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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KH8E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00904

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/05/2019** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathleen Lucas, Unit Supervisor 02/06//2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 02/06//2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/23/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the 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

DEPARTMENT OF HEALTH

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KH8E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00904

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(L1) **245245**

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(L2) **936651200**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/13/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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From (a) :
To (b) :

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13.Total Certified Beds **70** (L17)

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jody McLeod, HFE - NE II 01/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/14/2019 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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09/01/1982
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25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

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

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

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

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

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

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

Mr. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 12/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/10/18 through 12/13/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/10/18 through 12/13/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. An investigation of complaint H5245026 was completed. The complaint was substantiated at F602. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		1/21/19

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

Electronically Signed | 01/04/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 12/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 12/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 Based on observation, interview, and document review, the facility failed to ensure a urinary catheter bag was placed in a privacy bag to maintain dignity for 1 of 2 residents (R11) reviewed for dignity. Findings include: R11's Face Sheet dated 6/28/18, indicated diagnoses included obstructive & reflux uropathy (a structural or functional hindrance of normal urine flow). R11 was cognitively impaired and BIMS indicated he was rarely or never understood. R11's current care plan dated 10/27/18, indicated R11 was at risk for complications such as urinary tract infection (UTI) related to a Foley catheter and directed nursing assistants (NA) to empty catheter bag using aseptic technique, keep catheter bag below the level of the bladder, keep catheter bag in a privacy bag when up in wheelchair (w/c) or in bed, and keep catheter bag off of the floor. On 12/10/18, at 6:26 p.m. R11 was observed sitting in room, seated in his recliner just to the right of the doorway. R11's call light was on his lap within reach and R11 was watching television. Foley catheter bag was not in a privacy bag, it was exposed and visible from hallway. R11's catheter bag was approximately 1/3 full with bright clear yellow urine in the tubing and bag. R11's catheter bag was resting on the floor under the footrest of the recliner. On 12/11/18, at 8:19 a.m. R11 was observed sitting in the main dining room eating breakfast	F 550	F550: It's Heritage Manor's policy to provide privacy to our residents. DON and/or designee will implement corrective action for resident R11 affected by this practice by: • Providing R11 with privacy bag and a plastic basin to be used for his catheter bag when R11 is sitting in his recliner. • R11's catheter privacy bag strap was adjusted on his wheelchair by NA-A to prevent the bag from touching the floor on 12-12-2018. • NA-A was re-educated on 12-12-2018 to ensure that R11's catheter bag is kept in a privacy bag when in recliner and kept in a plastic basin to prevent bag from touching the floor. NA-A was also re-educated on ensuring the catheter privacy bag straps are tight enough on the wheelchair to prevent catheter bag from touching the floor. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents with catheters have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be re-educated on the Catheter Care Policy and Dignity Policy, including addressing the need to ensure all residents with catheters have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 12/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 independently. R11's catheter bag was placed in a cloth privacy bag under wheelchair. Cloth privacy bag was resting on the floor. On 12/11/18, at 9:30 a.m. Staff were observed wheeling R11 in wheelchair out of the dining area and to his room, cloth privacy bag was dragging on the floor under the wheelchair. On 12/11/18, at 10:21 a.m. R11 was observed sitting in his room in recliner with door open. R11's call light was on his lap within reach and watching television. R11's Foley catheter bag was not in a privacy bag, it was exposed and visible from hallway, and was resting on the floor under the footrest of the recliner. R11's Foley catheter bag was approximately 1/3 full with bright, clear yellow urine in the tubing and bag. On 12/12/18, at 7:05 a.m. R11 was observed sitting in his wheelchair in the main dining room. R11's catheter bag was in a cloth privacy bag. Cloth privacy bag was secured under his wheelchair, but resting on the dining room floor. On 12/12/18, at 12:00 p.m. R11 was observed sitting in main dining room eating lunch independently. R11's catheter bag was in a cloth privacy bag. Cloth privacy bag was secured under his wheelchair, but resting on the dining room floor. On 12/12/18, at 12:41 p.m. R11 was observed sitting in his room in recliner with door open. Foley catheter bag was not in a privacy bag, it was exposed and visible from hallway. R11's Foley catheter bag was approximately 1/2 full with bright clear yellow urine in the tubing and bag. Foley catheter bag was resting on the floor under	F 550	proper coverage of their catheter bag for dignity and that catheter bags are not touching the floor. • All residents with catheters will be assessed to ensure they have privacy bags for their catheters. They will also be assessed to ensure that there catheter privacy bag straps are tight enough so the bag is not touching the floor when in wheelchair and will ensure that a plastic basin is provided in room for those that the catheter bag hang where they touch the ground. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random privacy audits and proper placement of catheter bags, that will include observation of residents with catheter bags in rooms and other public areas at various times, will be completed by DON/designee daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter, to ensure privacy and proper placement is being provided for all residents with catheters, beginning the week of 01-07-2019. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 01-21-2019	

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	245245	A. BUILDING _____ B. WING _____	C 12/13/2018

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F 550	Continued From page 4 the footrest of the recliner. NA-A stated, that placing the catheter bag on the floor and without a cloth bag was the way R11's catheter care was to be completed. NA-A went on to state, that until she is told to do it differently, this is how she will complete the care. On 12/12/18, at 1:47 p.m. the director of nursing (DON) was interviewed and verified R11's catheter bag was to be placed in a privacy bag to maintain dignity. The facility's Dignity Policy, revised on 10/17, directed staff to provide care that would avoid anything that could be demeaning to the resident and to place catheter bags in a covered bag so the catheter bag would not be easily visible. The facility's undated Catheter Care Policy, directed staff to use a cloth storage bag to cover a catheter drainage bag while patient was up in wheelchair and in bed.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an assessment for self-administration of medication was completed to ensure the ability to safely self-administer eye drops for 1 of 2 residents (R49) reviewed for self administration of medication.	F 554	F554: It's Heritage Manor's policy to allow appropriate self-administration of medication to our residents. DON and/or designee will implement corrective action for resident R49 affected by this practice by:	1/21/19

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F 554	Continued From page 5 Findings include: R49's annual Minimum Data Set (MDS) dated 4/03/2018, indicated R49 was moderately cognitively impaired. R49 had diagnoses, which included arthritis, dementia, and Parkinson's (progressive nervous system disorder that affects movement). R49's quarterly Minimum Data Set (MDS) dated 12/4/18, indicated R49 required extensive assistance of one staff with dressing and grooming. During observations on 12/11/18, at 10:05 a.m. R49 was observed sitting in his room. No staff were present. Two unlabeled bottles of Systane (Lubricant Eye Drops) were located in view, next to R49's television. During follow up observations on 12/12/18, at 7:26 a.m. the two bottles of Systane remained next to R49's television. R49 stated when his eyes became dry or itchy, he self administered the eye drops to both eyes. R49 stated he administered the drops 1-2 times a day. When asked how many drops R49 administered, R49 replied "whatever comes out of the bottle." Review of R49's record lacked an order for Systane eye drops and documentation of administration of the drops. An undated self-administration assessment in R49's electronic medical record was blank. Registered nurse (RN)-A entered R49's room upon the surveyors request at 8:36 a.m. on	F 554	• RN staff will obtain an order for eye gtts for R49 and a self-administration of medication assessment was completed on 01-03-2019. MD will be faxed for order if appropriate to keep at bedside. R49 Care Plan and eMAR will be updated to reflect any necessary changes. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents have the potential to be affected by this practice. All residents' rooms will be audited for medications. If any are found, nursing will check to ensure that the resident has orders for that medication, that they are appropriate to self-administer that medication, and that they have orders to keep at bedside. If not, these medications will be removed immediately and orders will be sought for the medication and residents will be assessed for appropriateness to self-administer the meds and to keep at bedside. If yes, those orders will be obtained by the MD to keep at bedside. DON and/or designee will implement measures to ensure that this practice does not recur including: • All nursing staff will be educated on the Self-Administration of Medication Policy. Education will also be provided to NARs that if they see medication in a residents' rooms, to notify the nurse or if licensed nurse then they need to look at the eMAR, to ensure that the resident has an order for that medication, that they are	

