

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245245                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Manor                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>321 Northeast Sixth Street<br>Chisholm, MN 55719 |                                                 |
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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and document review, the facility failed to protect a resident's right to be free from mental abuse for 1 of 4 residents (R71) reviewed for abuse. This led to psychosocial harm when the resident barricaded herself into her room and caused her to discharge early from the facility prior to reaching her maximal level with therapy services. Findings include: R71's admission Minimum Data Set (MDS) dated [DATE], indicated R71 was cognitively intact. Diagnoses included osteoarthritis of the right hip and major depressive disorder. R71's Census List dated 7/30/26, indicated R71 was admitted on [DATE] and discharged from facility on 12/30/25. R71 remained in the same room throughout their stay. R71's care plan dated 12/24/25, indicated R71 was a vulnerable adult related to physical condition. Goals included the resident would be free from abuse, neglect, or financial exploitation. The care plan lacked interventions to protect from abuse. A Minnesota Adult Abuse Reporting Center (MAARC) report received 12/29/25 at 1:28 p.m., indicated R72 hit R71's bed at 1:00 a.m., and woke R71 up. R71 told R72 to leave. R72 grabbed a blanket off a chair and walked out. The MAARC report indicated R72 had entered R71's room without permission and had scared R71. The MAARC report further indicated a risk of physical abuse or sexual assault within 72 hours if nobody got involved. Further notes indicated on the night of 12/29/25, R72 attempted to enter R71's room. An alarm of sorts had been set up at the entrance to the room. A walker was used in the doorway to barricade R72 from getting in. R72 just pushed the walker out of the way and entered R71's room anyway and then left shortly after entering. R71's progress notes from 12/25/25 to 12/30/25, were reviewed and showed the following: On 12/27/25 at 2:28 p.m., Licensed practical nurse (LPN)-A wrote R71 approached nurse and reported R72 was in her room multiple times the night before and scared R71. R71 stated R72 had grabbed some belongings and left the room. R71 requested staff to call her lawyer. Director of Nursing (DON) was notified of the situation and provided with information to contact R71's lawyer. A stop sign banner was placed across R71's door. On 12/29/25 at 11:43 a.m., licensed social worker (LSW)-C wrote R71 requesting to be discharged (DC) from the facility on 12/30/25, after a 10:00a.m., appointment. The plan was not to return to the facility. On 12/29/25 at 2:22 p.m., LSW-C wrote a conversation occurred between SSD-A and R71 about a wanderer who entered her room. R71 had a stop sign in place across the door and was closing the room door. On 12/30/25 at 1:00 a.m., LPN-C wrote R71 on two different nights in a row placed a walker in front of the door to barricade R72 from entering room. R71 stated I'm scared to death of him. R71 had put the call light on at the beginning of the shift to report R72 had already attempted to enter R71's room. Staff informed R71 They could only redirect when they were able. R71 reported leaving in the morning. On 12/30/25 at 10:33 a.m., LSW-C wrote R71 DC'd from facility to return to home. R71's Occupational Therapy Treatment Encounter Note dated 12/29/25, indicated R71 had improvement, but (continued on next page)</p> |                                                                                               |                                                 |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE     | (X6) DATE                             |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                      | Event ID: | Facility ID:<br>245245                |
|                                                                          |           | If continuation sheet<br>Page 1 of 41 |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>needed more high-level therapy prior to DC from the facility. R71 told therapy staff she was leaving tomorrow after her appointment because she couldn't be here anymore because of my neighbor coming into my room. R72's admission MDS dated [DATE], indicated R72 had moderate cognitive impairment. Diagnoses included vascular dementia with agitation and Alzheimer's disease. The MDS indicated R72 paced and wandered daily and significantly disrupted the care or living environment of other residents. R72's Census List dated 7/30/26, indicated R72 was moved to another room on 12/19/25 that was near R71, and remained there until 4/15/26, when the next room change occurred. R72's Care plan dated 12/3/25, indicated R72 had behaviors like restlessness, agitation, sundowning, difficulty sleeping, wandering into other resident rooms and urinating in public. Goals included R72 would have no evidence of behavior problems by next review date. Interventions included medications, redirect me, one to one(1:1) time, and update provider with concerns.R72's progress notes from 12/25/25 to 12/30/25, were reviewed and indicated:On 12/26/25 at 4:09 p.m.,--R72 became agitated after family left. R72 began wandering into other resident rooms and became angry when staff attempted to redirect. R72 was cursing and attempted to become physically aggressive with