the level of the bladder, keep rivacy bag when up in in bed, and keep catheter bag			In a plastic basin to prevent bag fro touching the floor. NA-A was also re-educated on ensuring the cathe privacy bag straps are tight enough wheelchair to prevent catheter bag touching the floor.	ter h on the	
wheelchair (w/c) or i off of the floor. On 12/10/18, at 6:26 sitting in room, seate right of the doorway. lap within reach and Foley catheter bag v	26 p.m. R11 was observed ted in his recliner just to the y. R11's call light was on his d R11 was watching television. was not in a privacy bag, it visible from hallway. R11's			<ul> <li>residents having the potential to be affected by this practice including:</li> <li>All residents with catheters hav potential to be affected by this defi practice.</li> </ul>	ve the		
	catheter bag was a bright clear yellow o R11's catheter bag the footrest of the r	pproximately 1/3 full with urine in the tubing and bag. was resting on the floor under ecliner.			<ul> <li>DON and/or designee will implement measures to ensure that this pract does not recur including:</li> <li>Nursing staff will be re-educate the Catheter Care Policy and Dign</li> </ul>	ice ed on ity	
		9 a.m. R11 was observed lining room eating breakfast			Policy, including addressing the ne ensure all residents with catheters		

Facility ID: 00904

If continuation sheet Page 3 of 31

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/08/2019 APPROVED 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245245	B. WING			( 12/*	;  3/2018
NAME OF PRO	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE I	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
ind a pr Ou wh ar or Ou sit R° or Ou sit R° Ou sit R° Ou sit R° Ou sit Cl Wh Ou sit Fo Sit Cl Sit Cl Sit Cl Sit Cl Sit Cl Sit Cl Sit Sit Sit Sit Sit Sit Sit Sit Sit Sit	cloth privacy bag ivacy bag was res in 12/11/18, at 9:30 meeling R11 in who do to his room, cloo in the floor under the in 12/11/18, at 10:2 sting in his room in 11's call light was atching television. as not in a privacy sible from hallway der the footrest of theter bag was ap ight, clear yellow of theter bag was ap ight, clear yellow of the privacy bag we neelchair, but rest in 12/12/18, at 7:00 thing in his wheelch 11's catheter bag was oth privacy bag we neelchair, but rest in 12/12/18, at 12:00 the privacy bag we neelchair, but rest in 12/12/18, at 12:00 the privacy bag we neelchair, but rest in 12/12/18, at 12:00 the privacy bag we heelchair we we was dependently. R11 ivacy bag. Cloth privacy bag we heelchair we we we we we we we we we we the the privacy bag we we the the privacy bag we	's catheter bag was placed in under wheelchair. Cloth sting on the floor. D a.m. Staff were observed eelchair out of the dining area th privacy bag was dragging	F 5	550	<ul> <li>proper coverage of their catheter bags are in touching the floor.</li> <li>All residents with catheters will assessed to ensure they have private bags for their catheters. They will a assessed to ensure that there cather privacy bag straps are tight enough bag is not touching the floor when it wheelchair and will ensure that a pl basin is provided in room for those the catheter bag hang where they to the ground.</li> <li>DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions inclute.</li> <li>Random privacy audits and proplacement of catheter bags, that wi include observation of residents witt catheter bags in rooms and other p areas at various times, will be comp by DON/designee daily for 1wk, 3x/2 weeks, 2x/wk. for 2 weeks, and the monthly thereafter, to ensure privace proper placement is being provided residents with catheters, beginning week of 01-07-2019.</li> <li>Audit results will be brought to the QAPI committee quarterly for review further recommendation.</li> </ul>	ding: per llso be eter so the astic that ouch ding: per ll h ublic oleted wk. for nen cy and for all the	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/08/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMF	E SURVEY PLETED
		245245	B. WING			( 12/1	) 13/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	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 B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	3E	(X5) COMPLETION DATE
F 550 F 554 SS=D	placing the catheter a cloth bag was the to be completed. N she is told to do it d complete the care. On 12/12/18, at 1:4' (DON) was interview catheter bag was to maintain dignity. The facility's Dignity directed staff to pro- anything that could and to place catheter the catheter bag wo The facility's undated directed staff to use a catheter drainage wheelchair and in b Resident Self-Admi CFR(s): 483.10(c)(7) §483.10(c)(7) The r medications if the ir defined by §483.210 this practice is clinic This REQUIREMEN by: Based on observat review, the facility fa for self-administratic completed to ensure self-administer eye (R49) reviewed for s	ecliner. NA-A stated, that bag on the floor and without way R11's catheter care was A-A went on to state, that until ifferently, this is how she will 7 p.m. the director of nursing wed and verified R11's be placed in a privacy bag to Policy, revised on 10/17, ovide care that would avoid be demeaning to the resident er bags in a covered bag so ould not be easily visible. ed Catheter Care Policy, e a cloth storage bag to cover bag while patient was up in ed. n Meds-Clinically Approp 7) ight to self-administer nterdisciplinary team, as (b)(2)(ii), has determined that	F 5		F554: It's Heritage Manor's policy to allow appropriate self-administration medication to our residents. DON and/or designee will implement corrective action for resident R49 aff	n of It	1/21/19
	self-administer eye	drops for 1 of 2 residents					

Event ID: KH8E11

Facility ID: 00904

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/08/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245245	B. WING				C 13/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	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 554	Continued From pa	ge 5	F 5	554			
	Findings include:				<ul> <li>RN staff will obtain an order for gtts for R49 and a self-administration medication assessment was compli- on 01-03-2019. MD will be faxed for</li> </ul>	on of eted	
	4/03/2018, indicated cognitively impaired	uum Data Set (MDS) dated d R49 was moderately d. R49 had diagnoses, which ementia, and Parkinson's			if appropriate to keep at bedside. F Care Plan and eMAR will be update reflect any necessary changes.		
	(progressive nervou movement).	us system disorder that affects			DON and/or designee will assess residents having the potential to be affected by this practice including:		
	12/4/18, indicated F	imum Data Set (MDS) dated R49 required extensive taff with dressing and			<ul> <li>All residents have the potential affected by this practice. All residen rooms will be audited for medication any are found, nursing will check to ensure that the resident has orders</li> </ul>	its' ns. If	
	R49 was observed were present. Two	s on 12/11/18, at 10:05 a.m. sitting in his room. No staff unlabeled bottles of Systane os) were located in view, next			that medication, that they are appro- to self-administer that medication, a that they have orders to keep at bee If not, these medications will be rem immediately and orders will be soug the medication and residents will be	and dside. noved ght for	
	7:26 a.m. the two b next to R49's televis eyes became dry of the eye drops to bo	servations on 12/12/18, at ottles of Systane remained sion. R49 stated when his r itchy, he self administered th eyes. R49 stated he ops 1-2 times a day. When			assessed for appropriateness to self-administer the meds and to kee bedside. If yes, those orders will be obtained by the MD to keep at beds		
	asked how many dr replied "whatever co	ops R49 administered, R49 omes out of the bottle."			DON and/or designee will implement measures to ensure that this praction does not recur including:	ce	
	Systane eye drops administration of the self-administration a electronic medical r				<ul> <li>All nursing staff will be educated the Self-Administration of Medication Policy. Education will also be provide NARs that if they see medication in residents' rooms, to notify the nurse licensed nurse then they need to loop</li> </ul>	on led to a e or if ok at	
		RN)-A entered R49's room request at 8:36 a.m. on			the eMAR, to ensure that the reside an order for that medication, that th		

Facility ID: 00904

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			0.00			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION NG		E SURVEY PLETED
						0
		245245	B. WING			13/2018
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 DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 554	Continued From pa	ae 6	F 5	54		
	<ul> <li>12/12/18. When asi Systane located by up the 2 bottles and were in his room". If an order for the eye the drops should no informed R49 she w the physician and re R49's room. RN-Asi to let the nurse kno in a resident's room medical record and order for Systane e assessment comple medication.</li> <li>During an interview director of nursing ( self-administered m administration risk a nurse. The interdisc the assessment and self-administration of appropriate. The D assistant observes room and is unsure self-administers me assistants are to no medication.</li> <li>A facility policy Self- by Residents dated indicated all resider self-administer medication</li> </ul>	ked about the 2 bottles of R49's television, RN-A picked d stated "I never knew they RN-A stated R49 did not have e drops. RN-A went on to say of be in R49's room. RN-A would request an order from emoved the 2 bottles from stated nursing assistants are w if medication are observed h. RN-A reviewed R49's stated R49 did not have an ye drops and did not have an eted for self-administration of at 8:49 am on 12/12/18, the (DON) stated all hedications need to have a self assessment completed by a ciplinary team (IDT) reviews d notifies the physician for a order if deemed safe and PON further stated if a nursing medication in a resident's	ΓĴ	<ul> <li>appropriate to self-adminismedication, and that they likeep at bedside. Any med found, without a self-admin medication assessment coorder to keep at bedside, wuntil assessed. Any changeresidents plan of care will the electronic medical recorplan as needed by the Charlow DON and/or designee will corrective actions to ensure effectiveness of these action. Random room audits work completed by DON/design 1wk, 3x/wk. for 2 weeks, 2 weeks, and then monthly the ensure medications are not without the proper self-admin medication orders, beginn 01/07/19.</li> <li>Audit results will be brin QAPI committee quarterly further recommendation. Completion Date: 01-21-2</li> </ul>	have an order to ication that is histration of ompleted and will be removed ges with be updated in ord and care arge Nurse. monitor re the ons including: will be ee daily for x/wk. for 2 hereafter, to ot in rooms ninistration of ing the week of ought to the for review and	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/08/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			X3) DATE COM	E SURVEY PLETED
		245245	B. WING				C 13/2018
NAME OF I	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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
	reviewed by the IDT - Cognitive status - Physical status - Which medicati administered - Where the medication medication's use - How the nursing medication's use - How it will be de If resident is clinical will be put in place to periodic re-assesson appropriate of self-a Residents will be periodic re-assesson appropriate of self-admin Free from Misappropriate CFR(s): 483.12 The resident has the neglect, misappropriate and exploitation as includes but is not licorporal punishmer any physical or che treat the resident's This REQUIREMENT by: Based on observatt review the facility far were free from finant nursing staff took re- specifically antacides This had the potent	F and will include: s ions are appropriate to be self- lications will be stored g staff will monitor the ocumented lly appropriate interventions to accommodate wishes. A nent by IDT of the clinically administer medications. ermitted to retain medications wed by IDT and ordered by staff will ensure the electronic IAR) and care plan reflects the inistration of medications. opriation/Exploitation e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to	F 5		F602: It's Heritage Manor's policy to protect our residents from misappropriation of their property. DON and/or designee will implement corrective action for resident affected this practice by:	t	1/21/19