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F 554	Continued From page 6 12/12/18. When asked about the 2 bottles of Systane located by R49's television, RN-A picked up the 2 bottles and stated "I never knew they were in his room". RN-A stated R49 did not have an order for the eye drops. RN-A went on to say the drops should not be in R49's room. RN-A informed R49 she would request an order from the physician and removed the 2 bottles from R49's room. RN-A stated nursing assistants are to let the nurse know if medication are observed in a resident's room. RN-A reviewed R49's medical record and stated R49 did not have an order for Systane eye drops and did not have an assessment completed for self-administration of medication. During an interview at 8:49 am on 12/12/18, the director of nursing (DON) stated all self-administered medications need to have a self administration risk assessment completed by a nurse. The interdisciplinary team (IDT) reviews the assessment and notifies the physician for a self-administration order if deemed safe and appropriate. The DON further stated if a nursing assistant observes medication in a resident's room and is unsure if the resident self-administers medication, the nursing assistants are to notify the nurse of the medication. A facility policy Self-Administration of Medication by Residents dated reviewed/revised on 1/8/18, indicated all residents will be asked if they wish to self-administer medications upon admission. If residents wish to self-administer medications they will be assessed for their ability to self-administer medications. A Self Administration of Medications (SAM) assessment will be completed and	F 554	appropriate to self-administer that medication, and that they have an order to keep at bedside. Any medication that is found, without a self-administration of medication assessment completed and order to keep at bedside, will be removed until assessed. Any changes with residents plan of care will be updated in the electronic medical record and care plan as needed by the Charge Nurse. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random room audits will be completed by DON/designee daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter, to ensure medications are not in rooms without the proper self-administration of medication orders, beginning the week of 01/07/19. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 01-21-2019	

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F 554	Continued From page 7 reviewed by the IDT and will include: - Cognitive status - Physical status - Which medications are appropriate to be self-administered - Where the medications will be stored - How the nursing staff will monitor the medication's use - How it will be documented If resident is clinically appropriate interventions will be put in place to accommodate wishes. A periodic re-assessment by IDT of the clinically appropriate of self-administer medications. Residents will be permitted to retain medications in the room if approved by IDT and ordered by physician. Nursing staff will ensure the electronic medical record (EMAR) and care plan reflects the resident's self-administration of medications.	F 554		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure all residents were free from financial exploitation, when nursing staff took resident's medications, specifically antacids and Tylenol for personal use. This had the potential to affect all residents who had orders for antacids or Tylenol while in facility.	F 602	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 by this practice by:	1/21/19

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F 602	Continued From page 8 Findings include: During review of the medication cabinet in the medication storage area of the 100 wing on 12/11/18, at 1:41 p.m., there were 7 generic Tums antacid bottles with the pharmacy labels torn off, additionally there were 2 Tylenol bottles with pharmacy labels torn off. During an interview on 12/11/18, at 1:41 p.m. licensed practical nurse (LPN)-C stated unable to determine who took the labels off of the antacids or Tylenol bottles, when the labels were removed or which residents the medications belonged to before the labels were removed. LPN-C stated staff were using the antacids and Tylenol for personal use and did not know how long the antacids and Tylenol had been in the storage cabinet without labels. During an interview on 12/11/18, at 1:41 p.m. LPN-B stated LPN-B was unable to determine who took the labels off the antacids or Tylenol bottles, when the labels were removed, and who the medications belonged to before the labels were removed from the antacids or Tylenol bottles. LPN-B stated LPN-B was unaware how long these medications were in the storage cabinet without labels and was unaware that staff were using the Tylenol and antacids for personal use. During interview on 12/13/18, at 12:02 p.m. the director of nursing (DON) stated the nurses should not be removing labels from any medications. The DON stated if medications can not be returned to the pharmacy, the nurses should put those medications in a destruction bin.	F 602	• Unable to determine specific residents due to label's missing. All medications with missing labels will be destroyed per company policy. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents have the potential to be affected by this deficient practice. Any medication that is discontinued or a resident passes away that the pharmacy does not take back, must be destroyed per company policy. DON and/or designee will implement measures to ensure that this practice does not recur including: • All Licensed Nursing staff will be re-educated on the Drug Diversion Policy and Medication Destruction Policy, including how to properly destroy all medications that the pharmacy does not accept back, that resident medication is never utilized for staff use, and that we should not be removing resident labels from medication containers. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits of the medication rooms and medication carts will be completed to ensure all medications have appropriate labels for current residents and to ensure medications are being	

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F 602	Continued From page 9 The DON also stated nurses should not be taking resident medications for any reason and she was unaware this was happening in facility. During interview on 12/13/18, at 3:22 p.m. the Administrator stated he was unaware nurses were removing labels from resident medications and taking them for personal use. The Administrator stated medications that can not be returned to pharmacy need to be destroyed. The administrator stated he is not sure how many residents this practice affected. During record review on 12/13/18, the Medication Administration Record (MAR) for residents currently in facility indicated 6 residents were receiving antacids and 2 residents were receiving Tylenol. The facility Medication Destruction Policy dated 4/4/16 indicated the facility was to ensure unused medications are disposed of in a timely, efficient manner depending on individual circumstances. The Medication Destruction Policy also indicates current medications, except controlled substances belonging to the resident must be given to the resident or the resident's current guardian or designated representative, when discharged or transferred. The facility Drug Diversion Policy dated 4/4/16, indicated examples of drug diversion, including but not limited to using or taking possession of medication waste, i.e. left over medication. The facility Skilled Nursing Facility Maltreatment Reporting Guidelines dated 5/17/18, indicated the organization will report any allegations of maltreatment of a vulnerable adult residing in	F 602	destroyed appropriately, daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter, beginning the week of 01-07-2019. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 01-21-2019	

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F 602	Continued From page 10 care center to appropriate authorities and all alleged violations involving abuse, neglect, exploitation, or maltreatment including injuries of unknown source and misappropriation of resident property, will be reported immediately to administrator of the care center and to the appropriate officials.	F 602		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an intervention of timely repositioning for 1 of 2 residents (R47) reviewed who was at risk for pressure ulcers. Findings include: A Progress Note dated 10/25/18, indicated prior to admission to the facility the resident had a pressure ulcer, which was currently healed.	F 686	F686: It's Heritage Manor's policy to provide treatment and services to prevent pressure ulcers. DON and/or designee will implement corrective action for resident R47 affected by this practice by: • R47 NAR task list will be reviewed to ensure that correct reposition plan is in place. • NA-C will be educated on following resident's plan of care for repositioning.	1/21/19

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F 686	Continued From page 11 R48's annual Minimum Data Set (MDS) dated 11/6/18, identified R48 was cognitively intact. R48 required extensive assistance for transferring, toileting, bed mobility, dressing and personal hygiene. R48 had no pressure ulcers. R48 was at risk for pressure ulcers. R48's care plan dated 11/9/18, indicated R48 required assistance with bed mobility. R48's care plan directed staff to inspect skin weekly, observe skin daily with cares, moisturizing lotion with cares, observe skin for dryness and bruising, and observe feet for evidence of problems. The care plan directed to reposition every 2 hours. A Tissue Tolerance Test (TT) Repositioning Observation dated 11/18/19, indicated R48 had no concerns noted for current skin integrity. Results of R48's Tissue Tolerance indicated to reposition R48 every 2 hours when laying or sitting. R48's Comprehensive Skin Assessment dated 11/28/18, indicated R48 had no pressure ulcers. R48 was at moderate risk for pressure ulcer development. During continuous observations starting at 8:20 am on 12/13/18, the following was observed. - 8:19 a.m. received daily task list from staff. List indicated to reposition R48 every 2 hours. - 8:20 a.m. R48 in room in wheelchair watching TV. R48 was sitting on a black cushion - 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. - 8:57 a.m. LPN-A entered R48's room and provided R48 with water. LPN-A did not offer or	F 686	DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents at risk for pressure ulcers have the potential to be affected by this deficient practice. • All residents at risk for pressure ulcers will have their NAR task list and care plan reviewed to ensure accurate individualized repositioning plans. DON and/or designee will implement measures to ensure that this practice does not recur including: • All NAR staff will be re-educated on the Skin Ulcer Protocol policy, in regards to the importance of following the individualized repositioning plans in place for each resident on their NAR task list to prevent pressure ulcers. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits will be completed at various times in bed and w/c to ensure the care plan is being followed for repositioning, daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter, beginning the week of 01-07-2019. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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F 686	Continued From page 12 provide repositioning. - 9:12 a.m. R48 in wheelchair self-locomotion into common room looking at magazines. - 9:51 a.m. R48 remains in wheelchair sitting next to wall heater. - 10:19 a.m. R48 remains in wheelchair by wall heater. - 10:35 a.m. R48 remains in wheelchair, moved from wall heater to television. - 10:46 a.m. staff approached R48 for his meal choices. No repositioning offered or provided. - 11:09 a.m. R48 remains in wheelchair at a table. No staff offered or repositioned R48 between 8:20 a.m. and 11:09 a.m. (2 hours and 49 minutes). During and interview at 11:18 a.m., on 12/13/18, R48 stated staff last assisted him up at 7:30 a.m. R48 stated staff sometimes ask him if he wants to lay down. R48 does not recall how often the staff ask him. Following observations, on 12/13/18, at 11:22 a.m. the surveyor approached nursing assistant (NA)-C. NA-C stated staff are not assigned residents. When asked how she knows when and what cares each resident needs, NA-C walked to the laundry cart and returned with an untitled document. The form identified columns for resident name, toileting plan, time, and fall/skin interventions. The form did not identify intervention of repositioning for R48. Times of 9:08 a.m. and 11:05 a.m. were written in the column next to R48's name. These times were during constant observations, when no staff offered or repositioned R48. NA-C stated a co-worker must have documented the times for toileting. NA-C went on to say R48 could move	F 686	Completion Date: 01-21-2019	

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F 686	Continued From page 13	F 686		

himself around in the wheelchair and was not on a repositioning schedule.