staff. R72 entered a resident room and shook a fist at the resident's family member. Staff had difficulty removing R72 from room and punched resident door while being removed.On 12/27/26 at 8:26 p.m., R72 wandered into other resident rooms throughout building. Difficult to redirect and easily agitated. Residents and family members became upset with R72 entering other resident rooms and how difficult it is to remove R72 from those rooms. Resident placed on 1:1 supervision with nurse assistant. (the note did not state how long R72 remained on 1:1)On 12/28/25 at 2:03 p.m., R72 was at dining hall and started yelling NO, NO, NO. R72 picked up the fork and clothing protector, began walking around the park area with fork grabbed in hand and swinging clothing protector to hit things. R72 then requested to use the restroom so staff started to assist R72 to restroom. R72 then grabbed the staff member's hand and dug his nails in, breaking skin. R72 then went into a different resident room and urinated. R72 then grabbed a different resident wheelchair (WC) and started pulling the WC backwards. Lastly R72 took another resident's crossword puzzle from that resident and smashed it up and threw it. It took three different staff to redirect R72.On 12/28/25 at 5:20 p.m., R72 was witnessed taking a necklace and phone charger from a resident. When the staff member tried to check R72's pockets, R72 punched the staff member in the upper arm leaving a large red area.On 12/29/25 at 6:45 a.m., R72 was extremely agitated the end of evening shift into night shift. R72 was yelling, swearing, attempting to open office doors, pounding on doors, raising his fist to staff, turning over furniture, pounding the recliner remote on the over bed table and entering other resident rooms. R72 was unable to be redirected and became more agitated and angrier when staff attempted.On 12/30/25 at 1:22 a.m., R72 required 1:1 monitoring due to wandering into other resident rooms and other units of the building. Behaviors are not redirectable. Unable to keep R71 in one place at this time. (Note does not state how long R72 was on 1:1).On 12/30/25 at 2:49 a.m., R72 walked quickly and within a minute of nursing checking on another hallway, R72 was unable to be found in the previous area last seen. Staff had to check room by room to locate R72.During an interview on 7/29/26 at 10:26 a.m., nurse assistant (NA)-B stated R72 was very confused and would escalate behaviors very quickly. Just talking to him would cause him to get more aggressive. He was always wandering into other resident rooms. Sometimes he would even take other resident items while in their rooms. Staff would go in to redirect him, and he would just become more aggressive with the staff and get madder. A lot of times it would take two or more staff to get him out of another resident room. The facility attempted stop sign banner across a lot of the residents' doors. The stop sign banners would never stop him. Even closed doors didn't stop him, if R72 wanted to go into a room he would move whatever was in his way (continued on next page)</p> |                                                                                               |                                                 |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>and go in. Nobody had ever mentioned there were concerns directly related to R71 and R72. The administration staff wanted us to attempt 1:1 with R72 but we hardly had enough staff to care for all the residents in the facility, let alone assign a person just to work with him. The worst was on night shift where we normally only had two aides and one nurse to take care of the entire building. Staff were always going to the director of nursing (DON) asking more staff to keep a closer eye on R72 but nothing ever came out of it. Most of the residents were afraid of R72. During an interview on 7/29/26 at 11:27 a.m., licensed practical nurse (LPN)-A stated R71 came to her on the morning of 12/27/25, and reported R72 had come into the room several times the night before. When R71 told R72 to leave the room, R72 snarled at R71, grabbed R71's blanket, and then left the room. LPN-A stated R71 told her R71 was very scared of R72. The DON was notified of the resident-on-resident altercation. The DON said to put a stop sign banner across R71's door. LPN-A stated I reminded the DON the stop sign had not worked on R72 so far and was there any other measures to try. The DON stated to just keep an eye on R72. Several times throughout the week of Christmas we requested extra staff to do 1:1 observation with R72 and we were told by the DON the facility did not offer 1:1 care service. The staff were expected to do 1:1 service, when possible, when we never had enough staff to get everything done, we needed to get done routinely each day. Because of this, R72 was, for the most part, able to roam around the facility and enter other residents and we attempted to address after it happened and before somebody got hurt. During an interview on 7/29/26 at 11:00 a.m. LSW-C stated she had gone into R71's room because a staff member said she wanted to go home due to the issues related to R72 always going into R71's room. R71 requested to be discharged from the facility on the a.m. of 12/30/25, because her sister would be there to take her to an appointment and had no plan on returning to the facility. During an interview on 7/29/25 at 11:27 a.m., registered nurse (RN)-E stated anytime there were concerns of abuse or resident on resident incidents