Facility ID: 00904

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			· · ·	E SURVEY PLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G		C
		245245	B. WING			- 13/2018
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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 602	Continued From pa	ge 8	F 60	2		
	Findings include: During review of the	e medication cabinet in the area of the 100 wing on		• Unable to determine specif residents due to label's missing medications with missing labels destroyed per company policy.	. All	
	Tums antacid bottle	m., there were 7 generic es with the pharmacy labels / there were 2 Tylenol bottles els torn off.		DON and/or designee will asse residents having the potential to affected by this practice includir • All residents have the poten	o be ng: ntial to be	
	licensed practical n determine who took or Tylenol bottles, w or which residents t before the labels we	on 12/11/18, at 1:41 p.m. urse (LPN)-C stated unable to the labels off of the antacids when the labels were removed the medications belonged to ere removed. LPN-C stated		affected by this deficient practic medication that is discontinued resident passes away that the p does not take back, must be de per company policy.	or a bharmacy	
	personal use and d antacids and Tylend cabinet without labe			<ul><li>DON and/or designee will imple measures to ensure that this pr does not recur including:</li><li>All Licensed Nursing staff v</li></ul>	actice vill be	
	LPN-B stated LPN- who took the labels bottles, when the la the medications be were removed from bottles. LPN-B state long these medicat	on 12/11/18, at 1:41 p.m. B was unable to determine off the antacids or Tylenol bels were removed, and who longed to before the labels of the antacids or Tylenol ed LPN-B was unaware how ions were in the storage els and was unaware that staff		re-educated on the Drug Divers and Medication Destruction Pol including how to properly destro medications that the pharmacy accept back, that resident med never utilized for staff use, and should not be removing resider from medication containers.	icy, by all does not ication is that we	
	use. During interview on director of nursing ( should not be remo	nol and antacids for personal 12/13/18, at 12:02 p.m. the (DON) stated the nurses wing labels from any DON stated if medications can		<ul> <li>DON and/or designee will moning corrective actions to ensure the effectiveness of these actions in</li> <li>Random audits of the meding rooms and medication carts will completed to ensure all medication</li> </ul>	ncluding: cation l be	

Facility ID: 00904

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		AND HUMAN SERVICES				FORM	01/08/2019 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 13/2018
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 PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 602	The DON also state resident medication unaware this was h During interview on Administrator stated were removing labe and taking them for Administrator stated returned to pharma administrator stated residents this practi During record revie Administrator stated residents this practi During record revie Administration Reco currently in facility in receiving antacids a Tylenol. The facility Medicat 4/4/16 indicated the medications are dis manner depending The Medication Des current medications substances belong given to the resider guardian or designa discharged or trans The facility Drug Dir indicated examples but not limited to us medication waste, i The facility Skilled N	ad nurses should not be taking as for any reason and she was appening in facility. 12/13/18, at 3:22 p.m. the d he was unaware nurses als from resident medications personal use. The d medications that can not be cy need to be destroyed. The d he is not sure how many ice affected. w on 12/13/18, the Medication ord (MAR) for residents indicated 6 residents were and 2 residents were receiving ion Destruction Policy dated e facility was to ensure unused sposed of in a timely, efficient on individual circumstances. struction Policy also indicates s, except controlled ing to the resident must be at or the resident must be at or the resident's current ated representative, when ferred. version Policy dated 4/4/16, of drug diversion, including sing or taking possession of .e. left over medication. Nursing Facility Maltreatment es dated 5/17/18, indicated the	F 6	02	destroyed appropriately, daily for 1 3x/wk. for 2 weeks, 2x/wk. for 2 we and then monthly thereafter, begin week of 01-07-2019. • Audit results will be brought to QAPI committee quarterly for review further recommendation. Completion Date: 01-21-2019	eks, ning the the	
	The facility Skilled I Reporting Guideline organization will rep	Nursing Facility Maltreatment					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		E SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		PLETED
		245245	B. WING			C 13/2018
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		10/2010
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 PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 602	care center to appr alleged violations in exploitation, or mali unknown source an property, will be rep administrator of the appropriate officials	opriate authorities and all volving abuse, neglect, treatment including injuries of ad misappropriation of resident ported immediately to care center and to the	F 6			1/21/19
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that the (ii) A resident with professional standary promote healing, pro- new ulcers from de This REQUIREMENT by: Based on observator review, the facility faintervention of time residents (R47) rev pressure ulcers. Findings include: A Progress Note data	egrity sure ulcers. orehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and oressure ulcers receives and services, consistent andards of practice, to revent infection and prevent		F686: It's Heritage Manor provide treatment and serv pressure ulcers. DON and/or designee will corrective action for reside by this practice by: • R47 NAR task list will ensure that correct reposit place.	vices to prevent implement ent R47 affected be reviewed to	

Facility ID: 00904

	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTU	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
						С
		245245	B. WING		12/	13/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	BE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 686	Continued From pa	age 11	F 68	6		
	R48's annual Minin 11/6/18, identified F required extensive toileting, bed mobil hygiene. R48 had r risk for pressure ul R48's care plan da required assistance plan directed staff f skin daily with care cares, observe skir observe feet for ev plan directed to rep A Tissue Tolerance Observation dated no concerns noted Results of R48's Ti reposition R48 eve sitting. R48's Comprehens 11/28/18, indicated	num Data Set (MDS) dated R48 was cognitively intact. R48 assistance for transferring, ity, dressing and personal no pressure ulcers. R48 was at		<ul> <li>DON and/or designee will assess residents having the potential to l affected by this practice including</li> <li>All residents at risk for pressiulcers have the potential to be affithis deficient practice.</li> <li>All residents at risk for pressiulcers will have their NAR task liscare plan reviewed to ensure accoundividualized repositioning plans</li> <li>DON and/or designee will implem measures to ensure that this practoes not recur including:</li> <li>All NAR staff will be re-educate the Skin Ulcer Protocol policy, in to the importance of following the individualized repositioning plans for each resident on their NAR tag prevent pressure ulcers.</li> </ul>	be ure fected by ure at and burate ted on regards in place sk list to	
	During continuous am on 12/13/18, th - 8:19 a.m. recei List indicated to rep - 8:20 a.m. R48 TV. R48 was sitting - 8:37 a.m. licen entered R48's room juice. LPN-A did repositioning. - 8:57 a.m. LPN-	observations starting at 8:20 e following was observed. ived daily task list from staff. position R48 every 2 hours. in room in wheelchair watching g on a black cushion sed practical nurse (LPN)-A n and provided R48 with prune not offer or provide -A entered R48's room and water. LPN-A did not offer or		<ul> <li>corrective actions to ensure the effectiveness of these actions ind</li> <li>Random audits will be completed various times in bed and w/c to e care plan is being followed for repositioning, daily for 1wk, 3x/wl weeks, 2x/wk. for 2 weeks, and the monthly thereafter, beginning the 01-07-2019.</li> <li>Audit results will be brought the QAPI committee quarterly for revolutions for the care plane.</li> </ul>	eted at nsure the <. for 2 hen week of o the	

		AND HUMAN SERVICES				FORM	01/08/2019 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245245	B. WING				C 13/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR				21 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa	age 12	F6	686			
	into common room - 9:51 a.m. R48 next to wall heater.	in wheelchair self-locomotion looking at magazines. remains in wheelchair sitting			Completion Date: 01-21-2019		
	heater. - 10:35 a.m. R48 moved from wall he - 10:46 a.m. staf choices. No reposit	3 remains in wheelchair by wall 3 remains in wheelchair, eater to television. If approached R48 for his meal tioning offered or provided. 3 remains in wheelchair at a					
	No staff offered or	repositioned R48 between 9 a.m. (2 hours and 49					
	R48 stated staff las R48 stated staff so	w at 11:18 a.m., on 12/13/18, st assisted him up at 7:30 a.m. metimes ask him if he wants bes not recall how often the					
	a.m. the surveyor a (NA)-C. NA-C state residents. When as what cares each re the laundry cart and document. The forr resident name, toild interventions. The f intervention of repo 9:08 a.m. and 11:09 column next to R48	ions, on 12/13/18, at 11:22 approached nursing assistant ed staff are not assigned sked how she knows when and sident needs, NA-C walked to d returned with an untitled m identified columns for eting plan, time, and fall/skin form did not identify positioning for R48. Times of 5 a.m. were written in the 3's name. These times were					
	offered or repositio co-worker must ha	servations, when no staff ned R48. NA-C stated a ve documented the times for it on to say R48 could move					

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		AND HUMAN SERVICES					FORM	01/08/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	0	(X3) DAT COM	E SURVEY IPLETED
		245245	B. WING	i				C 13/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZI	P CODE	-	
HERITAC	GE MANOR			-	21 NORTHEAST SIXTH STREET HISHOLM, 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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 686	•	-	F	686				
	himself around in tr a repositioning sch	ne wheelchair and was not on edule.						
	Registered nurse (F R48's room to repo- buttocks. RN-B and assist R48 into a st removed R48's inco looks pretty red". Th intact skin. RN-B a toilet with the stand the physician for an buttocks. RN-B info assistance for off-lo During an interview director of nursing ( have concerns abo assistant director of	est, at 11:41 a.m. on 12/13/18, RN)-B and NA-C entered sition R48 and assess R48's d NA-C used a stand lift to anding position. RN-B pontinent brief. RN-B stated "it he area was blanchable with and NA-C assisted R48 on lift. RN-B stated she will call order for crème to the primed R48 he should ask for bading more often. tat 1:09 p.m. on 12/13/18, the (DON) stated if aides or staff ut skin integrity they email f nursing (ADON). ADON does and notified physician and						
	family to get treatm plan and has the fir care. DON stated a pressure reducing. the task list, which	ent started. ADON reviews the nal decision on the plan of Ill mattresses in facility are Nursing assistants are to use directed to reposition R48 lity staff are required to follow						
	residents identified the Braden scale w pressure ulcer risk appropriate, individ prevention and trea (Pressure relief ma in chair turn and rep	a Ulcer Protocol dated 11/1/15, at moderate to high risk of by ill have a comprehensive assessment to determine ualized interventions for thment of pressure/skin ulcers. ttress, pressure relief cushion position schedule and heel ents will receive daily						

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		PLETED
		245245	B. WING _			C 13/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		10/2010
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 PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 686	••••••	-	F 68	36		
F 688 SS=D		onitoring of skin concerns. ecrease in ROM/Mobility 1)-(3)	F 68	38		1/21/19
	§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and					
	motion receives ap services to increase	ident with limited range of propriate treatment and e range of motion and/or to rease in range of motion.				
	receives appropriat assistance to maint the maximum pract reduction in mobility	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				
	Based on observat review the facility fa	tion, interview, and document ailed to provide appropriate ent for 1 of 1 residents (R24) of motion services.		F688: It's Heritage Manor's prevent decrease in ROM m DON and/or designee will in corrective action for residen	obility.	
	Findings include:			<ul><li>by this practice by:</li><li>Occupational Therapy o</li></ul>	rders to	
	included cerebrova hypertension.			<ul> <li>evaluate and treat for R24 w on 12/14/18.</li> <li>Care Plan and NAR Tas updated to reflect Occupation</li> </ul>	k List will be	
	7/24/18, indicated F	num Data Set (MDS) dated R24 was an extensive to total s of daily living (ADL's). The		<ul> <li>recommendations.</li> <li>NA-D, NA-E, NA-F, LPN will be educated on following</li> </ul>	-D, and RN-C	

