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	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	321 Northeast Sixth Street Chisholm, MN 55719

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure there were sufficient numbers of staff to ensure all resident cares including getting residents out of bed when requested for 1 of 2 resident (R36) reviewed for choices, monitoring for and treating constipation for 1 of 2 (R16) and monitoring residents receiving dialysis for 1 of 1 resident (R111) reviewed for dialysis care. This had the potential to affect all residents residing in the facility. Findings include:Staff and Resident Interviews/Observations:On 6/23/25 at 2:53 p.m., R110 stated she had taken herself to the bathroom (said she had already waited 40 minutes) and was fearful of soiling self. R110 was tearful during the interview and further stated she had put on her artificial leg on to complete the transfer (even though she had not been cleared by therapy to do so). On 6/24/24 at 8:30 a.m., family member (FM)-F stated therapy had told them at the beginning of May there were only two nursing assistants for the entire building. FM-F stated they had a camera in their family member's room and on 5/4/25, between 2:00 p.m., and 3:00 p.m., one staff used the mechanical lift to put R35 into bed. At 8:00 p.m., two staff lifted R35 under the arms and pivot transferred her to bed (no lift was used). During an interview on 6/24/25 at 11:33 a.m., the medical director (MD) was asked about the concerns brought forward by family and residents (long waits, transferring themselves to the bathroom, not using the mechanical lift for transfers or one staff using the mechanical lift instead of two staff, cold food) the MD stated the root cause of the concerns listed would be related to not having enough staff. The MD stated he did not know what the number would be where the facility can't or shouldn't take any admissions. The MD stated the corporation thinks the facility should fill all the beds even though it might not have enough staff to take care of the residents.On 6/25/25 at 12:56 p.m., during the resident council interview, R20, R33, and R41 stated it sometimes took a long time to get their call light answered, they stated when there was a long wait, they assumed staff were busy and stated waits could be up to 40 minutes long. R20 stated when asked how long it took to get their call light answered, as long as it takes. During an interview 6/25/25 at 3:20 p.m., scheduler (S)-H explained the assignment sheets and stated the second nurse on the night shift hadn't been being filled for a couple of years. The assignment sheets identified one nurse and three nursing assistants for the entire building for nights. During an interview on 6/26/25 at 8:41 a.m., NA-C stated they worked on call so worked to fill in for call ins. NA-C stated sometimes had a bath aide, but not always, sometimes showers have to be skipped, and would be left for the next shift. During an interview on 6/26/25 at 8:43 a.m., NA-D stated would sometimes need to skip showers if it was very busy and would tell the next shift the showers weren't done. During an interview on 6/26/25 at 10:31 a.m., anonymous staff (AS)-G stated some days were really rough because of call ins, sometimes the staff for the shift would be one licensed person and two nursing assistance with new admits, falls, and hospice residents who would need medications every two hours. AS-G stated it was a big building with residents spread out. AS-G stated during the COVID-19 outbreak the second staff for nights was taken away (said this was supposed to be a temporary solution to lack of staff). AS-G stated their concerns have been brought to the director of nursing (DON) several times. Stated about six weeks ago started having an RN on call. AS-G stated with residents in the facility for short term rehabilitation after surgery they often need two staff to transfer them and require a lot of as needed pain medication. AS-G stated when working would try to run the bowel list but often no time to do it. AS-G stated two-hour turns are often late, many times the staffing was not safe when only three staff in the building. AS-G stated they would not mandate a third nursing assistant to stay for night call ins, leaving two NAs and a nurse. During an interview on 6/26/25 at 11:46 a.m., S-H verified on nights they would not mandate a nursing assistant to stay if one of the three NAs called in, leaving two NAs for the building. During an interview that occurred between the dates of 6/23/25, to 6/26/25, AS-O stated they were passing medications for 18 to 20 residents which was manageable. However, when scheduled with just one nursing assistant it was difficult to get medications passed on time. On those days, in addition to medication pass, they also had to work the floor helping to get people up, passing meal trays, answering call lights, toileting, and completing check and changes. AS-O stated they probably worked a quarter of their shifts short one nursing assistant. Residents did not get the same level of care when short staffed. Medications get delayed for cares, and residents wait longer for things like call lights, toileting, and repositioning. AS-O didn't think residents were neglected or any had had a seriously bad outcome while short staffed, but they did feel like they couldn't give the residents the quality of care they would like to. Between the dates of 6/23/25, and 6/26/25, an anonymous resident's