At surveyor's request, at 11:41 a.m. on 12/13/18, Registered nurse (RN)-B and NA-C entered R48's room to reposition R48 and assess R48's buttocks. RN-B and NA-C used a stand lift to assist R48 into a standing position. RN-B removed R48's incontinent brief. RN-B stated "it looks pretty red". The area was blanchable with intact skin. RN-B and NA-C assisted R48 on toilet with the stand lift. RN-B stated she will call the physician for an order for crème to the buttocks. RN-B informed R48 he should ask for assistance for off-loading more often.

During an interview at 1:09 p.m. on 12/13/18, the director of nursing (DON) stated if aides or staff have concerns about skin integrity they email assistant director of nursing (ADON). ADON does a skin assessment and notified physician and family to get treatment started. ADON reviews the plan and has the final decision on the plan of care. DON stated all mattresses in facility are pressure reducing. Nursing assistants are to use the task list, which directed to reposition R48 every 2 hours. Facility staff are required to follow care plans.

A facility policy Skin Ulcer Protocol dated 11/1/15, residents identified at moderate to high risk of by the Braden scale will have a comprehensive pressure ulcer risk assessment to determine appropriate, individualized interventions for prevention and treatment of pressure/skin ulcers. (Pressure relief mattress, pressure relief cushion in chair turn and reposition schedule and heel protectors). Residents will receive daily

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 14 assessment and monitoring of skin concerns.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide appropriate restorative equipment for 1 of 1 residents (R24) reviewed for range of motion services. Findings include: R24's face sheet indicated R24's diagnosis included cerebrovascular disease and hypertension. R24's annual Minimum Data Set (MDS) dated 7/24/18, indicated R24 was an extensive to total assist with activities of daily living (ADL's). The	F 688	F688: It's Heritage Manor's policy to prevent decrease in ROM mobility. DON and/or designee will implement corrective action for resident R24 affected by this practice by: • Occupational Therapy orders to evaluate and treat for R24 were obtained on 12/14/18. • Care Plan and NAR Task List will be updated to reflect Occupational Therapy recommendations. • NA-D, NA-E, NA-F, LPN-D, and RN-C will be educated on following resident's	1/21/19

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	245245	A. BUILDING _____ B. WING _____	C 12/13/2018

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F 688	Continued From page 15 MDS indicated R24's cognition was severely impaired. R24's care plan dated 10/26/18, indicated R24 was unable to express own needs. The care plan indicated R24 received maintenance ROM (range of motion) and was at risk for altered skin integrity. R24's care plan lacked documentation related to R24's application of a right palm protector. R24's functional maintenance plan (FMP) dated 7/13/16, that was hanging up on the inside door of R24's closet indicated don (to put on) right palm protector upon rising in the morning and to wear a right Posey finger contracture cushion (with finger separators), (prevents skin breakdown and support for the contracted hand and decreases risk of skin irritation) at night. During observation on 12/13/18, at 8:25 a.m. R24 was in the dining room sitting in a wheelchair and had no palm protector on the right hand. At 8:39 a.m. staff were observed bringing R24 back to R24's room in w/c no palm protector on her right. During an interview on 12/13/18, at 8:09 a.m. nursing assistant (NA)-D stated R24 does not need to wear the padded thing all day. NA-D stated R24's toileting sheet did not indicated to staff that R24 needed to wear the padded thing at all. During an interview on 12/13/18, at 8:14 a.m. NA-E stated therapy would update the restorative sheet if there were changes to a residents ROM. During an interview on 12/13/18, at 11:05 a.m. licensed practical nurse (LPN)-D stated R24 had	F 688	plan of care for splints/braces. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents that utilize splints/braces have potential to be affected by this practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • All residents who utilize splints/braces will have their plan of care reviewed to ensure the care plan and NAR task list is accurate in comparison to therapy recommendations and that the therapy recommendation is placed inside the resident's closet for reference. • Splinting Policy was reviewed and revised as necessary. • All Nursing Staff will be re-educated on the Splinting Policy, in regards to ensuring that we are following resident's plan of care for application of any splints/braces. • All Charge Nurses will be re-educated to ensure that resident care plans and NAR task lists are kept up to date with all therapy recommendations regarding splints/braces and that a copy of the therapy recommendation is placed in the residents closet. DON and/or designee will monitor corrective actions to ensure the	

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F 688	Continued From page 16 the palm protector discontinued over six months ago. 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. During an interview on 12/13/18, at 11:18 a.m. the occupational therapist, registered (OTR) stated R24 had a complete evaluation on 7/13/16, for the palm protector to be worn every day all day while awake. OTR stated there were no changes that had been made to R24 wearing the palm protector. The OTR stated the staff have been trained on how to apply the palm protector and the mentor employees should train the new staff on how to apply the palm protector. The OTR stated the nurses should know about the palm protector when we give them the therapy sheet and then they should add the information to the task list for the NA's. During an interview on 12/13/18, at 11:38 a.m. with NA-F stated R24 does not have a palm protector on the to do list so I do not have to put a palm protector on R24. During an interview on 12/13/18, at 11:45 a.m. the director of nursing (DON) stated the nurses would update the task list for the NA's to complete the therapy recommendation. The DON stated the NA's should have been trained to put the palm protector on R24 after morning cares. The facility Splinting Policy, undated, indicated splinting is used to protect joints and surrounding tissue. The Splinting Policy also indicated	F 688	effectiveness of these actions including: • Random audits will be completed to ensure that splints/braces are being applied per plan of care daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter. Random audits will include ensuring that care plans and NAR task lists reflect therapy recommendations and that a copy of the therapy recommendation is placed in the residents closet, beginning the week of 01 -07-2019. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 01-21-2019	

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F 688	Continued From page 17 directions for splinting will be documented on the care plan and education posted inside resident's closet.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		1/21/19

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F 690	Continued From page 18 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the faciltiy failed to ensure a urinary catheter drainage bag was kept elevated off the floor at all times and the Foley catheter port was properly cleaned after emptied to prevent urinary tract infections for 1 of 3 residents (R11) reviewed for catheter. Findings include: R11's Face Sheet dated 6/28/18, indicated diagnoses that included obstructive & reflux uropathy (a structural or functional hindrance or normal urine flow). R11's current Care Plan dated 10/27/18, indicated R11 was at risk for complications such as urinary tract infection (UTI) related to a Foley catheter, secondary to benign prostatic hyperplasia (BPH), a prostate gland enlargement causing difficulty in urination. R11's current Care Plan dated 10/27/18, indicated catheter care instructions for Certified Nursing Assistants (NA). Instructions included, NA staff was to empty catheter bag using aseptic technique, keep catheter bag below the level of the bladder, keep catheter bag in a privacy bag when up in wheelchair (w/c) or in bed, and keep catheter bag off of the floor. Record review of MD orders for R11 indicated R11 was treated with Macrobid 100 mg on 9/22/18, and was discontinued on 9/23/18.	F 690	F690: It's Heritage Manor's policy to protect our residents from bowel/bladder incontinence, catheter, UTI. DON and/or designee will implement corrective action for resident R11 affected by this practice by: • R11's catheter privacy bag strap was adjusted on his wheelchair by NA-A to prevent the bag from touching the floor on 12-12-2018. • NA-A will be re-educated on the Catheter Care Policy and will show competency in Catheter Cares. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents with catheters have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be re-educated on the Catheter Care Policy, including addressing that catheter bags cannot touch the floor. • All residents with catheters will be assessed to ensure that their catheter privacy bag straps are tight enough so the bag is not touching the floor when in wheelchair and will ensure that a plastic basin is provided in room for those that	