Facility ID: 00904

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		245245	B. WING			( <b>12</b> /1	)  3/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E MANOR			32	21 NORTHEAST SIXTH STREET		
				C	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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688		ge 15 's cognition was severely	F 6	88	plan of care for splints/braces.		
	was unable to expre indicated R24 recei of motion) and was integrity. R24's car	ed 10/26/18, indicated R24 ess own needs. The care plan ved maintenance ROM (range at risk for altered skin e plan lacked documentation plication of a right palm			<ul> <li>DON and/or designee will assess residents having the potential to be affected by this practice including:</li> <li>All residents that utilize splints/k have potential to be affected by this practice.</li> </ul>		
	7/13/16, that was ha of R24's closet indic palm protector upor wear a right Posey (with finger separate breakdown and sup and decreases risk During observation was in the dining ro had no palm protec a.m. staff were obse R24's room in w/c r	aintenance plan (FMP) dated anging up on the inside door cated don (to put on) right n rising in the morning and to finger contracture cushion ors), (prevents skin oport for the contracted hand of skin irritation) at night. on 12/13/18, at 8:25 a.m. R24 om sitting in a wheelchair and tor on the right hand. At 8:39 erved bringing R24 back to no palm protector on her right.			<ul> <li>DON and/or designee will implement measures to ensure that this practic does not recur including:</li> <li>All residents who utilize splints/ will have their plan of care reviewed ensure the care plan and NAR task accurate in comparison to therapy recommendations and that the therapy recommendation is placed inside the resident's closet for reference.</li> <li>Splinting Policy was reviewed a revised as necessary.</li> <li>All Nursing Staff will be re-educe on the Splinting Policy, in regards to ensuring that we are following reside plan of care for application of any splints/praces.</li> </ul>	ce braces d to list is apy le ind cated	
	need to wear the pa stated R24's toiletin staff that R24 need all. During an interview NA-E stated therap sheet if there were	NA)-D stated R24 does not added thing all day. NA-D ing sheet did not indicated to ed to wear the padded thing at on 12/13/18, at 8:14 a.m. y would update the restorative changes to a residents ROM.			<ul> <li>splints/braces.</li> <li>All Charge Nurses will be re-ed to ensure that resident care plans a NAR task lists are kept up to date w therapy recommendations regarding splints/braces and that a copy of the therapy recommendation is placed residents closet.</li> </ul>	ind vith all g e	
		on 12/13/18, at 11:05 a.m. urse (LPN)-D stated R24 had			DON and/or designee will monitor corrective actions to ensure the		

Facility ID: 00904

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PRINTED: 01/08/2019

		AND HUMAN SERVICES				FORM	01/08/2019 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 13/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	BE MANOR				21 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	the palm protector of ago. During an interview registered nurse (R unaware that R24 h verified there was r plan regarding a par During an interview occupational therap R24 had a complete the palm protector of while awake. OTR that had been made protector. The OTR trained on how to a the mentor employed on how to apply the stated the nurses s protector when we and then they shou task list for the NA's During an interview with NA-F stated R protector on the to palm protector on F During an interview director of nursing ( update the task list therapy recommend NA's should have b protector on R24 af The facility Splinting	discontinued over six months of on 12/13/18, at 11:07 a.m. N)-C stated that RN-C was had a palm protector. RN-C to information in R24's care alm protector. To on 12/13/18, at 11:18 a.m. the pist, registered (OTR) stated e evaluation on 7/13/16, for to be worn every day all day stated there were no changes e to R24 wearing the palm R stated the staff have been pply the palm protector and ees should train the new staff e palm protector. The OTR hould know about the palm give them the therapy sheet Id add the information to the s. on 12/13/18, at 11:38 a.m. 24 does not have a palm do list so I do not have to put a R24. on 12/13/18, at 11:45 a.m. the (DON) stated the nurses would for the NA's to complete the dation. The DON stated the even trained to put the palm fer morning cares. g Policy, undated, indicated	F6	\$88	effectiveness of these actions inclue Random audits will be complete ensure that splints/braces are being applied per plan of care daily for 1w 3x/wk. for 2 weeks, 2x/wk. for 2 we and then monthly thereafter. Rando audits will include ensuring that care and NAR task lists reflect therapy recommendations and that a copy of therapy recommendation is placed residents closet, beginning the wee -07-2019. Audit results will be brought to for QAPI committee quarterly for review further recommendation. Completion Date: 01-21-2019	ed to g /k, eks, om e plans of the in the in the k of 01	
	splinting is used to	g Policy, undated, indicated protect joints and surrounding ng Policy also indicated					

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
		IDENTIFICATION NOMBER.	A. BUILDING	3		C
		245245	B. WING			/13/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	Ε	
HERITAC	BE 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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 688	-	-	F 688	3		
		ing will be documented on the cation posted inside resident's				
F 690 SS=D		ontinence, Catheter, UTI 1)-(3)	F 690	)		1/21/19
	resident who is cor admission receives maintain continenc	facility must ensure that atinent of bladder and bowel on a services and assistance to e unless his or her clinical omes such that continence is				
	incontinence, base comprehensive ass ensure that- (i) A resident who e indwelling catheter	sessment, the facility must enters the facility without an is not catheterized unless the				
	catheterization was (ii) A resident who indwelling catheter is assessed for ren as possible unless demonstrates that	ondition demonstrates that s necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary;				
	receives appropriat	is incontinent of bladder te treatment and services to at infections and to restore extent possible.				
	incontinence, base comprehensive ass ensure that a resid	a resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel te treatment and services to				

		AND HUMAN SERVICES			F	FORM	01/08/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (>		E SURVEY PLETED
		245245	B. WING				_  3/2018
NAME OF I	PROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	SE 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 PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 690	restore as much no	ige 18 ormal bowel function as	F 6	90			
	by: Based on observat review, the facility f catheter drainage b floor at all times an properly cleaned af tract infections for 2 for catheter. Findings include: R11's Face Sheet of diagnoses that inclu- uropathy (a structur normal urine flow). R11's current Care R11 was at risk for tract infection (UTI) secondary to benig a prostate gland en urination. R11's current Care catheter care instru Assistants (NA). In was to empty cathet technique, keep ca the bladder, keep ca	NT is not met as evidenced tion, interview, and document ailed to ensure a urinary bag was kept elevated off the d the Foley catheter port was ter emptied to prevent urinary 1 of 3 residents (R11) reviewed dated 6/28/18, indicated uded obstructive & reflux ral or functional hindrance or Plan dated 10/27/18, indicated complications such as urinary related to a Foley catheter, n prostatic hyperplasia (BPH), ilargement causing difficulty in Plan dated 10/27/18, indicated totions for Certified Nursing instructions included, NA staff eter bag using aseptic theter bag below the level of tatheter bag in a privacy bag nair (w/c) or in bed, and keep the floor.			<ul> <li>F690: It's Heritage Manor's policy to protect our residents from bowel/black incontinence, catheter, UTI.</li> <li>DON and/or designee will implement corrective action for resident R11 affeed by this practice by: <ul> <li>R11's catheter privacy bag strap adjusted on his wheelchair by NA-A t prevent the bag from touching the flot 12-12-2018.</li> <li>NA-A will be re-educated on the Catheter Care Policy and will show competency in Catheter Cares.</li> </ul> </li> <li>DON and/or designee will assess residents having the potential to be affected by this practice including: <ul> <li>All residents with catheters have potential to be affected by this practice does not recur including:</li> <li>Nursing staff will be re-educated the Catheter Care Policy, including addressing that catheter bags cannot touch the floor.</li> <li>All residents with catheters will be assessed to ensure that their catheter bags is not touching the floor when in wheelchair and will ensure that a plas basin is provided in room for those the state of the catheter and will ensure that a plas basin is provided in room for those the state of the state and will ensure that a plas basin is provided in room for those the state of the state and will ensure that a plas basin is provided in room for those the state of the state and will ensure that a plas basin is provided in room for those the state of the state and will ensure that a plas basin is provided in room for those the state of the state and will ensure that a plas basin is provided in room for those the state of the state and will ensure that a plas basin is provided in room for those the state of the state and will ensure that a plas basin is provided in room for those the state of the state of the state and will ensure that a plas basin is provided in room for those the state of the state o</li></ul></li></ul>	dder tected was to por on the ent t e on t e er so the stic	

Facility ID: 00904

		AND HUMAN SERVICES			O		APPROVE 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
245245		B. WING _			C 12/13/2018		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HERITAC	GE 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 PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 690	On 12/7/18, R11 wa follow-up, history of orders noted for vis R11's current Physi 12/12/18, included concentrate capsul mouth at 8:00 a.m. On 12/10/18, at 6:2 sitting in his room, a the right of the door open and Foley cat hallway and was no catheter bag was a bright, clear yellow was resting on the recliner. On 12/11/18, at 8:1 siting in the main di independently. R1' a cloth privacy bag was resting on the On 12/11/18, at 9:3 wheeling R11 in w/ his room, cloth priv floor under the w/c. On 12/11/18, at 10: sitting in his room, a the right of the door	as seen by MD for routine f frequent UTIs. No new sit. icians Order Sheet dated orders for cranberry e, 500 milligram (mg) by for UTI. 26 p.m. R11 was observed seated in his recliner just to rway. R11's door was wide theter bag was visible from the ot in a privacy bag. R11's pproximately 1/3 full with rurine. R11's catheter bag floor under the footrest of the 9 a.m. R11 was observed ining room eating breakfast 1's catheter bag was placed in under w/c. Cloth privacy bag floor. 0 a.m. Staff was observed c out of the dining area and to acy bag was dragging on the 21 a.m. R11 was observed seated in his recliner just to rway. R11's door was wide	F 69	90	the catheter bag hang where they t the ground. • Nursing staff will be re-educate the Catheter Care Policy. Education include ensuring that catheter bags not touching the floor. If in the room catheter bag (while in a privacy bag be placed in a plastic basin. Educa also include that catheter bag priva straps on wheelchair must be tight enough where the catheter bag hol not touching the ground. All Nursing will also be educated on catheter car DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions inclu • Random audits on catheter car be completed by DON/designee da 1wk, 3x/wk. for 2 weeks, 2x/wk. for weeks, and then monthly thereafter ensure proper infection control is b provided for all residents beginning week of 01-07-2019. • Random audits to ensure proper placement of catheter bags, that wi include observation of residents wit catheter bags in rooms and other p areas at various times, will be com by DON/designee daily for 1wk, 3x, 2 weeks, 2x/wk. for 2 weeks, and the monthly thereafter, to ensure cathe bags are not touching the ground,	ed on n will a are n, the g) must tion will cy der is g staff ares. ding: res, will illy for 2 r, to eing the er ill th public pleted /wk. for hen	
	open and Foley cat hallway and was no catheter bag was a bright, clear yellow	theter bag was visible from the ot in a privacy bag. R11's pproximately 1/3 full with ourine. R11's catheter bag floor under the footrest of the				the	