they would be reported to the administration. All notes made the last 24 hours, and any abuse concerns would then be brought up and discussed in the Inter-Disciplinary Team (IDT). RN-E stated she was part of the IDT team. The team would discuss the concerns related to any abuse or resident on resident altercations and what needed to be done to protect the residents. RN-E reviewed R71's progress notes and acknowledged the notes from 12/27/25 to 12/30/25. RN-E stated an inability to remember if the notes were discussed in IDT, but assumed they were since all notes from the last 24 hours entered into resident notes would have been reviewed and anything concerning, such as those notes, would have been brought to the IDT meeting to discuss. RN-E also could not remember if there was anything done to protect R71 from R72 since the notes did discuss R71 was very scared of R72. The IDT notes from the IDT meetings on 12/26/25 through 12/30/25 were requested but not provided. During an interview on 7/29/26 at 11:39 a.m., the DON stated on 12/26/25, she was not the DON at the time of the allegations, but the evening charge nurse. She had been made aware of the situation but was unsure what all the administration team or IDT team had discussed. The DON stated she was aware the stop sign was placed but did not believe anything else was done to protect R71 from R72. The DON reviewed R71's progress notes and acknowledge concerns arose even after the stop sign banner was placed across the doorway. During an interview on 7/30/26 at 9:40 a.m., the administrator stated the resident had a stop sign banner placed across her door. Staff was doing 1:1 with the resident. The facility even brought in extra staff just to be able to work 1:1 with R72. I'm not sure what else we could have done to protect any resident. On 7/30/26 at 10:00 a.m., the facility assessment (FA) dated 6/1/26, was reviewed and indicated a staffing plan with the following number of licensed nurses were needed to staff the facility: Days-3, Evenings-3, Nights-1. The FA indicated the following number of NA's were needed to staff the facility: Days-5/6, Evenings-5/6, Nights-3. The daily staff (continued on next page)</p> |                                                                                               |                                                 |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>assignment sheets for 12/26/25 through 12/30/25 were reviewed for all shifts and indicated the following staff numbers:12/26/25: Days-4 nurses and 4.5 NA, Evenings - 4 nurses and 6 NA, Nights- 1 nurse and 3 NA12/27/25: Days-3 nurses and 4 NA, Evenings - 3 nurses and 6 NA, Nights- 1 nurse and 3 NA.12/28/25: Days-4 nurses and 4 NA, Evenings - 3 nurses and 6 NA, Nights- 1nurse and 2 NA.12/29/25: Days-3 nurses and 6 NA, Evenings - 4 nurses and 4 NA, nights- 1 nurse and 2 NA.12/30/25: Days-3 nurses and 6 NA, Evenings - 4 nurses and 4.5 NA, nights- 1 nurse and 2 NA.The assignment sheets from 12/26/25 to 12/30/25, lacked a staff member responsible for 1:1 observation with R72 or that any extra staff were brought in to work any shift. Many shifts indicated short staffing for either nurses or aides for several shifts, based on the staffing plan in the FA.In an email received from the DON on 7/30/26 at 12:00 p.m., the email indicated room change would not have been offered because the facility wanted trial the stop signs. Room change was rarely offered on first complaints.During an interview on 7/30/26 at 12:09 p.m., the therapy director (TD) reviewed all R71's therapy notes from 12/26/25 to 12/30/25, and stated the notes clearly indicated R71 was improving on a daily basis but still needed to work on high level activities of daily living prior to therapy agreeing with a discharge back to home. The TD stated based on the occupational therapy notes from 12/29/25, it was clear R71 was requesting a discharge to home prior to reaching maximum levels was because of another resident continually trying/coming into R71's room.During an interview on 7/30/26 at 2:01 p.m., LPN-C stated she worked night shift in the facility and had worked the night of 12/28/25 and 12/29/25. R72 was very difficult to handle, especially on night shift. For whatever reason, R72 liked going in/trying to go into R71's room, I assume it was because they were next to each other. On the first night R71 tried to block R72 from coming into her room by utilizing the walker, and putting it behind the closed door as a barricade. R71 would just push the door and walker out of the way and go in. we would have to rush over and redirect R72 out of R71's room, but he would keep roaming and wandering into other rooms. After that occurrence on the night of 12/28/25, and on the night of 12/29/25, R71 began utilizing her closet door, bedside table, and walker together as a barricade against the closed door to keep R72 from coming in. Those steps did not keep R72 from trying to go into R71's room and pounding on R71's room door. you could tell R71 was really afraid of R72 due to all the steps R71 took to keep R72 out of her room. Both mornings we had to have R71 move items from her door so staff could get in and issue early morning medications.During an interview on 7/31/26 at 9:48 a.m., the scheduler (SC)-A confirmed the numbers on the facility assessment were the numbers the facility tried to staff daily. nurses would be written in the nursing columns and aides would be written in the NA column. If a name had a circle around it, that meant the person called