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F 690	Continued From page 19 On 12/7/18, R11 was seen by MD for routine follow-up, history of frequent UTIs. No new orders noted for visit. R11's current Physicians Order Sheet dated 12/12/18, included orders for cranberry concentrate capsule, 500 milligram (mg) by mouth at 8:00 a.m. for UTI. On 12/10/18, at 6:26 p.m. R11 was observed sitting in his room, seated in his recliner just to the right of the doorway. R11's door was wide open and Foley catheter bag was visible from the hallway and was not in a privacy bag. R11's catheter bag was approximately 1/3 full with bright, clear yellow urine. R11's catheter bag was resting on the floor under the footrest of the recliner. On 12/11/18, at 8:19 a.m. R11 was observed siting in the main dining room eating breakfast independently. R11's catheter bag was placed in a cloth privacy bag under w/c. Cloth privacy bag was resting on the floor. On 12/11/18, at 9:30 a.m. Staff was observed wheeling R11 in w/c out of the dining area and to his room, cloth privacy bag was dragging on the floor under the w/c. On 12/11/18, at 10:21 a.m. R11 was observed sitting in his room, seated in his recliner just to the right of the doorway. R11's door was wide open and Foley catheter bag was visible from the hallway and was not in a privacy bag. R11's catheter bag was approximately 1/3 full with bright, clear yellow urine. R11's catheter bag was resting on the floor under the footrest of the recliner.	F 690	the catheter bag hang where they touch the ground. • Nursing staff will be re-educated on the Catheter Care Policy. Education will include ensuring that catheter bags are not touching the floor. If in the room, the catheter bag (while in a privacy bag) must be placed in a plastic basin. Education will also include that catheter bag privacy straps on wheelchair must be tight enough where the catheter bag holder is not touching the ground. All Nursing staff will also be educated on catheter cares. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits on catheter cares, will be completed by DON/designee daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter, to ensure proper infection control is being provided for all residents beginning the week of 01-07-2019. • Random audits to ensure proper placement of catheter bags, that will include observation of residents with catheter bags in rooms and other public areas at various times, will be completed by DON/designee daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter, to ensure catheter bags are not touching the ground, beginning the week of 01-07-2019 • Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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F 690	Continued From page 20 On 12/12/18, at 7:05 a.m. R11 was observed sitting in his w/c in the main dining room. R11's catheter bag was in a cloth privacy bag. Cloth privacy bag was secured under R11's w/c but was resting on the dining room floor. On 12/12/18, at 12:00 p.m. R11 was observed sitting in main dining room eating lunch independently. R11's catheter bag was in a cloth privacy bag. Cloth privacy bag was secured under his w/c but was resting on the dining room floor. On 12/12/18, at 12:41 p.m. R11 was observed sitting in his room, seated in his recliner just to the right of the doorway. R11's door wide open and Foley catheter bag was visible from the hallway and was not in a privacy bag. Foley catheter bag was approximately 1/2 full with bright, clear yellow urine. Foley catheter bag was resting on the floor under the footrest of the recliner. NA-A stated, that placing the catheter bag on the floor and without a cloth bag was the way R11's catheter care was to be completed. NA-A went on further to state that until she is told to do it differently, this is how she will do the care. On 12/12/18, at 12:43 p.m. NA-A was asked to demonstrate how R11's catheter bag would be emptied. NA-A washed her hands at the bathroom sink. Put on gloves and went to R11's bed side cabinet to retrieve a urinal. NA-A opened the spout of the catheter and emptied into the plastic portable urinal. NA-A then clipped the port back onto the catheter bag and placed the catheter bag back onto the floor. NA-A then went to the bathroom and flushed the urine into the toilet. NA-A then rinsed the urinal with water and	F 690	Completion Date: 01-21-2019	

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F 690	Continued From page 21 placed back into R11's side cabinet. NA-A took off her gloves and exited the room, leaving R11's catheter bag to rest on the floor. NA-A then exited the room. NA-A was asked if she normally would wash her hands after removing gloves, NA-A replied the facility has stated they can use sanitizer if hands are not visibly soiled. NA-A then applied a liquid hand sanitizer On 12/12/18, at 1:47 DON was interviewed about catheter care and infection prevention. DON stated staff should wash their hands, put on gloves, empty into a graduate or urinal, empty into toilet, wash basin, wipe end of spout with alcohol, remove gloves and wash hands. The DON stated was her expectation for all staff to follow these steps. The DON stated it was her expectation that staff always wipe port end of catheter bag with alcohol, and that this step is important for infection prevention for residents that have catheters. The DON stated staff have access to alcohol wipes, they are located in the storage room. The DON further stated it was her expectation that staff place a residents catheter bag in a privacy bag and elevate off the floor at all times. The facility's Catheter Care Policy, which was undated, indicates staff are to ensure drainage bag was not touching the floor. Staff are to place a barrier between the floor and collection device when emptying drainage bag. When draining a catheter bag, staff are to cleanse spout with alcohol wipe once completed prior to re-clamping spout. Staff are instructed to remove gloves and wash hands when finished with the task.	F 690		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		1/21/19

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F 732	Continued From page 22 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 732		

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F 732	Continued From page 23 Based on interview and document review, the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect any of the 62 residents residing in the facility and/or their visitors who may wish to view this information. Findings include: When reviewing the facility's daily nursing hour postings for 11/01/18 - 12/12/18, the daily postings were noted to be blank on the afternoon shift for 18 out of 30 days in November, and 3 out of 13 days for December's postings. When interviewed on 12/13/18, at 12:28 p.m. director of nursing (DON) stated daily nurse staff posting is completed by the morning nurse, the afternoon spot is supposed to be completed by the afternoon nurse. The afternoon is left blank in the morning just in case there would be call-ins the posting would change. The nurse consultant (NC) stated that the required nurse staff posting information needs to be completely filled out every morning and changes need to be made to it if there are call-ins throughout the day, the NC went on to say it needs to be filled out in real time so it is kept current. A policy was requested, none received.	F 732	F732: It's Heritage Manor's policy to post nurse staffing information DON and/or designee will implement corrective action for resident affected by this practice by: • Unit 1 Nurse Manager was educated to fill in all nursing hours for the day, on the staff posting sheet, at the beginning of their shift on 12-12-2018. • Unit 2 Nurse Manager was educated to fill in all nursing hours for the day, on the staff posting sheet, at the beginning of their shift if Unit 1 Nurse Manager is not working on 01-03-2019. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents have the potential to be affected by this practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • Nurse Staffing Posting Policy was created on 01-03-2019. All Nursing staff will be educated on the Nurse Staffing Posting Policy, including who is responsible for completing this form and how to accurately complete this form. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits of the nursing staff	

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F 732	Continued From page 24	F 732	hour posting will be completed daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter, to ensure nursing staff posting is completed beginning the week of 01-07-2019. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: 01-21-2019	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain correct rinsing temperature to ensure heat sanitation of dishes.	F 812	F812: It's Heritage Manor's practice to provide safe and satisfactory food under sanitary conditions according to	1/21/19

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F 812	Continued From page 25 This deficient practice had the potential to affect 62 of 62 residents. 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". During observations on 12:43 p.m., on 12/12/18, with dietary manager (DM) and dietary aide (DA)-A, placed a rack of dirty cups into the dishwasher. The rinse temperature reached 172 degrees Fahrenheit (F). DM stated it was the correct rinse temperature. DM was directed to the Dishwasher Temperature Log, located on the wall in the dishwasher room. The log indicated a final rinse temperature needed to be 180 degrees. When asked what is done when the temperature is out of range, DM stated maintenance is to be notified. DA-A placed the rack of cups into the dishwasher for a second time. The Final rinse temperature reached 182 degrees. Surveyor pointed out Dishwasher Temperature Log, noted in the left lower section of the form * Acceptable temp ranges: WHEN OUTSIDE of acceptable ranges (wash 140-160) F and final rinse 180 F), notify dietary manager and environmental services director IMMEDIATELY. Upon further review of the December 2018 Dishwasher Temperature Log with DM, several documented temperatures below 180 degrees F were recorded on the log. DM stated no staff had notified her about the out of range temperatures and was unaware the temperatures were out of range. DM stated the facility gets dishwashing chemicals from Hillyard (a manufacturer and	F 812	appropriate rules and regulations. Dietary Manager and/or designee will implement corrective action for resident affected by this practice by: • Residents currently are served meals in a sanitary manor. • Environmental Service Director inspected dishwasher and ran several cycles and all rinse temps were above 180 degrees. Dietary Manager and/or designee will assess residents having the potential to be affected by this practice including: • All residents have the potential to be affected by this deficient practice. Dietary Manager and/or designee will implement measures to ensure that this practice does not recur including: • Dishwasher temperature policy was updated. • Dietary staff will be re-educated on dishwasher temperature policy to include completing logs and notifying dietary manager of any temperatures that do not meet the limits. Dietary Manager and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random kitchen audits, that will include observation for soiled pans/dishware in clean storage areas and dishwasher temps, will be completed by	

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	245245	A. BUILDING _____ B. WING _____	C 12/13/2018