Facility ID: 00904

		AND HUMAN SERVICES				FORM	01/08/2019 APPROVED 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245245	B. WING _				C 13/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
HERITA	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 CO (EACH CORRECTIVE ACTIC) CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD	BE	(X5) COMPLETION DATE
F 690	Continued From pa	ge 20	F 69	90			
	sitting in his w/c in t catheter bag was in privacy bag was se resting on the dinin	-		Completion Date: 01-21-2	2019		
	sitting in main dinin independently. R1 <sup>2</sup> privacy bag. Cloth	00 p.m. R11 was observed g room eating lunch I's catheter bag was in a cloth privacy bag was secured as resting on the dining room					
	sitting in his room, s the right of the door and Foley catheter hallway and was no catheter bag was a bright, clear yellow resting on the floor recliner. NA-A stat bag on the floor and way R11's catheter NA-A went on further	41 p.m. R11 was observed seated in his recliner just to way. R11's door wide open bag was visible from the of in a privacy bag. Foley pproximately 1/2 full with urine. Foley catheter bag was under the footrest of the ted, that placing the catheter d without a cloth bag was the care was to be completed. er to state that until she is told his is how she will do the care.					
	demonstrate how F emptied. NA-A was bathroom sink. Put bed side cabinet to opened the spout of the plastic portable port back onto the of catheter bag back of to the bathroom an	43 p.m. NA-A was asked to A11's catheter bag would be shed her hands at the t on gloves and went to R11's retrieve a urinal. NA-A f the catheter and emptied into urinal. NA-A then clipped the catheter bag and placed the botto the floor. NA-A then went d flushed the urine into the nsed the urinal with water and					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/08/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245245	B. WING				C 13/2018
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	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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	off her gloves and e catheter bag to rest exited the room. No would wash her har NA-A replied the fac sanitizer if hands ar then applied a liquid On 12/12/18, at 1:4 catheter care and in stated staff should v gloves, empty into a into toilet, wash bas alcohol, remove glo DON stated was he follow these steps. expectation that sta catheter bag with al important for infecti that have catheters access to alcohol w storage room. The expectation that sta bag in a privacy bag times. The facility's Cathet undated, indicates a bag was not touchin a barrier between the when emptying drait catheter bag, staff a alcohol wipe once of spout. Staff are ins wash hands when f	<ul> <li>I's side cabinet. NA-A took exited the room, leaving R11's con the floor. NA-A then A-A was asked if she normally has after removing gloves, cility has stated they can use the not visibly soiled. NA-A d hand sanitizer</li> <li>7 DON was interviewed about a fection prevention. DON was their hands, put on a graduate or urinal, empty sin, wipe end of spout with oves and wash hands. The er expectation for all staff to The DON stated it was her aff always wipe port end of loohol, and that this step is on prevention for residents. The DON stated staff have ripes, they are located in the DON further stated it was her aff place a residents catheter g and elevate off the floor at all</li> <li>ter Care Policy, which was staff are to ensure drainage hag. When draining a are to cleanse spout with completed prior to re-clamping tructed to remove gloves and inished with the task.</li> </ul>	F 6				1/21/19
F 732 SS=C	Posted Nurse Staffi CFR(s): 483.35(g)(		F 7	32			1/21/19

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	INSTRUCTION			0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDII	NG			COM	PLETED
		245245	B. WING _			C 12/13/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	E MANOR				ORTHEAST SIXTH STREET HOLM, MN 55719			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	2	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD	BE	(X5) COMPLETION DATE
F 732	Continued From pa	ge 22	F 7:	32				
	§483.35(g) Nurse S §483.35(g)(1) Data must post the follow basis: (i) Facility name. (ii) The current date (iii) The total number by the following cate unlicensed nursing resident care per sh (A) Registered nurse (B) Licensed practic vocational nurses (a (C) Certified nurses (a (C) Certified nurses (a (iv) Resident censu §483.35(g)(2) Posti (i) The facility must specified in paragra daily basis at the be (ii) Data must be po (A) Clear and reada (B) In a prominent p residents and visito §483.35(g)(3) Publi staffing data. The f written request, ma available to the pub exceed the commu §483.35(g)(4) Facili requirements. The posted daily nurse s	A staffing Information. requirements. The facility ving information on a daily e. er and the actual hours worked egories of licensed and staff directly responsible for hift: less. cal nurses or licensed as defined under State law). aides. s. ng requirements. post the nurse staffing data uph (g)(1) of this section on a eginning of each shift. losted as follows: able format. blace readily accessible to rs. c access to posted nurse acility must, upon oral or ke nurse staffing data lic for review at a cost not to nity standard.						
	This REQUIREMEN	NT is not met as evidenced						

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PRINTED: 01/08/2019

		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 01/08/2019 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			DATE SURVEY COMPLETED C
		245245	B. WING			12/13/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
HERITAG	E 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Based on interview facility failed to ensu- information was pos- potential to affect an in the facility and/or view this information Findings include: When reviewing the postings for 11/01/1 postings were noted shift for 18 out of 30 of 13 days for Dece When interviewed of director of nursing ( posting is complete afternoon spot is su- the afternoon nurse in the morning just the posting would c (NC) stated that the information needs t every morning and if there are call-ins the went on to say it ne so it is kept current.	and document review, the ure the required nurse staffing sted daily. This had the ny of the 62 residents residing their visitors who may wish to n. a facility's daily nursing hour 8 - 12/12/18, the daily d to be blank on the afternoon 0 days in November, and 3 out ember's postings. an 12/13/18, at 12:28 p.m. DON) stated daily nurse staff d by the morning nurse, the apposed to be completed by a. The afternoon is left blank in case there would be call-ins hange. The nurse consultant a required nurse staff posting o be completely filled out changes need to be made to it throughout the day, the NC eds to be filled out in real time	F	732	<ul> <li>F732: It's Heritage Manor's policy to p nurse staffing information</li> <li>DON and/or designee will implement corrective action for resident affected b this practice by: <ul> <li>Unit 1 Nurse Manager was educate to fill in all nursing hours for the day, on the staff posting sheet, at the beginning their shift on 12-12-2018.</li> <li>Unit 2 Nurse Manager was educate to fill in all nursing hours for the day, on the staff posting sheet, at the beginning their shift of 12-12-2018.</li> <li>Unit 2 Nurse Manager was educate to fill in all nursing hours for the day, on the staff posting sheet, at the beginning their shift if Unit 1 Nurse Manager is no working on 01-03-2019.</li> </ul> </li> <li>DON and/or designee will assess residents having the potential to be affected by this practice including: <ul> <li>All residents have the potential to b affected by this practice.</li> </ul> </li> <li>DON and/or designee will implement measures to ensure that this practice does not recur including: <ul> <li>Nurse Staffing Posting Policy was created on 01-03-2019. All Nursing stawill be educated on the Nurse Staffing Posting Policy, including who is responsible for completing this form an how to accurately complete this form.</li> </ul></li></ul>	y d of d of t ff
					<ul> <li>corrective actions to ensure the effectiveness of these actions including</li> <li>Random audits of the nursing staff</li> </ul>	:

Facility ID: 00904

If continuation sheet Page 24 of 31

		AND HUMAN SERVICES				FORM	01/08/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	`́сом	E SURVEY IPLETED
		245245	B. WING				C 13/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		10/2010
HERITAG	SE 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 PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 732	Continued From pa	ige 24	F 73	32	<ul> <li>hour posting will be completed daily 1wk, 3x/wk. for 2 weeks, 2x/wk. for weeks, and then monthly thereafter ensure nursing staff posting is com beginning the week of 01-07-2019.</li> <li>Audit results will be brought to QAPI committee quarterly for review further recommendation.</li> </ul>	2 , to pleted the	
F 812 SS=F	CFR(s): 483.60(i)(1 §483.60(i) Food sat The facility must - §483.60(i)(1) - Proc approved or consid state or local autho (i) This may include from local producer and local laws or re (ii) This provision de facilities from using gardens, subject to safe growing and fo (iii) This provision co from consuming for §483.60(i)(2) - Stor serve food in accor standards for food	fety requirements. cure food from sources lered satisfactory by federal, rities. a food items obtained directly rs, subject to applicable State egulations. oes not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices. loes not preclude residents ods not procured by the facility. e, prepare, distribute and dance with professional	F 81	12	Completion Date: 01-21-2019		1/21/19
	Based on observation review the facility factors	tion, interview and document ailed to maintain correct rinsing ure heat sanitation of dishes.			F812: It's Heritage Manor's practic provide safe and satisfactory food u sanitary conditions according to		

Facility ID: 00904

If continuation sheet Page 25 of 31

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		0938-039 E SURVEY
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	G	COMPLETED		
					С	
245245     B. WING       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE				12/	13/2018	
NAME OF I	PROVIDER OR SUPPLIER					
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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	Continued From pa	age 25	F 81	2		
		ice had the potential to affect	1 01/	appropriate rules and regulations.		
	12:14 p.m. to 12:38 preparing food, C-E storage room to dis "we need a new dis During observation			<ul> <li>Dietary Manager and/or designee implement corrective action for re- affected by this practice by:</li> <li>Residents currently are served in a sanitary manor.</li> <li>Environmental Service Director inspected dishwasher and ran sev cycles and all rinse temps were at 180 degrees.</li> </ul>	sident d meals or reral	
	(DA)-A, placed a ra dishwasher. The rir degrees Fahrenhei correct rinse tempe Dishwasher Tempe in the dishwasher r	er (DM) and dietary aide ack of dirty cups into the nse temperature reached 172 t (F). DM stated it was the erature. DM was directed to the erature Log, located on the wall oom. The log indicated a final needed to be 180 degrees.		Dietary Manager and/or designee assess residents having the poter be affected by this practice includi • All residents have the potentia affected by this deficient practice.	itial to ng:	
	When asked what is is out of range, DM notified. DA-A place dishwasher for a set temperature reache pointed out Dishwa in the left lower sec temp ranges: WHE ranges (wash 140- notify dietary mana services director IM	asked what is done when the temperature of range, DM stated maintenance is to be d. DA-A placed the rack of cups into the asher for a second time. The Final rinse erature reached 182 degrees. Surveyor d out Dishwasher Temperature Log, noted left lower section of the form * Acceptable ranges: WHEN OUTSIDE of acceptable s (wash 140-160) F and final rinse 180 F), dietary manager and environmental es director IMMEDIATELY. Upon further of the December 2018 Dishwasher		<ul> <li>Dietary Manager and/or designee implement measures to ensure the practice does not recur including:</li> <li>Dishwasher temperature police updated.</li> <li>Dietary staff will be re-educated dishwasher temperature policy to completing logs and notifying dietar manager of any temperatures that meet the limits.</li> </ul>	at this y was ed on include ary	
	Temperature Log w temperatures below recorded on the log notified her about th and was unaware t range. DM stated th	wher 2018 Disnwasher vith DM, several documented v 180 degrees F were g. DM stated no staff had he out of range temperatures he temperatures were out of he facility gets dishwashing yard (a manufacturer and		Dietary Manager and/or designee monitor corrective actions to ensu effectiveness of these actions incl • Random kitchen audits, that w include observation for soiled pans/dishware in clean storage ar dishwasher temps, will be comple	re the uding: /ill eas and	

Facility ID: 00904

STATEMENT		KOMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY	
AND PLAN C	IDENTIFICATION IDENTIFICATION NONDER.		A. BUILDING			COMPLETED C		
	245245 B. WING							
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
HERITAC	E MANOR				21 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 PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE	
F 812	Continued From pa	age 26	F 8 <sup>-</sup>	12				
	Hillyard services the basis. Hillyard Kitchen Re- rinse temperature of report identified a r Both, above the mi However, review of Temperature Log for identified 15 of 29 for were below 180 de for action taken was During an interview when asked about placed in the dishw stated the need for she was making co	ing and hygiene solutions). e dishwasher on a monthly eports dated 9/7/18 identified a of 184 degrees F. A 10/31/18 inse temp of 185 degrees F. nimum of 180 degrees F. f the facility's December or dates 12/1/18 to 12/12/18, times, final rinse temperatures grees F. A column on the log is blank. v at 12:59 p.m. on 12/12/18, the 3 baking pans C-B had vashing room earlier when she a new dishwasher, C-B stated ornbread and each pan she an storage area was dirty.			<ul> <li>Dietary Manager/designee daily fo 3x/wk. for 2 weeks, 2x/wk. for 2 we and then monthly thereafter, to en- privacy is being provided for all res as needed beginning the week of ( 2019.</li> <li>Audit results will be brought to QAPI committee for review and fur recommendation.</li> <li>Completion Date: 01-21-2019</li> </ul>	eeks, sure sidents 01-07- the		
	stated temperature	11:57 a.m. on 12/12/18, DA-A logs are filled out once per unch, and dinner for the wash le temperatures.						
	12/12/18, DA-A rev temperature log, st 12/6/18. For all 5 d documented below DM is to be contac	interview at 12:05 p.m. on viewed the December ating she worked 12/2/18 to ays, the rinse temperature was v 180 degrees F. DA-A stated ted when temperatures are out ted she did not notify DM with mperatures.						
	representative (SR SR-A stated he wo	v via phone with Hillyard sales )-A at 1:26 p.m. on 12/12/18, uld need to find out the e temperature and call back.						