in. if there was a dollar sign next to the name, that meant the staff member received a bonus for working extra. The facility did not offer bonuses of try to call people in unless the numbers were really low. For example, if a night shift only had one aide working and one nurse then they would call to try to get extra aides to work. If there were two aides working the facility would say that was ok unless the census was high. SC-A stated she could not remember if extra staff were requested in around Christmas, even if they were it would have been almost impossible to get because of being short of staff at that time. We couldn't get our own staff or agency staff to pick up shifts around the end of December, so the facility was lucky if we had enough staff to cover the normal shifts.Facility policy Maltreatment Investigation and Reporting dated 3/10/26, indicated when physical, sexual, or mental abuse is reported the supervisor must promptly secure the resident's safety and complete an initial assessment. Immediate interventions must be put in place to safeguard the resident(s) and prevent further harm. An initial report would be made to the SA. That report would a description of the event, immediate interventions taken to protect the resident and the status of the alleged perpetrator. (continued on next page)</p> |                                                                                               |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | after the immediate protection was in place, the incident would be reviewed by the IDT. The review would evaluate the effectiveness of interventions and determine the need for corrective or preventive actions. Any operational or systemic changes and training needed to prevent recurrence would be implemented based on investigative findings. |                                                                                               |                                                 |

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| F 0550<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were provided with the current Combined Federal and State [NAME] of Rights. This had the potential to affect all 62 residents and their representatives who resided in the facility. Findings include: In response to a concern reported in 2026, R26 felt their rights had been violated when they resided in the facility for six days. A review of the facility's admission folder identified they were providing residents with the Combined Federal and State [NAME] of Rights dated 2/1/17. The most current Federal and State [NAME] of Rights has a date of 12/22/25. During an interview on 7/30/26 at 12:03 p.m., the director of nursing (DON) stated they did not know how residents received their admission packet. During an interview on 7/30/26 at 12:22 p.m., registered nurse (RN)-I stated residents can receive their admission packet in paper form or electronically.</p> |                                                                                               |                                                 |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and document review, the facility failed to review and revise the care plan to reflect the resident's current needs for 4 of 4 residents (R25, R48, R3, R5) reviewed for care planning. Findings include:</p> <p>R25:</p> <p>R25's quarterly minimum data set (MDS) dated [DATE], identified severely impaired cognition and diagnoses of diabetes mellitus, malignant neoplasm of the lung, and secondary malignant neoplasm of the bone. R25 needed set-up assistance for eating, maximum assistance with toilet hygiene, and dressing the lower body. The MDS also indicated R25 was occasionally incontinent of urine and always incontinent of bowel.</p> <p>R25's care plan dated 6/12/25 identified a focus statement for activities of daily living (ADL)s self-care performance deficit and included interventions for partial to moderate assist with showers, R25 able to complete upper, lower body and footwear independently, and was independent with eating, personal hygiene and oral care. R25 needed to be offered to bring to the toilet every two hours and as needed due to bladder incontinence. The care plan further identified R25 was alert and oriented to person, place, and time with intermittent confusion. BIMS (cognitive score) indicated moderate cognitive impairment.</p> <p>During an interview on 7/30/26 at 11:24 a.m., registered nurse (RN)-H, who identified as the MDS coordinator, stated there wasn't enough change in R25's quarterly MDS (compared with a significant change MDS of 4/9/26) from her baseline to be a significant change again. RN-H stated care planning was done by the nurses when they did the assessments, they will update the care plan and RN-H added once she was fully running, she would be updating the care plans.</p> <p>During an interview on 7/30/26 at 11:52 a.m., RN-E, who identified as the charge nurse, stated she was given a list of what assessments were due and when, and then she along with the other charge nurses would update the care plan. RN-E stated an up-to-date care plan would be important to be able to care for the residents safely and properly.</p> <p>R48:</p> <p>R48's quarterly MDS dated [DATE], identified intact cognition and diagnoses of encephalopathy, aphasia, spondylosis of the thoracic, lumbar and cervical regions. R48 was independent with eating and needed set-up oral care. R48 needed maximum assist with showers, personal and toilet hygiene, transfers, and bed mobility, and was dependent for toilet hygiene with occasional bowel incontinence.