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F 812	Continued From page 26 distributor of cleaning and hygiene solutions). Hillyard services the dishwasher on a monthly basis. Hillyard Kitchen Reports dated 9/7/18 identified a rinse temperature of 184 degrees F. A 10/31/18 report identified a rinse temp of 185 degrees F. Both, above the minimum of 180 degrees F. However, review of the facility's December Temperature Log for dates 12/1/18 to 12/12/18, identified 15 of 29 times, final rinse temperatures were below 180 degrees F. A column on the log for action taken was blank. During an interview at 12:59 p.m. on 12/12/18, when asked about the 3 baking pans C-B had placed in the dishwashing room earlier when she stated the need for a new dishwasher, C-B stated she was making cornbread and each pan she took out of the clean storage area was dirty. During interview at 11:57 a.m. on 12/12/18, DA-A stated temperature logs are filled out once per shift at breakfast, lunch, and dinner for the wash cycle and rinse cycle temperatures. During a follow up interview at 12:05 p.m. on 12/12/18, DA-A reviewed the December temperature log, stating she worked 12/2/18 to 12/6/18. For all 5 days, the rinse temperature was documented below 180 degrees F. DA-A stated DM is to be contacted when temperatures are out of range. DA-A stated she did not notify DM with the out of range temperatures. During an interview via phone with Hillyard sales representative (SR)-A at 1:26 p.m. on 12/12/18, SR-A stated he would need to find out the minimum final rinse temperature and call back.	F 812	Dietary Manager/designee daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter, to ensure privacy is being provided for all residents as needed beginning the week of 01-07-2019. • Audit results will be brought to the QAPI committee for review and further recommendation. Completion Date: 01-21-2019	

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F 812	Continued From page 27 During an interview on 1:30 p.m. on 12/12/18, DM stated SR-A called and stated 180 degrees F was the minimum final rinse temperature needed. Hobart Instruction Manual Model AM-14C-dishwasher-undated, directed: Sterilizing Mode Wash Rinse Hot water 150 F Celsius (66 C) 180 F (82 C) A policy regarding the monitoring of dishwasher temperatures was requested and provided.	F 812		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure headboards were safe and in good repair in 4 of 8 resident rooms (309, 310, 312, 313), a footboard was in good repair and free from sharp edges in 1 of 8 rooms (310), and walls were free from gouges and were in homelike appearance in 1 of 8 rooms (310) reviewed for environment. Findings include: On 12/13/18, at 8:15 a.m. all rooms on unit 1 were checked for any maintenance issues. The inspection of all rooms reveled that the	F 921	F921: It's Heritage Manor's policy to provide our residents with a safe/comfortable environment. Environmental Service Director and/or designee will implement corrective action for resident affected by this practice by: • Headboards were fixed in room 309, 310, 312, and 313. • Footboard was replaced in room 310. • Walls were repaired and painted in room 310. • Foam on bed rail was removed in room 310.	1/21/19

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F 921	Continued From page 28 headboards in rooms 309, 310, 312, 313 were all leaning at approximately a 30 degree angle. Room 310 also had extensive areas on the walls that were nicked and in need of painting. On 12/13/18, at 9:07 a.m. a tour with the environmental service director (ESD) of unit 1 was completed. ESD stated the process that all staff were to follow to inform him of the facilities maintenance needs. ESD stated there was a maintenance log book located at both nurses' stations for staff to write down any maintenance issues. ESD stated he checks the books every hour and then addresses the needs such as burnt out lights, TV issues, mattress issues etc. A maintenance log book, red in color, was located at the nurses' station and reviewed. The review of the maintenance log books revealed there was no entries from staff reguarding the headboards or walls needing ESD to address repairs. On 12/13/18, at 9:09 a.m. ESD was asked about his routine for checking rooms and equipment to ensure all were in good repair and he stated, he went only by the log books. ESD further stated, he felt the maintenance of the building was too much for one person to handle and he was overwhelmed. ESD stated he did look over a room quickly for repairs when he was in the room. ESD also stated he would meet with new staff at their new employee orientation, and informed new employees to make maintenance aware of any issues by way of the maintenance log books located at the nurses station. On 12/13/18, at 9:10 ESD went into room 310 to verify the maintenance issues found during observation. ESD verified the foot of bed was heavily nicked and scraped. ESD stated this	F 921	Environmental Service Director and/or designee will assess residents having the potential to be affected by this practice including: • All residents with have the potential to be affected by this deficient practice. • Facility wide audit will be performed on 01-04-2019, noting any beds and rooms that are in need of repair. Environmental Service Director and/or designee will implement measures to ensure that this practice does not recur including: • Building Maintenance policy was updated and reviewed to include weekly rounds by ESD or designee. • Nursing staff will be re-educated on Building Maintenance policy to inform Environmental Services of issues regarding bed repair, wall repair, and other equipment repair needs by writing in maintenance logs located at each unit. Environmental Service Director and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Building walk through audits, that will include observation of residents rooms and equipment, will be completed by ESD/designee daily for 1wk, 3x/wk. for 2 weeks, 2x/wk. for 2 weeks, and then monthly thereafter, to ensure privacy is	

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F 921	Continued From page 29 would be something he would want to be made aware of. ESD stated the sharp edges come from staff ramming the loft equipment into items in the room. ESD verified the headboards were leaning at approximately a 30 degree angle towards the mattress. ESD stated the headboards are broken from staff not lowering the beds properly when pulling the beds away from the wall. ESD verified these maintenance issues would be something he should be made aware of by the facility staff via the maintenance log books located at both nurses stations. In room 310 the metal bed frame had ablack piece of foam taped around the right side of the bed frame. The foam was approximately 12 inches in length and torn on both ends. ESD was asked if this was something he would want to be made aware of, ESD stated yes. He further stated the torn foam padding was not a cleanable surface. On 12/13/18, at 9:26 a.m., review of the maintenance log books revealed no entries had been made for repairs or concerns regarding the need for room maintenance of furniture repairs. Maintenance log books were reviewed for the past 120 days. During the unit 1 tour on 12/13/18, at 9:33 a.m. headboards in room 309, 310, 312, 313, all appear to be bent, leaning forward, toward the resident's head or pillow at a 30 degree angle. ESD was made aware of the number of rooms with this issue in unit 1 hallway. Unit 1 hallway included rooms 301-313. ESD verified the findings in each room. On 12/13/18, at 9:38 a.m. the administrator was asked about a schedule for maintenance to	F 921	being provided for all residents as needed beginning the week of 01-07-2019. • Audit results will be brought to the QAPI committee for review and further recommendation. Completion Date: 01-21-2019	

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F 921	Continued From page 30	F 921		

routinely check to ensure rooms and furniture are in good repair. The Administrator stated there is not a schedule or tracking, ESD is checking the maintenance log books on the units every hour. He stated the facility does not have an assistant or additional staff besides ESD to address the facilities maintenance issues. Administrator stated the previous maintenance assistant resigned in October 2018. The former assistant has been helping the ESD when available per her new position as a nursing assistant (NA). Administrator also verified the log books were the way staff were to communicate to ESD when needs arise. He further stated, the lack of information provided in the books regarding room issues such as walls and furniture, would result in ESD not being aware of these issues. Administrator verified the expectation would be for staff to report furniture and resident room maintenance concerns to ESD, and for ESD to note which rooms were in need of maintenance and repair. Administer stated this was something maintenance should be taking care of.

The undated facility Building Maintenance Policy indicated the facility was to maintain a clean and homelike environment for the residents and guests. The policy directed the Environmental Service Director (ESD) to perform monthly room/building inspections and when a resident moved to another room or was discharged from the facility. The policy further directed all staff to be attentive to facility surroundings during the work day for areas of building that need repair and write need in maintenance log. ESD was to maintain maintenance log, and sign and date when project was completed in log.

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/10/18 - 12/13/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide appropriate restorative equipment for 1 of 1 residents (R24) reviewed for range of motion services. Findings include: R24's face sheet indicated R24's diagnosis included cerebrovascular disease and hypertension. R24's annual Minimum Data Set (MDS) dated	2 890	Corrected	1/21/19

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2 890	Continued From page 3 7/24/18, indicated R24 was an extensive to total assist with activities of daily living (ADL's). The MDS indicated R24's cognition was severely impaired. R24's care plan dated 10/26/18, indicated R24 was unable to express own needs. The care plan indicated R24 received maintenance ROM (range of motion) and was at risk for altered skin integrity. R24's care plan lacked documentation related to R24's application of a right palm protector. R24's functional maintenance plan (FMP) dated 7/13/16, that was hanging up on the inside door of R24's closet indicated don (to put on) right palm protector upon rising in the morning and to wear a right Posey finger contracture cushion (with finger separators), (prevents skin breakdown and support for the contracted hand and decreases risk of skin irritation) at night. During observation on 12/13/18, at 8:25 a.m. R24 was in the dining room sitting in a wheelchair and had no palm protector on the right hand. At 8:39 a.m. staff were observed bringing R24 back to R24's room in w/c no palm protector on her right. During an interview on 12/13/18, at 8:09 a.m. nursing assistant (NA)-D stated R24 does not need to wear the padded thing all day. NA-D stated R24's toileting sheet did not indicated to staff that R24 needed to wear the padded thing at all. During an interview on 12/13/18, at 8:14 a.m. NA-E stated therapy would update the restorative sheet if there were changes to a residents ROM. During an interview on 12/13/18, at 11:05 a.m.	2 890		