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				0938-039
		. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
					C	2
		245245	B. WING		12/1	3/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	SE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From pa	ge 27	F 81	2		
	stated SR-A called	on 1:30 p.m. on 12/12/18, DM and stated 180 degrees F was inse temperature needed.				
	Hobart Instruction N AM-14C-dishwashe Sterilizing Mode Rinse	/anual Model r-undated, directed: Wash				
	Hot water	150 F 180 F (82 C)				
F 921 SS=E	temperatures was r	he monitoring of dishwasher equested and provided. nitary/Comfortable Environ	F 92	1		1/21/19
SS=E	The facility must pro sanitary, and comfor residents, staff and This REQUIREMEN	nvironmental Conditions ovide a safe, functional, ortable environment for the public. NT is not met as evidenced				
	review the facility fa were safe and in go	ion, interview, and document iled to ensure headboards ood repair in 4 of 8 resident 12, 313), a footboard was in		F921: It's Heritage Manor's policy t provide our residents with a safe/comfortable environment.	to	
	good repair and free rooms (310), and w	e from sharp edges in 1 of 8 alls were free from gouges ke appearance in 1 of 8 rooms		Environmental Service Director and designee will implement corrective a for resident affected by this practice • Headboards were fixed in room 310, 312, and 313.	action by:	
	Findings include:			<ul><li>Footboard was replaced in room</li><li>Walls were repaired and painted</li></ul>		
		5 a.m. all rooms on unit 1 ny maintenance issues. The ms reveled that the		<ul><li>room 310.</li><li>Foam on bed rail was removed room 310.</li></ul>	in	

Facility ID: 00904

If continuation sheet Page 28 of 31
		AND HUMAN SERVICES				FORM	01/08/201 APPROVE 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	COM	E SURVEY PLETED
		245245	B. WING			12/13/2018	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE,		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 921	leaning at approxim Room 310 also had that were nicked an On 12/13/18, at 9:0 environmental serv was completed. ES staff were to follow maintenance needs maintenance log bo stations for staff to issues. ESD stated hour and then addr out lights, TV issue maintenance log bo at the nurses' static of the maintenance no entries from staf or walls needing ES On 12/13/18, at 9:0 his routine for chec ensure all were in g went only by the log he felt the maintenan much for one perso overwhelmed. ESD room quickly for rep ESD also stated he their new employee employees to make	<ul> <li>ans 309, 310, 312, 313 were all nately a 30 degree angle.</li> <li>ately ately at</li></ul>	FS	921	<ul> <li>Environmental Service Director a designee will assess residents h potential to be affected by this p including:</li> <li>All residents with have the p be affected by this deficient prace</li> <li>Facility wide audit will be pe on 01-04-2019, noting any beds rooms that are in need of repair.</li> <li>Environmental Service Director a designee will implement measure ensure that this practice does not including:</li> <li>Building Maintenance policy updated and reviewed to include rounds by ESD or designee.</li> <li>Nursing staff will be re-educ Building Maintenance policy to it Environmental Services of issue regarding bed repair, wall repair other equipment repair needs by maintenance logs located at eace</li> </ul>	aving the ractice otential to ctice. rformed and and/or res to ot recur was weekly ated on nform s, and y writing in ch unit. and/or actions to	
	On 12/13/18, at 9:1 verify the maintena observation. ESD	e maintenance log books es station. 0 ESD went into room 310 to nce issues found during verified the foot of bed was scraped. ESD stated this			<ul> <li>including:</li> <li>Building walk through audits include observation of residents and equipment, will be complete ESD/designee daily for 1wk, 3x/ weeks, 2x/wk. for 2 weeks, and monthly thereafter, to ensure prior</li> </ul>	rooms d by wk. for 2 then	

Facility ID: 00904

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		AND HUMAN SERVICES				FORM	01/08/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245245	B. WING				C 13/2018
NAME OF	PROVIDER OR SUPPLIER	I	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•=	
HERITAC	GE MANOR				1 NORTHEAST SIXTH STREET HISHOLM, MN 55719		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 921	aware of. ESD stat from staff ramming in the room. ESD v leaning at approxim towards the mattres headboards are bro the beds properly w from the wall. ESD issues would be so aware of by the fac log books located a room 310 the metal of foam taped arou frame. The foam w length and torn on the this was something aware of, ESD state torn foam padding w On 12/13/18, at 9:2 maintenance log bo been made for repaneed for room main Maintenance log bo past 120 days. During the unit 1 to headboards in room appear to be bent, the resident's head or p ESD was made aw with this issue in un included rooms 30 findings in each root On 12/13/18, at 9:3	g he would want to be made ted the sharp edges come the loft equipment into items verified the headboards were hately a 30 degree angle ss. ESD stated the oken from staff not lowering when pulling the beds away overified these maintenance mething he should be made ility staff via the maintenance to both nurses stations. In I bed frame had ablack piece and the right side of the bed vas approximately 12 inches in both ends. ESD was asked if he would want to be made ed yes. He further stated the was not a cleanable surface. 66 a.m., review of the boks revealed no entries had airs or concerns regarding the thenance of furniture repairs. boks were reviewed for the ur on 12/13/18, at 9:33 a.m. n 309, 310, 312, 313, all leaning forward, toward the billow at a 30 degree angle. are of the number of rooms hit 1 hallway. Unit 1 hallway 1-313. ESD verified the om.	F 9	21	<ul> <li>being provided for all residents as r beginning the week of 01-07-2019.</li> <li>Audit results will be brought to t QAPI committee for review and furt recommendation.</li> <li>Completion Date: 01-21-2019</li> </ul>	the	
	maintenance log bo been made for repa need for room main Maintenance log bo past 120 days. During the unit 1 to headboards in room appear to be bent, I resident's head or p ESD was made aw with this issue in un included rooms 30 findings in each room On 12/13/18, at 9:3	books revealed no entries had airs or concerns regarding the ntenance of furniture repairs. books were reviewed for the ur on 12/13/18, at 9:33 a.m. n 309, 310, 312, 313, all leaning forward, toward the billow at a 30 degree angle. are of the number of rooms hit 1 hallway. Unit 1 hallway 1-313. ESD verified the bm.					

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/08/2019 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	Сом	E SURVEY IPLETED
		245245	B. WING	i			C 13/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE MANOR				21 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 921	routinely check to e in good repair. The not a schedule or tr maintenance log bo He stated the facilit or additional staff b facilities maintenan stated the previous resigned in October has been helping th new position as a n Administrator also v way staff were to co needs arise. He fur information provide issues such as wall ESD not being awa Administrator verifie for staff to report fur maintenance concer note which rooms v and repair. Administrator werifie for staff to report fur maintenance should The undated facility indicated the facility homelike environm guests. The policy Service Director (E room/building inspe- moved to another re the facility. The pol be attentive to facilit work day for areas and write need in m	ensure rooms and furniture are e Administrator stated there is racking, ESD is checking the boks on the units every hour. ty does not have an assistant besides ESD to address the nee issues. Administrator maintenance assistant r 2018. The former assistant he ESD when available per her bursing assistant (NA). verified the log books were the communicate to ESD when rther stated, the lack of ed in the books regarding room Is and furniture, would result in are of these issues. ed the expectation would be irrniture and resident room erns to ESD, and for ESD to were in need of maintenance ster stated this was something d be taking care of. y Building Maintenance Policy y was to maintain a clean and ent for the residents and directed the Environmental SD) to perform monthly ections and when a resident oom or was discharged from licy further directed all staff to ity surroundings during the of building that need repair naintenance log. ESD was to nce log, and sign and date	FS	921			

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Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		00904	B. WING		( 12/1	C <b> 3/2018</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HERITAC	GE MANOR		HEAST SIX <sup>-</sup> M, MN 5571			
(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 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 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 lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf elicensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 01/04/19

Electronically Signed

STATE FORM

L

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	- (X3) DATE SURVEY COMPLETED		
		00904	B. WING			C 12/13/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
HERITAC	GE MANOR		THEAST SIXTI 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	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 000	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, th corrected prior to el Minnesota Departm On 12/10/18 - 12/13 Department's staff the following correct Please indicate in y correction that you and identify the data Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th	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					
	are the Suggested Time period for Cor PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED	
		00904	B. WING		C	
					12/13/2018	
	PROVIDER OR SUPPLIER		THEAST SIX	STATE, ZIP CODE TH STREET		
IERITAG	E MANOR		LM, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLE	
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 890	MN Rule 4658.0525 Motion	5 Subp. 2 A Rehab - Range of	2 890		1/21/19	
	that is directed towa through positioning implemented and m 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 rar 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				
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview, and document iled to provide appropriate ent for 1 of 1 residents (R24) of motion services.		Corrected		
	Findings include:					
	R24's face sheet in included cerebrovas hypertension.	dicated R24's diagnosis scular disease and				
	R24's annual Minim	um Data Set (MDS) dated				