</p> <p>R48's care plan dated 3/27/26, identified a focus statement for an ADL self-care performance deficit and included interventions for total dependence and assist of two staff for bathing, transferring with non-mechanical standing lift and assist of two staff and if he was unable to stand with that then use (continued on next page)</p> |                                                                                               |                                                 |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>the mechanical sling lift. R48's care plan also included a focus statement for requiring g-tube feedings due to dysphagia (difficulty swallowing) with interventions to administer feedings as ordered but may have ice chips with supervision. R48 had bowel incontinence related to immobility and interventions for staff to check every two hours and assist with toilet and provide peri care PRN.</p> <p>R48's therapy orders included a memo on the inside of his closet door dated 7/23/26, for R48 to use a stand pivot transfer using a gait belt and contact guard assist of one.</p> <p>During an interview on 7/27/26 at 5:10 p.m., R48 was eating his dinner in his room and stated he didn't use his feeding tube anymore, just for one of his medications.</p> <p>During an interview on 7/28/26 at 3:23 p.m., nursing assistant (NA)-D stated she knew how to transfer R48 because of the posting from therapy in his closet. NA-D also stated R48 used the toilet, not a bed pan as the care plan indicated.</p> <p>During an interview on 7/28/26 at 3:27 p.m., RN-E, who identified as a charge nurse, stated if something needed to be updated to the care plan she would just do it but thinks the MDS nurse also has a part in it.</p> <p>During an interview on 7/29/26 at 1:56 p.m., the therapy director (TD)-I stated once they established the plan of care through evaluation, they write a care plan for transfer and level of assist, or walking program or whatever applied. TD-I stated they then put that care plan in the resident's room in their cabinet door and gave a copy to the director of nursing (DON) and nurse managers, and on a weekly basis he presents a weekly update to DON, MDS coordinator, nurse managers and department heads.</p> <p>A policy, Person Centered Care Planning dated 6/16/26, identified its purpose was to provide guidance to care center staff on developing and establishing the resident's person-centered care plan. Person-centered care planning identifies each resident's individualized strengths, needs, preferences, supports, and goals to guide care and services. Care plans must include measurable goals and timeframes based on the comprehensive assessment. If the comprehensive assessment identifies changes in goals, interventions, or functioning that were not identified in the baseline care plan, those changes will be communicated to the resident and/or representative, with an updated care plan provided. The comprehensive care plan will be reviewed and revised quarterly, upon significant change in condition, or as otherwise necessary to reflect the resident's current needs, goals, and preferences.</p> <p>R3:</p> <p>R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had diagnoses which included hemiplegia/hemiparesis (complete or severe paralysis on one side of the body/mild to moderate weakness on one side of the body), dysphagia (difficulty or discomfort when swallowing foods, liquids, or even saliva), hyperlipidemia, aphasia (a brain disorder that affects how one speaks, reads, writes, and understanding what other people say), hypertension. In addition, R3's MDS identified she had unclear speech, was severely cognitively impaired, and was dependent on staff for activities of daily living.</p> <p>(continued on next page)</p> |                                                                                               |                                                 |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>R3's care plan reviewed on 7/28/26, (care plan was requested but not provided) did not identify that R3 did not want male care givers.</p> <p>R3's progress note dated 3/8/26, identified no males for personal cares.</p> <p>During an interview on 7/29/26 at 1:42 p.m., nursing assistant (NA)-G stated it was only word of mouth that R3 only wanted female care givers for personal cares. NA-G verified there was nothing on the care guides to indicate she only wanted female care givers.</p> <p>During an interview on 7/29/26 at 1:44 p.m., licensed practical nurse (LPN)-A verified the care plan did not identify R3 preferred only female care givers.</p> <p>During an interview on 7/30/26 at 12:29 p.m., the director of nursing (DON) stated she was aware R3 did not want any male care givers. The DON verified this information should have been part of her care plan.</p> <p>R5:</p> <p>R5's admission MDS dated [DATE], identified she had diagnoses which included dementia, heart failure (the heart muscle does not pump blood as well as it should), diabetes mellitus, depression, hyperlipidemia, and heart disease. In addition, R5's MDS identified she was moderately cognitively intact, required supervision with eating and partial to moderate assistance with activities of daily living.</p> <p>A review of R5's care plan on 7/28/26, identified R5's care plan did not identify she needed to be out of bed for meals.