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2 890	Continued From page 4 licensed practical nurse (LPN)-D stated R24 had the palm protector discontinued over six months ago. 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. During an interview on 12/13/18, at 11:18 a.m. the occupational therapist, registered (OTR) stated R24 had a complete evaluation on 7/13/16, for the palm protector to be worn every day all day while awake. OTR stated there were no changes that had been made to R24 wearing the palm protector. The OTR stated the staff have been trained on how to apply the palm protector and the mentor employees should train the new staff on how to apply the palm protector. The OTR stated the nurses should know about the palm protector when we give them the therapy sheet and then they should add the information to the task list for the NA's. During an interview on 12/13/18, at 11:38 a.m. with NA-F stated R24 does not have a palm protector on the to do list so I do not have to put a palm protector on R24. During an interview on 12/13/18, at 11:45 a.m. the director of nursing (DON) stated the nurses would update the task list for the NA's to complete the therapy recommendation. The DON stated the NA's should have been trained to put the palm protector on R24 after morning cares. The facility Splinting Policy, undated, indicated splinting is used to protect joints and surrounding tissue. The Splinting Policy also indicated	2 890		

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2 890	Continued From page 5 directions for splinting will be documented on the care plan and education posted inside resident's closet. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could audit resident splints and braces to ensure they are being applied consistent with care planned instructions. The director of nursing or designee could educate all staff on facility policies and procedures related to range of motion and splint services, and revise them as needed. The director of nursing or designee could bring results of audits to the facility quality assurance committee for further recommendations and follow up. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores	2 900		1/21/19

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2 900	Continued From page 6 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an intervention of timely repositioning for 1 of 2 residents (R47) reviewed who was at risk for pressure ulcers. Findings include: A Progress Note dated 10/25/18, indicated prior to admission to the facility the resident had a pressure ulcer, which was currently healed. R48's annual Minimum Data Set (MDS) dated 11/6/18, identified R48 was cognitively intact. R48 required extensive assistance for transferring, toileting, bed mobility, dressing and personal hygiene. R48 had no pressure ulcers. R48 was at risk for pressure ulcers. R48's care plan dated 11/9/18, indicated R48 required assistance with bed mobility. R48's care plan directed staff to inspect skin weekly, observe skin daily with cares, moisturizing lotion with cares, observe skin for dryness and bruising, and observe feet for evidence of problems. The care plan directed to reposition every 2 hours. A Tissue Tolerance Test (TT) Repositioning Observation dated 11/18/19, indicated R48 had no concerns noted for current skin integrity. Results of R48's Tissue Tolerance indicated to reposition R48 every 2 hours when laying or sitting.	2 900	Corrected	

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2 900	Continued From page 7 R48's Comprehensive Skin Assessment dated 11/28/18, indicated R48 had no pressure ulcers. R48 was at moderate risk for pressure ulcer development. During continuous observations starting at 8:20 am on 12/13/18, the following was observed. - 8:19 a.m. received daily task list from staff. List indicated to reposition R48 every 2 hours. - 8:20 a.m. R48 in room in wheelchair watching TV. R48 was sitting on a black cushion - 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. - 8:57 a.m. LPN-A entered R48's room and provided R48 with water. LPN-A did not offer or provide repositioning. - 9:12 a.m. R48 in wheelchair self-locomotion into common room looking at magazines. - 9:51 a.m. R48 remains in wheelchair sitting next to wall heater. - 10:19 a.m. R48 remains in wheelchair by wall heater. - 10:35 a.m. R48 remains in wheelchair, moved from wall heater to television. - 10:46 a.m. staff approached R48 for his meal choices. No repositioning offered or provided. - 11:09 a.m. R48 remains in wheelchair at a table. No staff offered or repositioned R48 between 8:20 a.m. and 11:09 a.m. (2 hours and 49 minutes). During and interview at 11:18 a.m., on 12/13/18, R48 stated staff last assisted him up at 7:30 a.m. R48 stated staff sometimes ask him if he wants to lay down. R48 does not recall how often the staff ask him.	2 900		

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2 900	Continued From page 8 Following observations, on 12/13/18, at 11:22 a.m. the surveyor approached nursing assistant (NA)-C. NA-C stated staff are not assigned residents. When asked how she knows when and what cares each resident needs, NA-C walked to the laundry cart and returned with an untitled document. The form identified columns for resident name, toileting plan, time, and fall/skin interventions. The form did not identify intervention of repositioning for R48. Times of 9:08 a.m. and 11:05 a.m. were written in the column next to R48's name. These times were during constant observations, when no staff offered or repositioned R48. NA-C stated a co-worker must have documented the times for toileting. NA-C went on to say R48 could move himself around in the wheelchair and was not on a repositioning schedule. At surveyor's request, at 11:41 a.m. on 12/13/18, Registered nurse (RN)-B and NA-C entered R48's room to reposition R48 and assess R48's buttocks. RN-B and NA-C used a stand lift to assist R48 into a standing position. RN-B removed R48's incontinent brief. RN-B stated "it looks pretty red". The area was blanchable with intact skin. RN-B and NA-C assisted R48 on toilet with the stand lift. RN-B stated she will call the physician for an order for crème to the buttocks. RN-B informed R48 he should ask for assistance for off-loading more often. During an interview at 1:09 p.m. on 12/13/18, the director of nursing (DON) stated if aides or staff have concerns about skin integrity they email assistant director of nursing (ADON). ADON does a skin assessment and notified physician and family to get treatment started. ADON reviews the plan and has the final decision on the plan of	2 900		

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2 900	Continued From page 9 care. DON stated all mattresses in facility are pressure reducing. Nursing assistants are to use the task list, which directed to reposition R48 every 2 hours. Facility staff are required to follow care plans. A facility policy Skin Ulcer Protocol dated 11/1/15, residents identified at moderate to high risk of by the Braden scale will have a comprehensive pressure ulcer risk assessment to determine appropriate, individualized interventions for prevention and treatment of pressure/skin ulcers. (Pressure relief mattress, pressure relief cushion in chair turn and reposition schedule and heel protectors). Residents will receive daily assessment and monitoring of skin concerns. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder	2 910		1/21/19

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2 910	Continued From page 10 management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the faciltiy failed to ensure a urinary catheter drainage bag was kept elevated off the floor at all times and the Foley catheter port was properly cleaned after emptied to prevent urinary tract infections for 1 of 3 residents (R11) reviewed for catheter. Findings include: R11's Face Sheet dated 6/28/18, indicated diagnoses that included obstructive & reflux uropathy (a structural or functional hindrance or normal urine flow). R11's current Care Plan dated 10/27/18, indicated R11 was at risk for complications such as urinary tract infection (UTI) related to a Foley catheter, secondary to benign prostatic hyperplasia (BPH), a prostate gland enlargement causing difficulty in urination.	2 910	Corrected	

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2 910	Continued From page 11	2 910		

R11's current Care Plan dated 10/27/18, indicated catheter care instructions for Certified Nursing Assistants (NA). Instructions included, NA staff was to empty catheter bag using aseptic technique, keep catheter bag below the level of the bladder, keep catheter bag in a privacy bag when up in wheelchair (w/c) or in bed, and keep catheter bag off of the floor.

Record review of MD orders for R11 indicated R11 was treated with Macrobid 100 mg on 9/22/18, and was discontinued on 9/23/18.

On 12/7/18, R11 was seen by MD for routine follow-up, history of frequent UTIs. No new orders noted for visit.

R11's current Physicians Order Sheet dated 12/12/18, included orders for cranberry concentrate capsule, 500 milligram (mg) by mouth at 8:00 a.m. for UTI.

On 12/10/18, at 6:26 p.m. R11 was observed sitting in his room, seated in his recliner just to the right of the doorway. R11's door was wide open and Foley catheter bag was visible from the hallway and was not in a privacy bag. R11's catheter bag was approximately 1/3 full with bright, clear yellow urine. R11's catheter bag was resting on the floor under the footrest of the recliner.

On 12/11/18, at 8:19 a.m. R11 was observed siting in the main dining room eating breakfast independently. R11's catheter bag was placed in a cloth privacy bag under w/c. Cloth privacy bag was resting on the floor.