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.			С
		00904	B. WING			13/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HERITAG	GE MANOR		THEAST SIXT LM, MN 55719	-		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 890	Continued From pa	ge 3	2 890			
	assist with activities	R24 was an extensive to total of daily living (ADL's). The 's cognition was severely				
	was unable to expre indicated R24 recei of motion) and was integrity. R24's car	ed 10/26/18, indicated R24 ess own needs. The care plar ved maintenance ROM (range at risk for altered skin e plan lacked documentation blication of a right palm				
	R24's functional maintenance plan (FMP) d 7/13/16, that was hanging up on the inside of R24's closet indicated don (to put on) rig palm protector upon rising in the morning a wear a right Posey finger contracture cushi (with finger separators), (prevents skin breakdown and support for the contracted h and decreases risk of skin irritation) at nigh	anging up on the inside door cated don (to put on) right n rising in the morning and to finger contracture cushion ors), (prevents skin oport for the contracted hand				
	was in the dining ro had no palm protec a.m. staff were obs	on 12/13/18, at 8:25 a.m. R24 om sitting in a wheelchair and tor on the right hand. At 8:39 erved bringing R24 back to no palm protector on her right.				
	nursing assistant (N need to wear the pa stated R24's toiletin	on 12/13/18, at 8:09 a.m. IA)-D stated R24 does not added thing all day. NA-D ig sheet did not indicated to ed to wear the padded thing at	t			
	NA-E stated therap	on 12/13/18, at 8:14 a.m. y would update the restorative changes to a residents ROM.				
	During an interview	on 12/13/18, at 11:05 a.m.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED	
		00904	B. WING			C 12/13/2018	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 890	Continued From pa	age 4	2 890				
		urse (LPN)-D stated R24 had discontinued over six months					
	During an interview on 12/13/18, at 11:07 a.m. registered nurse (RN)-C stated that RN-C was unaware that R24 had a palm protector. RN-C verified there was no information in R24's care plan regarding a palm protector.						
	occupational therap R24 had a complete the palm protector to while awake. OTR that had been made protector. The OTF trained on how to a the mentor employed on how to apply the stated the nurses s protector when we	on 12/13/18, at 11:18 a.m. the bist, registered (OTR) stated e evaluation on 7/13/16, for to be worn every day all day stated there were no changes e to R24 wearing the palm R stated the staff have been pply the palm protector and ees should train the new staff e palm protector. The OTR hould know about the palm give them the therapy sheet Id add the information to the s.					
	with NA-F stated R	on 12/13/18, at 11:38 a.m. 24 does not have a palm do list so I do not have to put a R24.	1				
	director of nursing ( update the task list therapy recommend	on 12/13/18, at 11:45 a.m. the (DON) stated the nurses would for the NA's to complete the dation. The DON stated the been trained to put the palm fter morning cares.					
	splinting is used to	g Policy, undated, indicated protect joints and surrounding ng Policy also indicated					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00904	B. WING			12/13/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
HERITAG	BE MANOR		THEAST SIXTI	-			
(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	TION SHOULD BE	(X5) COMPLETI DATE	
2 890	Continued From pa	ge 5	2 890				
		ng will be documented on the ation posted inside resident's					
	The director of nurse resident splints and being applied consi- instructions. The d could educate all st procedures related services, and revise director of nursing of of audits to the facil	HOD OF CORRECTION: sing or designee could audit braces to ensure they are stent with care planned irector of nursing or designee aff on facility policies and to range of motion and splint e them as needed. The or designee could bring results lity quality assurance er recommendations and					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			1/21/19	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					
	B. a resident w	ho has pressure sores					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED	
		00904	B. WING			C 12/13/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
HERITAG	GE MANOR		THEAST SIX LM, MN 557				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	ge 6	2 900				
		y treatment and services to event infection, and prevent veloping.					
	by: Based on observati review, the facility fa intervention of time	ent is not met as evidenced on, interview, and document ailed to implement an ly repositioning for 1 of 2 iewed who was at risk for		Corrected			
	Findings include:						
	to admission to the	ited 10/25/18, indicated prior facility the resident had a ch was currently healed.					
	11/6/18, identified F required extensive toileting, bed mobili	num Data Set (MDS) dated R48 was cognitively intact. R48 assistance for transferring, ty, dressing and personal to pressure ulcers. R48 was at cers.					
	required assistance plan directed staff t skin daily with care cares, observe skin observe feet for evi	ted 11/9/18, indicated R48 with bed mobility. R48's care o inspect skin weekly, observe s, moisturizing lotion with for dryness and bruising, and dence of problems. The care osition every 2 hours.	•				
	Observation dated no concerns noted Results of R48's Tis	e Test (TT) Repositioning 11/18/19, indicated R48 had for current skin integrity. ssue Tolerance indicated to ry 2 hours when laying or					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
HERITAG	SE MANOR		THEAST SIXT	-			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ge 7	2 900				
	11/28/18, indicated	ive Skin Assessment dated R48 had no pressure ulcers. ite risk for pressure ulcer					
	<ul> <li>During continuous observations starting at 8:20 am on 12/13/18, the following was observed.</li> <li>8:19 a.m. received daily task list from staff.</li> <li>List indicated to reposition R48 every 2 hours.</li> <li>8:20 a.m. R48 in room in wheelchair watching TV. R48 was sitting on a black cushion</li> <li>8:37 a.m. licensed practical nurse (LPN)-A entered R48's room and provided R48 with prune juice. LPN-A did not offer or provide repositioning.</li> </ul>						
	<ul> <li>8:57 a.m. LPN- provided R48 with v provide repositionir</li> <li>9:12 a.m. R48 i into common room</li> <li>9:51 a.m. R48 i</li> </ul>	A entered R48's room and water. LPN-A did not offer or ng. n wheelchair self-locomotion looking at magazines. remains in wheelchair sitting					
	heater. - 10:35 a.m. R48 moved from wall he - 10:46 a.m. staf choices. No reposit	f approached R48 for his mea ioning offered or provided.					
	table. No staff offered or r	remains in wheelchair at a repositioned R48 between 9 a.m. (2 hours and 49					
	R48 stated staff las R48 stated staff sor	w at 11:18 a.m., on 12/13/18, t assisted him up at 7:30 a.m. metimes ask him if he wants bes not recall how often the					

	ta Department of He		1			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.			0
		00904	B. WING			C 13/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
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2 900	Continued From pa	ge 8	2 900			
	a.m. the surveyor a (NA)-C. NA-C state residents. When as what cares each residents. When as what cares each resident and document. The form resident name, toile interventions. The form intervention of repo 9:08 a.m. and 11:05 column next to R48 during constant obs offered or reposition co-worker must hav toileting. NA-C wen	sitioning for R48. Times of 5 a.m. were written in the 5 name. These times were servations, when no staff ned R48. NA-C stated a ve documented the times for t on to say R48 could move ne wheelchair and was not on				
	Registered nurse (F R48's room to repo- buttocks. RN-B and assist R48 into a sta removed R48's inco looks pretty red". Th intact skin. RN-B a toilet with the stand the physician for an buttocks. RN-B info assistance for off-lo	0				
	director of nursing ( have concerns abor assistant director of a skin assessment	at 1:09 p.m. on 12/13/18, the DON) stated if aides or staff ut skin integrity they email f nursing (ADON). ADON does and notified physician and ent started. ADON reviews the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
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ME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ERITAG	E MANOR		RTHEAST SIXTI LM, MN 55719				
X4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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) COMPLET DATE	
2 900	Continued From pa	ge 9	2 900				
	pressure reducing. the task list, which	Il mattresses in facility are Nursing assistants are to use directed to reposition R48 lity staff are required to follow					
	residents identified the Braden scale w pressure ulcer risk appropriate, individ prevention and trea (Pressure relief ma in chair turn and re protectors). Reside	a Ulcer Protocol dated 11/1/15 at moderate to high risk of by ill have a comprehensive assessment to determine ualized interventions for tment of pressure/skin ulcers. ttress, pressure relief cushion position schedule and heel ents will receive daily onitoring of skin concerns.					
	The director of nurs all residents at risk they are receiving the treatment/services from developing an pressure ulcers. The designee, could condelivery of care; to	to prevent pressure ulcers d to promote healing of ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			1/21/19	
		nce. A nursing home must program of bowel and bladder					

STATE FORM

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	СОМ	E SURVEY PLETED
	00904	B. WING		12/13/2018	
AME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
IERITAGE MANOR		THEAST SIX .M, MN 557 <sup>,</sup>	TH STREET 19		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
<ul> <li>unnecessary use of comprehensive resthome must ensure</li> <li>A. a resident without an indwelling unless the resident that catheterization</li> <li>B. a resident without an indwelling unless the resident that catheterization</li> <li>B. a resident without an indwelling prevent urinary tracemuch normal blade</li> <li>This MN Requirem by:</li> <li>Based on observate review, the facility for catheter drainage to floor at all times and properly cleaned at tract infections for for catheter.</li> <li>Findings include:</li> <li>R11's Face Sheet of diagnoses that incluropathy (a structur normal urine flow).</li> <li>R11's current Care R11 was at risk for</li> </ul>	duce incontinence and the f catheters. Based on the sident assessment, a nursing		Corrected		

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		C 12/13/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXT M, 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 ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	ige 11	2 910			
	catheter care instru Assistants (NA). In was to empty cathet technique, keep ca the bladder, keep c when up in wheelch catheter bag off of Record review of M R11 was treated wi 9/22/18, and was c On 12/7/18, R11 wa follow-up, history of orders noted for vis	ID orders for R11 indicated th Macrobid 100 mg on discontinued on 9/23/18. as seen by MD for routine f frequent UTIs. No new				
	12/12/18, included	orders for cranberry e, 500 milligram (mg) by				
	sitting in his room, s the right of the door open and Foley cat hallway and was no catheter bag was a bright, clear yellow	6 p.m. R11 was observed seated in his recliner just to rway. R11's door was wide heter bag was visible from the ot in a privacy bag. R11's pproximately 1/3 full with r urine. R11's catheter bag floor under the footrest of the				
	siting in the main di independently. R1 <sup>2</sup>	9 a.m. R11 was observed ining room eating breakfast 1's catheter bag was placed in under w/c. Cloth privacy bag floor.				
		0 a.m. Staff was observed cout of the dining area and to				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
		00904	B. WING	B. WING		C 12/13/2018	
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	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT		FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	••••••	acy bag was dragging on the	2 910				
	On 12/11/18, at 10:27 sitting in his room, se the right of the doorw open and Foley cathe hallway and was not catheter bag was app bright, clear yellow u	21 a.m. R11 was observed seated in his recliner just to way. R11's door was wide heter bag was visible from the it in a privacy bag. R11's pproximately 1/3 full with urine. R11's catheter bag floor under the footrest of the					
	sitting in his w/c in t catheter bag was in	5 a.m. R11 was observed he main dining room. R11's a cloth privacy bag. Cloth cured under R11's w/c but was g room floor.	5				
	sitting in main dinin independently. R11 privacy bag. Cloth	00 p.m. R11 was observed g room eating lunch I's catheter bag was in a cloth privacy bag was secured as resting on the dining room					
	sitting in his room, s the right of the door and Foley catheter hallway and was no catheter bag was a	41 p.m. R11 was observed seated in his recliner just to way. R11's door wide open bag was visible from the t in a privacy bag. Foley pproximately 1/2 full with urine. Foley catheter bag was					
	resting on the floor recliner. NA-A stat bag on the floor and way R11's catheter NA-A went on furthe	under the footrest of the red, that placing the catheter d without a cloth bag was the care was to be completed. er to state that until she is told his is how she will do the care.					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00904	B. WING		C 12/13/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
IERITAC	GE MANOR		THEAST SIXT .M, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ige 13	2 910			
	demonstrate how F emptied. NA-A was bathroom sink. Put bed side cabinet to opened the spout of the plastic portable port back onto the of catheter bag back of to the bathroom an toilet. NA-A then rin placed back into R off her gloves and of catheter bag to resi exited the room. N would wash her han NA-A replied the fam	43 p.m. NA-A was asked to R11's catheter bag would be shed her hands at the t on gloves and went to R11's retrieve a urinal. NA-A of the catheter and emptied into urinal. NA-A then clipped the catheter bag and placed the boto the floor. NA-A then went d flushed the urine into the nsed the urinal with water and 11's side cabinet. NA-A took exited the room, leaving R11's t on the floor. NA-A then A-A was asked if she normally nds after removing gloves, cility has stated they can use re not visibly soiled. NA-A d hand sanitizer				
	catheter care and in stated staff should gloves, empty into a into toilet, wash bas alcohol, remove glo DON stated was he follow these steps. expectation that sta catheter bag with a important for infect that have catheters access to alcohol w storage room. The expectation that sta	7 DON was interviewed about nfection prevention. DON wash their hands, put on a graduate or urinal, empty sin, wipe end of spout with oves and wash hands. The er expectation for all staff to The DON stated it was her aff always wipe port end of lcohol, and that this step is ion prevention for residents bion prevention for residents to The DON stated staff have vipes, they are located in the DON further stated it was her aff place a residents catheter g and elevate off the floor at all				
		ter Care Policy, which was staff are to ensure drainage				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00904	B. WING		12/13/2018	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
HERITAC	GE MANOR		THEAST SIXT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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
2 910	Continued From pa	ge 14	2 910			
	a barrier between the when emptying dra catheter bag, staff a alcohol wipe once of spout. Staff are ins	ng the floor. Staff are to place he floor and collection device inage bag. When draining a are to cleanse spout with completed prior to re-clamping structed to remove gloves and inished with the task.				
	Director of Nursing revise policies and care. The DON or o	THOD OF CORRECTION: The or designee could review and procedures related to catheter designee could provide ter care and audit for correct procedures.				
	TIMEFRAME FOR (21) days	CORRECTION- Twenty one				
21160	MN Rule 4658.067 Cleaning and Sanit	5 Subp. 6 Mechanical izing; Hot Water	21160			1/21/19
	hot water for sanitiz wash water and put clean and water is in temperature specifi Standard No. 3, inc subpart 2, under wh A pressure gauge r immediately adjace control valve in the this requirement do	sanitization. Machines using ting may be used provided that mped rinse water are kept maintained at not less than the ded by NSF International porporated by reference in hich the machine is evaluated. must be installed with a valve ent to the supply side of the final rinse line provided that we not pertain to a ne with a pumped final rinse.				
	by:	ent is not met as evidenced				
	Based on observati	ion, interview and document		Corrected		

STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00904	B. WING		C 12/13/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	GE MANOR	321 NOR	HEAST SIXT	TH STREET		
HENHAG		CHISHOL	M, MN 55719	9		
(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 ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21160	Continued From pa	ge 15	21160			
	temperature to ensu	iled to maintain correct rinsing ure heat sanitation of dishes. ice had the potential to affect				
	Finding include:					
	During kitchen observation on 12/12/18, from 12:14 p.m. to 12:38 p.m. while cook (C)-B was preparing food, C-B took 3 baking pans from the storage room to dishwashing room and stated "we need a new dishwasher".					
	with dietary manage (DA)-A, placed a ra dishwasher. The rin degrees Fahrenheit correct rinse tempe Dishwasher Tempe in the dishwasher ro rinse temperature n When asked what is	s on 12:43 p.m., on 12/12/18, er (DM) and dietary aide ck of dirty cups into the use temperature reached 172 t (F). DM stated it was the rature. DM was directed to the rature Log, located on the wall born. The log indicated a final ueeded to be 180 degrees. s done when the temperature				
	notified. DA-A place dishwasher for a se temperature reache pointed out Dishwas in the left lower sec	stated maintenance is to be ed the rack of cups into the cond time. The Final rinse ed 182 degrees. Surveyor sher Temperature Log, noted tion of the form * Acceptable N OUTSIDE of acceptable				
	ranges (wash 140-1 notify dietary manag services director IM	I60) F and final rinse 180 F), ger and environmental IMEDIATELY. Upon further nber 2018 Dishwasher				
	Temperature Log w temperatures below recorded on the log	<ul> <li>ith DM, several documented</li> <li>180 degrees F were</li> <li>DM stated no staff had</li> <li>ne out of range temperatures</li> </ul>				
	and was unaware the	ne temperatures were out of ne facility gets dishwashing				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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					12/	13/2010	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
HERITAC	GE MANOR		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	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21160	Continued From pa	ge 16	21160				
	distributor of cleani	yard (a manufacturer and ng and hygiene solutions). e dishwasher on a monthly					
	rinse temperature of report identified a ri Both, above the min However, review of Temperature Log for identified 15 of 29 t	ports dated 9/7/18 identified a of 184 degrees F. A 10/31/18 inse temp of 185 degrees F. nimum of 180 degrees F. the facility's December or dates 12/1/18 to 12/12/18, imes, final rinse temperatures grees F. A column on the log s blank.					
	when asked about placed in the dishw stated the need for she was making co	at 12:59 p.m. on 12/12/18, the 3 baking pans C-B had ashing room earlier when she a new dishwasher, C-B stated rnbread and each pan she n storage area was dirty.					
	stated temperature	11:57 a.m. on 12/12/18, DA-A logs are filled out once per inch, and dinner for the wash le temperatures.	x				
	12/12/18, DA-A rev temperature log, sta 12/6/18. For all 5 da documented below DM is to be contact	nterview at 12:05 p.m. on iewed the December ating she worked 12/2/18 to ays, the rinse temperature was 180 degrees F. DA-A stated ted when temperatures are out ed she did not notify DM with nperatures.					
	representative (SR) SR-A stated he wou	via phone with Hillyard sales )-A at 1:26 p.m. on 12/12/18, uld need to find out the e temperature and call back.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00904	B. WING			C 12/13/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
IERITAC	GE MANOR		THEAST SIXTI				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21160	Continued From pa	ge 17	21160				
	stated SR-A called	on 1:30 p.m. on 12/12/18, DM and stated 180 degrees F was inse temperature needed.					
	Hobart Instruction M AM-14C-dishwashe Sterilizing Mode Rinse Hot water	Manual Model er-undated, directed: Wash 150 F					
	Celsius (66 C)	180 F (82 C)					
		he monitoring of dishwasher equested and provided.					
	dietary manager an could review and re- related to assessing documentation of d Dietary staff could k completing dishwas when temperatures manager and/or cou	HOD OF CORRECTION: The d/or maintenance director evise policies and procedures g, monitoring, and ishwasher temperatures. be educated on the process of sher temps and actions to take out of range. The dietary uld train staff and could regular basis to ensure					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one					
21426	MN St. Statute 144, Prevention And Cor	A.04 Subd. 3 Tuberculosis htrol	21426			1/21/19	
		e provider must establish and nensive tuberculosis					

STATE FORM

KH8E11

If continuation sheet 18 of 27

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00904	B. WING			13/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
HERITAG	BE MANOR		THEAST SIX1 _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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	bgram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of technical assistance intation of the guidelines.	21426			
	by: Based on interview facility failed to ens and 3 of 5 employe proper documentat results as directed (CDC) guidelines. Findings include: R162's face sheet i	ent is not met as evidenced and document review the ure 1 of 5 residents (R162) es (E-F, E-G, and E-H) had ion of Tuberculin skin testing by Center for Disease Control ndicated R162 was admitted nedical record included		Corrected		
	documentation of th test (TST) on 11/30 second step TST of	ne initial step tuberculin skin /18. R162 received the n 12/4/18. R161's second ocumentation of the results of				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00904	B. WING		12/13/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXT			
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT		FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	record included door received the first an However, the result of induration for eith E-G was hired on 1 record included door the first two step on not received the set E-H was hired on 8 included documentar reading did not inclu- negative for tubercu During an interview	0/29/18, E-G's personnel cumentation of E-G receiving a 10/29/18. However, E-G had cond TST. /29/18, E-H's personnel record ation of a chest x-ray and the ude if the chest x-ray was ulosis.	ł			
	had the second ste interview at 1:39 p.r read the results of t induration and write paper documentation were trained to read nursing (DON). RN	N)-D stated R162 should have p of the TST. During a later m. RN-D stated RN-D would the TST and document e positive or negative on the on. RN-D stated employees d the TST by the director of I-D indicated E-F, E-G, and ation was not documented				
	DON stated employ to read and docume The facility policy R Prevention and Cor TST must be read a hours of administra directed staff to doc	on 12/12/18, at 1:56 p.m. the yees were trained by the DON ent the results of the TST. esident Tuberculosis htrol dated 6/5/17, indicated a after 48 hours and before 72 tion. The policy further cument the number of mm uration and circle if negative or				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C	
		00904	B. WING		12/13/2018	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIX LM, MN 5571			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ge 20	21426			
	Prevention and Cor there is no written or receive a chest x-ra	mployee Tuberculosis ntrol dated 6/5/17, indicated if locumentation, they must ay to exclude a diagnosis of se before having any direct				
	director of nursing of policies regarding T	HOD OF CORRECTION: The or designee could review B screening, could educate ure audits were conducted to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21565	MN Rule 4658.1329 Medications Self Ac	5 Subp. 4 Administration of Imin	21565			1/21/19
	self-administer med resident assessme care as required in 4658.0405 indicate	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there on the attending physician.				
	by: Based on observati review, the facility f for self-administrati completed to ensur self-administer eye	ent is not met as evidenced on, interview, and document ailed to ensure an assessment on of medication was e the ability to safely drops for 1 of 2 residents self administration of	t	Corrected		
	Findings include:					
	R49's annual Minim	num Data Set (MDS) dated				

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED
	00904		B. WING			13/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, ST	ATE, ZIP CODE		
HERITAC	BE MANOR		THEAST SIXT			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	ige 21	21565			
	cognitively impaired included arthritis, d	d R49 was moderately d. R49 had diagnoses, which ementia, and Parkinson's us system disorder that affects				
	R49's quarterly Minimum Data Set (MDS) dated 12/4/18, indicated R49 required extensive assistance of one staff with dressing and grooming.					
	R49 was observed were present. Two	s on 12/11/18, at 10:05 a.m. sitting in his room. No staff unlabeled bottles of Systane ps) were located in view, next				
	7:26 a.m. the two b next to R49's televi eyes became dry o the eye drops to bo administered the dr asked how many dr	eservations on 12/12/18, at ottles of Systane remained sion. R49 stated when his r itchy, he self administered th eyes. R49 stated he rops 1-2 times a day. When rops R49 administered, R49 omes out of the bottle."				
	Systane eye drops administration of th	cord lacked an order for and documentation of e drops. An undated assessment in R49's record was blank.				
	upon the surveyors 12/12/18. When as Systane located by up the 2 bottles and were in his room". I an order for the eye	RN)-A entered R49's room request at 8:36 a.m. on ked about the 2 bottles of R49's television, RN-A picked d stated "I never knew they RN-A stated R49 did not have e drops. RN-A went on to say bt be in R49's room. RN-A				

STATEME	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
00904		00904	B. WING		C 12/13/201	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	GE MANOR	321 NOR	THEAST SIXT	H STREET		
		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 ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21565	Continued From pa	ge 22	21565			
	informed R49 she w the physician and re R49's room. RN-As to let the nurse kno in a resident's room medical record and order for Systane e assessment comple medication. During an interview director of nursing ( self-administered m administration risk a nurse. The interdisc the assessment and self-administration of appropriate. The D assistant observes room and is unsure self-administers me assistants are to no medication. A facility policy Self- by Residents dated indicated all resider self-administer med residents wish to se will be assessed for medications. A Self (SAM) assessment reviewed by the IDT - Cognitive status - Physical status - Which medication	would request an order from emoved the 2 bottles from stated nursing assistants are wif medication are observed n. RN-A reviewed R49's stated R49 did not have an ye drops and did not have an eted for self-administration of at 8:49 am on 12/12/18, the (DON) stated all nedications need to have a sel assessment completed by a ciplinary team (IDT) reviews d notifies the physician for a order if deemed safe and DON further stated if a nursing medication in a resident's e if the resident edication, the nursing otify the nurse of the -Administration of Medication reviewed/revised on 1/8/18, nts will be asked if they wish to dications upon admission. If elf-administer medications they will be completed and T and will include: s				
		lications will be stored g staff will monitor the				

Minnesota Department of Health STATE FORM

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		с	
		00904	B. WING		12/13/2018	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IERITAG	E MANOR		RTHEAST 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 DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DAT	
21565	Continued From pa	ge 23	21565			
	will be put in place a periodic re-assessmappropriate of self-a Residents will be period in the room if approphysician. Nursing a medical record (EM	ocumented Ily appropriate interventions to accommodate wishes. A ment by IDT of the clinically administer medications. ermitted to retain medications ved by IDT and ordered by staff will ensure the electronic IAR) and care plan reflects the inistration of medications.				
	administrator, direct designee could revi administration of m evidence based pra- staff could be educa- importance of ensu administering their quarterly, annually, resident's physical of Nursing staff could physician's order in nurse/medication a The DON or designer resident's medical r with appropriate me DON or designee c QAPI to ensure cor	HOD OF CORRECTION: The tor of nursing (DON) or ew and revise policies for self edication according to actices/procedures. Nursing ated as necessary to the ring the resident is capable of own medications initially, or with a change to a or mental ability to do so. also ensure there is a place, prior to a ide administering medication. ee, could audit any/all ecords, to ensure compliance edication administration. The ould take that information to npliance and determine the acation/monitoring/compliance				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21810	MN St. Statute 144 Residents of HC Fa	651 Subd. 6 Patients & c.Bill of Rights	21810		1/21/*	

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMF	SURVEY PLETED
	00904		B. WING	C 12/13/2018		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIX M, MN 5571	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21810	Continued From pa	ge 24	21810			
	residents shall have medical and persor needs. Appropriate care designed to er highest level of phy This right is limited	iate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve their sical and mental functioning. where the service is not blic or private resources.				
	by: Based on observati review, the facility fa catheter bag was p	ent is not met as evidenced on, interview, and document ailed to ensure a urinary laced in a privacy bag to 1 of 2 residents (R11)		Corrected		
	Findings include:					
	diagnoses included	ated 6/28/18, indicated obstructive & reflux uropathy tional hindrance of normal				
	R11 was cognitively he was rarely or ne	impaired and BIMS indicated ver understood.				
	R11 was at risk for tract infection (UTI) and directed nursin catheter bag using catheter bag below catheter bag in a pr	blan dated 10/27/18, indicated complications such as urinary related to a Foley catheter g assistants (NA) to empty aseptic technique, keep the level of the bladder, keep ivacy bag when up in in bed, and keep catheter bag				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:	······		
		00904	B. WING			C 13/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	GE MANOR	321 NOF	THEAST SIXT	H STREET		
		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	TION SHOULD BE	(X5) COMPLETI DATE
21810	Continued From pa	ge 25	21810			
	sitting in room, seat right of the doorway lap within reach and Foley catheter bag was exposed and v catheter bag was a bright clear yellow u R11's catheter bag the footrest of the ro On 12/11/18, at 8:11 sitting in the main d independently. R11 a cloth privacy bag privacy bag was res On 12/11/18, at 9:3 wheeling R11 in wh	9 a.m. R11 was observed lining room eating breakfast I's catheter bag was placed in under wheelchair. Cloth				
	sitting in his room ir R11's call light was watching television. was not in a privacy visible from hallway under the footrest of catheter bag was a bright, clear yellow	he wheelchair. 21 a.m. R11 was observed n recliner with door open. on his lap within reach and . R11's Foley catheter bag y bag, it was exposed and y, and was resting on the floor of the recliner. R11's Foley pproximately 1/3 full with urine in the tubing and bag. 5 a.m. R11 was observed				
	sitting in his wheelc R11's catheter bag Cloth privacy bag w wheelchair, but rest	hair in the main dining room. was in a cloth privacy bag. vas secured under his ting on the dining room floor.				
		00 p.m. R11 was observed g room eating lunch				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	00904		B. WING			C 13/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HERITAC	GE MANOR		THEAST SIXTI	-		
(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	TION SHOULD BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 26	21810			
	privacy bag. Cloth	I's catheter bag was in a cloth privacy bag was secured ir, but resting on the dining				
	sitting in his room in Foley catheter bag was exposed and v Foley catheter bag bright clear yellow u Foley catheter bag the footrest of the re placing the catheter a cloth bag was the to be completed. N	41 p.m. R11 was observed in recliner with door open. was not in a privacy bag, it isible from hallway. R11's was approximately 1/2 full with urine in the tubing and bag. was resting on the floor under ecliner. NA-A stated, that r bag on the floor and without way R11's catheter care was IA-A went on to state, that until ifferently, this is how she will				
	(DON) was intervie	7 p.m. the director of nursing wed and verified R11's be placed in a privacy bag to				
	directed staff to pro anything that could and to place cathet	/ Policy, revised on 10/17, ovide care that would avoid be demeaning to the resident er bags in a covered bag so ould not be easily visible.				
	DON could provide care and on mainta care. The DON or c	HOD OF CORRECTION: The training on proper catheter ining dignity when providing designee could audit to ensure re providing care in a dignified				
	TIMELINE FOR CC days.	DRRECTION: Twenty One (21)	)			

		AND HUMAN SERVICES & MEDICAID SERVICES		FSZ	45029		FORM	: 01/07/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	TIPLE CONS		DR	(X3) DA	TE SURVEY MPLETED
		245245	B, WING				12	/11/2018
	PROVIDER OR SUPPLIER	• i		321 NOF	ADDRESS, CITY RTHEAST SIXT DLM, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE ROSS-REFERE	PLAN OF CORRECT CTIVE ACTION SHOU NCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	К 0	00				
	FIRE SAFETY							
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT C ONSITE REVISIT C CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.						
	Minnesota Departn Fire Marshal Divisio Heritage Manor wa the requirements for Medicare/Medicaid 483.70(a), Life Safe edition of National	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			E	POC		
		E AN EPOC, A PAPER COPY CORRECTION IS NOT						
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY						
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITL	E		(X6) DATE 01/04/2019
Electron	ically Signed							01/04/2018

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				FORM	01/07/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - HERITAGE MANOR	(X3) DATE	E SURVEY PLETED
		245245	B. WING			12/	11/2018
NAME OF	PROVIDER OR SUPPLIER	l,		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE MANOR				NORTHEAST SIXTH STREET ISHOLM, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	К 0	00			
	HEALTH CARE FII STATE FIRE MAR 445 MINNESOTA S ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145					
	By e-mail to: FM.HC.Inspections	@state.mn.us					
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:					
	1. A description of to correct the defic	what has been, or will be, done iency.					
	2. The actual, or pr	oposed, completion date.					
	responsible for cor	er title of the person rection and monitoring to ence of the deficiency.					
	basement. The orig in 1953 and was de construction. In 19 constructed to the be of Type II(111) or original building an construction type a this facility was sur	a 1-story building with a full ginal building was constructed atermined to be of Type II(111) 81 & 2001 additions were building that was determined to construction. Because the d its additions meet the illowed for existing buildings, veyed as a single building. as an apartment complex operly separated.					
	facility has a fire al	v sprinklered throughout, the arm system with smoke rridors and spaces open to the read the spaces open to the rridors and spaces open to the rridors and spaces open to the read the space of					

If continuation sheet Page 2 of 4

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G 01 - HERITAGE MANOR		MPLETED
		245245	B. WING			2/11/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
HERITAG	SE MANOR			321 NORTHEAST SIXTH STREET CHISHOLM, MN 55719		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5) COMPLETIO
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		DATE
K 000	Continued From pa	age 2	K 00	D		
		onitored for automatic fire				
		ation. Other hazardous areas				
		etection or smoke detection				
	with the Minnesota	alarm system in accordance State Fire Code.				
		apacity of 70 beds and had a time of the survey.				
	The requirement a	The requirement at 42 CFR, Subpart 483.70(a) is				
	NOT MET.					
	Electrical Equipme CFR(s): NFPA 101	nt - Power Cords and Extens	K 92	0		1/21/19
	Electrical Equipme Extension Cords	nt - Power Cords and				
1	used for componer					
		d electrical equipment				
	by qualified person	es that have been assembled nel and meet the conditions of rips in the patient care vicinity				
	may not be used for electronics), except	or non-PCREE (e.g., personal t in long-term care resident				Ĩ.
:		use PCREE. Power strips for 363A or UL 60601-1. Power				
-		EE in the patient care rooms				
:	(outside of vicinity)	meet UL 1363. In non-patient				
		strips meet other UL				
:		ver strips are used with general				
		nsion cords are not used as a wiring of a structure.				
		sed temporarily are removed				
	immediately upon	completion of the purpose for		4		
		ed and meets the conditions of				
	10.2.4. 10.2.3.6 (NFPA 99)					

If continuation sheet Page 3 of 4

PRINTED: 01/07/2019

CLAINER OF DEFICIENCIES       (A1) PROVIDERSUPPLIERCIA       (A2) MULTIFIE CONSTRUCTION       (A2) MULTIFIE CONSTRUCTION         AND FUN OF DEFICIENCIES       (A1) PROVIDERSUPPLIERCIA       (A2) MULTIFIE CONSTRUCTION       (A2) MULTIFIE CONSTRUCTION         AMD OF PROVIDER OR SUPPLIER       245245       (A1) PROVIDERS PLAN PROVIDERSUPPLIERCIA       (A2) MULTIFIE CONSTRUCTION         MARE OF PROVIDER OR SUPPLIER       245245       (A1) PROVIDERS PLAN PROVIDERSUPPLIERCIA       (A2) MULTIFIE CONSTRUCTION         MARE OF PROVIDER OR SUPPLIER       245245       (A1) PROVIDERS PLAN PLAN PLAN PLAN PLAN PLAN PLAN PLAN			AND HUMAN SERVICES			0		APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         HERITAGE MANOR       STREET ADDRESS, CITY, STATE, ZIP CODE         (M) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDERS PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)       000000000000000000000000000000000000	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	SURVEY
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Facility ID: 00904

If continuation sheet Page 4 of 4

PRINTED: 01/07/2019



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 27, 2018

Administrator Heritage Manor 321 Northeast Sixth Street Chisholm, MN 55719

Re: State Nursing Home Licensing Orders - Project Numbers S5245031 and H5245026

Dear Administrator:

The above facility was surveyed on December 10, 2018 through December 13, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5245026. 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>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</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.

Heritage Manor December 27, 2018 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:

Kathleen Lucas, Unit Supervisor St. Cloud B Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: kathleen.lucas@state.mn.us Phone: (320) 223-7343 Fax: (320) 223-7348

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.

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us