On 12/11/18, at 9:30 a.m. Staff was observed wheeling R11 in w/c out of the dining area and to

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2 910	Continued From page 12 his room, cloth privacy bag was dragging on the floor under the w/c. On 12/11/18, at 10:21 a.m. R11 was observed sitting in his room, seated in his recliner just to the right of the doorway. R11's door was wide open and Foley catheter bag was visible from the hallway and was not in a privacy bag. R11's catheter bag was approximately 1/3 full with bright, clear yellow urine. R11's catheter bag was resting on the floor under the footrest of the recliner. On 12/12/18, at 7:05 a.m. R11 was observed sitting in his w/c in the main dining room. R11's catheter bag was in a cloth privacy bag. Cloth privacy bag was secured under R11's w/c but was resting on the dining room floor. On 12/12/18, at 12:00 p.m. R11 was observed sitting in main dining room eating lunch independently. R11's catheter bag was in a cloth privacy bag. Cloth privacy bag was secured under his w/c but was resting on the dining room floor. On 12/12/18, at 12:41 p.m. R11 was observed sitting in his room, seated in his recliner just to the right of the doorway. R11's door wide open and Foley catheter bag was visible from the hallway and was not in a privacy bag. Foley catheter bag was approximately 1/2 full with bright, clear yellow urine. Foley catheter bag was resting on the floor under the footrest of the recliner. NA-A stated, that placing the catheter bag on the floor and without a cloth bag was the way R11's catheter care was to be completed. NA-A went on further to state that until she is told to do it differently, this is how she will do the care.	2 910		

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2 910	Continued From page 13 On 12/12/18, at 12:43 p.m. NA-A was asked to demonstrate how R11's catheter bag would be emptied. NA-A washed her hands at the bathroom sink. Put on gloves and went to R11's bed side cabinet to retrieve a urinal. NA-A opened the spout of the catheter and emptied into the plastic portable urinal. NA-A then clipped the port back onto the catheter bag and placed the catheter bag back onto the floor. NA-A then went to the bathroom and flushed the urine into the toilet. NA-A then rinsed the urinal with water and placed back into R11's side cabinet. NA-A took off her gloves and exited the room, leaving R11's catheter bag to rest on the floor. NA-A then exited the room. NA-A was asked if she normally would wash her hands after removing gloves, NA-A replied the facility has stated they can use sanitizer if hands are not visibly soiled. NA-A then applied a liquid hand sanitizer On 12/12/18, at 1:47 DON was interviewed about catheter care and infection prevention. DON stated staff should wash their hands, put on gloves, empty into a graduate or urinal, empty into toilet, wash basin, wipe end of spout with alcohol, remove gloves and wash hands. The DON stated was her expectation for all staff to follow these steps. The DON stated it was her expectation that staff always wipe port end of catheter bag with alcohol, and that this step is important for infection prevention for residents that have catheters. The DON stated staff have access to alcohol wipes, they are located in the storage room. The DON further stated it was her expectation that staff place a residents catheter bag in a privacy bag and elevate off the floor at all times. The facility's Catheter Care Policy, which was undated, indicates staff are to ensure drainage	2 910		

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2 910	Continued From page 14 bag was not touching the floor. Staff are to place a barrier between the floor and collection device when emptying drainage bag. When draining a catheter bag, staff are to cleanse spout with alcohol wipe once completed prior to re-clamping spout. Staff are instructed to remove gloves and wash hands when finished with the task. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise policies and procedures related to catheter care. The DON or designee could provide education on catheter care and audit for compliance of the correct procedures. TIMEFRAME FOR CORRECTION- Twenty one (21) days	2 910		
21160	MN Rule 4658.0675 Subp. 6 Mechanical Cleaning and Sanitizing; Hot Water Subp. 6. Hot water sanitization. Machines using hot water for sanitizing may be used provided that wash water and pumped rinse water are kept clean and water is maintained at not less than the temperature specified by NSF International Standard No. 3, incorporated by reference in subpart 2, under which the machine is evaluated. A pressure gauge must be installed with a valve immediately adjacent to the supply side of the control valve in the final rinse line provided that this requirement does not pertain to a dishwashing machine with a pumped final rinse. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21160	Corrected	1/21/19

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21160	Continued From page 15	21160		

review the facility failed to maintain correct rinsing temperature to ensure heat sanitation of dishes. This deficient practice had the potential to affect 62 of 62 residents.

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".

During observations on 12:43 p.m., on 12/12/18, with dietary manager (DM) and dietary aide (DA)-A, placed a rack of dirty cups into the dishwasher. The rinse temperature reached 172 degrees Fahrenheit (F). DM stated it was the correct rinse temperature. DM was directed to the Dishwasher Temperature Log, located on the wall in the dishwasher room. The log indicated a final rinse temperature needed to be 180 degrees. When asked what is done when the temperature is out of range, DM stated maintenance is to be notified. DA-A placed the rack of cups into the dishwasher for a second time. The Final rinse temperature reached 182 degrees. Surveyor pointed out Dishwasher Temperature Log, noted in the left lower section of the form * Acceptable temp ranges: WHEN OUTSIDE of acceptable ranges (wash 140-160) F and final rinse 180 F), notify dietary manager and environmental services director IMMEDIATELY. Upon further review of the December 2018 Dishwasher Temperature Log with DM, several documented temperatures below 180 degrees F were recorded on the log. DM stated no staff had notified her about the out of range temperatures and was unaware the temperatures were out of range. DM stated the facility gets dishwashing

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21160	Continued From page 16	21160		

chemicals from Hillyard (a manufacturer and distributor of cleaning and hygiene solutions). Hillyard services the dishwasher on a monthly basis.

Hillyard Kitchen Reports dated 9/7/18 identified a rinse temperature of 184 degrees F. A 10/31/18 report identified a rinse temp of 185 degrees F. Both, above the minimum of 180 degrees F. However, review of the facility's December Temperature Log for dates 12/1/18 to 12/12/18, identified 15 of 29 times, final rinse temperatures were below 180 degrees F. A column on the log for action taken was blank.

During an interview at 12:59 p.m. on 12/12/18, when asked about the 3 baking pans C-B had placed in the dishwashing room earlier when she stated the need for a new dishwasher, C-B stated she was making cornbread and each pan she took out of the clean storage area was dirty.

During interview at 11:57 a.m. on 12/12/18, DA-A stated temperature logs are filled out once per shift at breakfast, lunch, and dinner for the wash cycle and rinse cycle temperatures.

During a follow up interview at 12:05 p.m. on 12/12/18, DA-A reviewed the December temperature log, stating she worked 12/2/18 to 12/6/18. For all 5 days, the rinse temperature was documented below 180 degrees F. DA-A stated DM is to be contacted when temperatures are out of range. DA-A stated she did not notify DM with the out of range temperatures.

During an interview via phone with Hillyard sales representative (SR)-A at 1:26 p.m. on 12/12/18, SR-A stated he would need to find out the minimum final rinse temperature and call back.

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21160	Continued From page 17 During an interview on 1:30 p.m. on 12/12/18, DM stated SR-A called and stated 180 degrees F was the minimum final rinse temperature needed. Hobart Instruction Manual Model AM-14C-dishwasher-undated, directed: Sterilizing Mode Wash Rinse Hot water 150 F Celsius (66 C) 180 F (82 C) A policy regarding the monitoring of dishwasher temperatures was requested and provided. SUGGESTED METHOD OF CORRECTION: The dietary manager and/or maintenance director could review and revise policies and procedures related to assessing, monitoring, and documentation of dishwasher temperatures. Dietary staff could be educated on the process of completing dishwasher temps and actions to take when temperatures out of range. The dietary manager and/or could train staff and could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21160		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis	21426		1/21/19

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21426	Continued From page 18 infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 5 residents (R162) and 3 of 5 employees (E-F, E-G, and E-H) had proper documentation of Tuberculin skin testing results as directed by Center for Disease Control (CDC) guidelines. Findings include: R162's face sheet indicated R162 was admitted 11/30/18. R162's medical record included documentation of the initial step tuberculin skin test (TST) on 11/30/18. R162 received the second step TST on 12/4/18. R161's second step TST lacked documentation of the results of the TST.	21426	Corrected	

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21426	Continued From page 19 E-F was hired on 10/24/18, E-F's personnel record included documentation of E-F having received the first and second two step TST. However, the results were not documented in mm of induration for either reading. E-G was hired on 10/29/18, E-G's personnel record included documentation of E-G receiving the first two step on 10/29/18. However, E-G had not received the second TST. E-H was hired on 8/29/18, E-H's personnel record included documentation of a chest x-ray and the reading did not include if the chest x-ray was negative for tuberculosis. During an interview on 12/12/18, at 8:55 a.m. registered nurse (RN)-D stated R162 should have had the second step of the TST. During a later interview at 1:39 p.m. RN-D stated RN-D would read the results of the TST and document induration and write positive or negative on the paper documentation. RN-D stated employees were trained to read the TST by the director of nursing (DON). RN-D indicated E-F, E-G, and E-H's result information was not documented correctly. During an interview on 12/12/18, at 1:56 p.m. the DON stated employees were trained by the DON to read and document the results of the TST. The facility policy Resident Tuberculosis Prevention and Control dated 6/5/17, indicated a TST must be read after 48 hours and before 72 hours of administration. The policy further directed staff to document the number of mm (millimeters) of induration and circle if negative or positive.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00904	A. BUILDING: _____ B. WING _____	C 12/13/2018

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

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21426	Continued From page 20 The facility policy Employee Tuberculosis Prevention and Control dated 6/5/17, indicated if there is no written documentation, they must receive a chest x-ray to exclude a diagnosis of infectious TB disease before having any direct patient contact. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies regarding TB screening, could educate staff and could ensure audits were conducted to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an assessment for self-administration of medication was completed to ensure the ability to safely self-administer eye drops for 1 of 2 residents (R49) reviewed for self administration of medication. Findings include: R49's annual Minimum Data Set (MDS) dated	21565	Corrected	1/21/19

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21565	Continued From page 21	21565		

4/03/2018, indicated R49 was moderately cognitively impaired. R49 had diagnoses, which included arthritis, dementia, and Parkinson's (progressive nervous system disorder that affects movement).

R49's quarterly Minimum Data Set (MDS) dated 12/4/18, indicated R49 required extensive assistance of one staff with dressing and grooming.

During observations on 12/11/18, at 10:05 a.m. R49 was observed sitting in his room. No staff were present. Two unlabeled bottles of Systane (Lubricant Eye Drops) were located in view, next to R49's television.

During follow up observations on 12/12/18, at 7:26 a.m. the two bottles of Systane remained next to R49's television. R49 stated when his eyes became dry or itchy, he self administered the eye drops to both eyes. R49 stated he administered the drops 1-2 times a day. When asked how many drops R49 administered, R49 replied "whatever comes out of the bottle."

Review of R49's record lacked an order for Systane eye drops and documentation of administration of the drops. An undated self-administration assessment in R49's electronic medical record was blank.

Registered nurse (RN)-A entered R49's room upon the surveyors request at 8:36 a.m. on 12/12/18. When asked about the 2 bottles of Systane located by R49's television, RN-A picked up the 2 bottles and stated "I never knew they were in his room". RN-A stated R49 did not have an order for the eye drops. RN-A went on to say the drops should not be in R49's room. RN-A

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21565	Continued From page 22	21565		

informed R49 she would request an order from the physician and removed the 2 bottles from R49's room. RN-A stated nursing assistants are to let the nurse know if medication are observed in a resident's room. RN-A reviewed R49's medical record and stated R49 did not have an order for Systane eye drops and did not have an assessment completed for self-administration of medication.

During an interview at 8:49 am on 12/12/18, the director of nursing (DON) stated all self-administered medications need to have a self administration risk assessment completed by a nurse. The interdisciplinary team (IDT) reviews the assessment and notifies the physician for a self-administration order if deemed safe and appropriate. The DON further stated if a nursing assistant observes medication in a resident's room and is unsure if the resident self-administers medication, the nursing assistants are to notify the nurse of the medication.

A facility policy Self-Administration of Medication by Residents dated reviewed/revised on 1/8/18, indicated all residents will be asked if they wish to self-administer medications upon admission. If residents wish to self-administer medications they will be assessed for their ability to self-administer medications. A Self Administration of Medications (SAM) assessment will be completed and reviewed by the IDT and will include:
- Cognitive status
- Physical status
- Which medications are appropriate to be self-administered
- Where the medications will be stored
- How the nursing staff will monitor the medication's use

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21565	Continued From page 23 - How it will be documented If resident is clinically appropriate interventions will be put in place to accommodate wishes. A periodic re-assessment by IDT of the clinically appropriate of self-administer medications. Residents will be permitted to retain medications in the room if approved by IDT and ordered by physician. Nursing staff will ensure the electronic medical record (EMAR) and care plan reflects the resident's self-administration of medications. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights	21810		1/21/19

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21810	Continued From page 24 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a urinary catheter bag was placed in a privacy bag to maintain dignity for 1 of 2 residents (R11) reviewed for dignity. Findings include: R11's Face Sheet dated 6/28/18, indicated diagnoses included obstructive & reflux uropathy (a structural or functional hindrance of normal urine flow). R11 was cognitively impaired and BIMS indicated he was rarely or never understood. R11's current care plan dated 10/27/18, indicated R11 was at risk for complications such as urinary tract infection (UTI) related to a Foley catheter and directed nursing assistants (NA) to empty catheter bag using aseptic technique, keep catheter bag below the level of the bladder, keep catheter bag in a privacy bag when up in wheelchair (w/c) or in bed, and keep catheter bag off of the floor.	21810	Corrected	

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21810	Continued From page 25 On 12/10/18, at 6:26 p.m. R11 was observed sitting in room, seated in his recliner just to the right of the doorway. R11's call light was on his lap within reach and R11 was watching television. Foley catheter bag was not in a privacy bag, it was exposed and visible from hallway. R11's catheter bag was approximately 1/3 full with bright clear yellow urine in the tubing and bag. R11's catheter bag was resting on the floor under the footrest of the recliner. On 12/11/18, at 8:19 a.m. R11 was observed sitting in the main dining room eating breakfast independently. R11's catheter bag was placed in a cloth privacy bag under wheelchair. Cloth privacy bag was resting on the floor. On 12/11/18, at 9:30 a.m. Staff were observed wheeling R11 in wheelchair out of the dining area and to his room, cloth privacy bag was dragging on the floor under the wheelchair. On 12/11/18, at 10:21 a.m. R11 was observed sitting in his room in recliner with door open. R11's call light was on his lap within reach and watching television. R11's Foley catheter bag was not in a privacy bag, it was exposed and visible from hallway, and was resting on the floor under the footrest of the recliner. R11's Foley catheter bag was approximately 1/3 full with bright, clear yellow urine in the tubing and bag. On 12/12/18, at 7:05 a.m. R11 was observed sitting in his wheelchair in the main dining room. R11's catheter bag was in a cloth privacy bag. Cloth privacy bag was secured under his wheelchair, but resting on the dining room floor. On 12/12/18, at 12:00 p.m. R11 was observed sitting in main dining room eating lunch	21810		

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21810	Continued From page 26	21810		

independently. R11's catheter bag was in a cloth privacy bag. Cloth privacy bag was secured under his wheelchair, but resting on the dining room floor.

On 12/12/18, at 12:41 p.m. R11 was observed sitting in his room in recliner with door open. Foley catheter bag was not in a privacy bag, it was exposed and visible from hallway. R11's Foley catheter bag was approximately 1/2 full with bright clear yellow urine in the tubing and bag. Foley catheter bag was resting on the floor under the footrest of the recliner. NA-A stated, that placing the catheter bag on the floor and without a cloth bag was the way R11's catheter care was to be completed. NA-A went on to state, that until she is told to do it differently, this is how she will complete the care.

On 12/12/18, at 1:47 p.m. the director of nursing (DON) was interviewed and verified R11's catheter bag was to be placed in a privacy bag to maintain dignity.

The facility's Dignity Policy, revised on 10/17, directed staff to provide care that would avoid anything that could be demeaning to the resident and to place catheter bags in a covered bag so the catheter bag would not be easily visible.

SUGGESTED METHOD OF CORRECTION: The DON could provide training on proper catheter care and on maintaining dignity when providing care. The DON or designee could audit to ensure nurses and aides are providing care in a dignified manor.

TIMELINE FOR CORRECTION: Twenty One (21) days.

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	245245	A. BUILDING **01 - HERITAGE MANOR** B. WING _____	**12/11/2018**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Heritage Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

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

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	245245	A. BUILDING **01 - HERITAGE MANOR** B. WING _____	**12/11/2018**

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K 000	Continued From page 1	K 000		

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Heritage Manor, is a 1-story building with a full basement. The original building was constructed in 1953 and was determined to be of Type II(111) construction. In 1981 & 2001 additions were constructed to the building that was determined to be of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building also has an apartment complex attached that is properly separated.

The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the

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	245245	A. BUILDING **01 - HERITAGE MANOR** B. WING _____	**12/11/2018**

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K 000	Continued From page 2 corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 70 beds and had a census of 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920		1/21/19

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	245245	A. BUILDING **01 - HERITAGE MANOR** B. WING _____	**12/11/2018**

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K 920	Continued From page 3 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with NFPA 70 (11), National Electrical Code. This deficient practice could negatively affect 62 of 62 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. to 2:30 p.m. on 12/11/2018, observations revealed the following deficient conditions: 1. There is an extension cord used with the lights on the Christmas tree in the Main entry. 2. There is an extension cord used with the lights on the Christmas tree in the Main dining room. 3. There is an extension cord used with the lights on the Christmas tree in the park area. This deficient condition was verified by a Maintenance Supervisor.	K 920	K920 CHC will properly use electrical equipment – power cords and extensions. In order to comply with NFPA 101 and NFPA 70 (11): 1. All extension cords located on the Christmas trees in the main entry, main dining room, and the park area were removed on 12/11/18. ESD completed a tour of facility to ensure compliance with extension cords and power strips. ESD will tour facility randomly to ensure future compliance. 2. Completion Date: 01-21-2019 3. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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, Enforcement Specialist
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