</p> <p>A progress note dated 7/6/26 written at 1:59 p.m., identified therapy reported increased confusion and weakness when sitting at the bedside. The note identified she was unable to hold herself up. The note identified she was also spilling food when eating in bed. Therapy recommended they would like her to be up in her chair for meals.</p> <p>During an observation on 7/28/26 at 12:10 p.m., R5 was observed lying in her bed eating her lunch.</p> <p>During an observation on 7/29/26 at 8:37 a.m., R5 was observed lying in bed eating breakfast.</p> <p>During an interview on 7/29/26 at 1:39 p.m., nursing assistant (NA)-G and licensed practical nurse (LPN)-A both stated they were not aware R5 was supposed to be out of bed for meals. They were unsure how therapy communicated the information for R5 to be in her chair for meals. LPN-A verified the information was in the progress notes but the care plan had not been updated with the information.</p> <p>During an interview on 7/30/26 at 10:52 a.m., therapy director (PTA)-A stated staff in the therapy department would write a care plan for the resident to identify the resident needed to be up for meals, that information would go to the nurse manager and the DON and then the information would get put (continued on next page)</p> |                                                                                               |                                                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Manor                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>321 Northeast Sixth Street<br>Chisholm, MN 55719 |                                                 |
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| F 0657<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>into the resident's closet. PTA-A reviewed the notes and identified nursing had been informed of the change but that a care plan change had not been made. PTA-A stated therapy would be responsible for making the changes and posting the changes in the closet.</p> <p>During an interview on 7/30/26 at 12:14 p.m., the DON stated she would expect nursing to get R5 up for meals per therapy's recommendation and make this part of her care plan. She would expect staff to continue to evaluate R5's care and update the care plan as needed.</p> <p>Person Centered Care Planning dated 4/20/23, identified the facility would develop a comprehensive person-centered care plan with the resident and/or family representative for each resident. In addition, the care plan would be reviewed every 90 days or more frequently if necessary, based on changes that occurred between care conferences.</p> |                                                                                               |                                                 |

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| <p>F 0883</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to consistently educate, offer, or administer influenza and pneumococcal immunizations for 3 of 5 residents (R14, R48, R54) reviewed for immunizations. Findings include: R14's admission Record dated 7/31/26, identified an admission date of 3/4/26. R14's undated and unsigned Vaccination Consent didn't identify if R14 had previously had an influenza or pneumococcal vaccination or if R14 wanted, or was eligible for, these vaccinations. In the area where a resident or representative could sign, or the facility could document phone notification, it was written No! signed health unit coordinator (HUC)-G. R14's electronic medical record (EMR) identified R14 had received Prevnar 13 on 12/15/15, and influenza vaccine on 12/3/25. According to the CDC, R14 was eligible for shared decision making with their provider to decide if PCV20 or PCV21 should be administered as it was more than one year since the Prevnar 13 dose. R54's record didn't include evidence of shared decision making or receipt of additional pneumococcal vaccination. R48's admission Record dated 7/31/26, identified an admission date of 3/26/26. R48's Vaccination Consent dated 5/7/26, didn't identify R48 had history of receiving the influenza vaccine and identified no to receiving it now. Under pneumococcal vaccination, it identified no to having received prior vaccinations and no to receiving it now. The Consent contains the following: Enclosed is the vaccine information sheet from the Centers for Disease Control (CDC) that addresses the potential benefits, precautions, side effects, and reactions. I have read the vaccine information from the CDC and understand the benefits and risks associated with receiving the vaccine, with a signature line for the resident or representative which was not signed. A section for resident representative notification via telephone identified HUC-G notified R48's spouse via telephone and spouse declined all immunizations. R48's Immunization Report dated 7/31/26, identified R48 had received PPSV23 on 11/19/14 and Prevnar 13 on 12/16/15. According to the CDC, R48 was eligible for shared decision making with their provider to decide if PCV20 or PCV21 should be administered as it was more than five years since the Prevnar 13 dose. R54's admission Record dated 7/31/26, identified an admission date of 8/8/25. R54's Vaccination Consent dated 4/15/26, identified R54 had received pneumococcal vaccines and would like to receive it. The form also indicated a vaccine information sheet (VIS) was given to R54 on 5/29/26 and was signed by R54's power of attorney on 4/15/26. R54's record in PCC identified receiving Prevnar 13 on 11/8/16, and PPSV23 on 11/22/19. According to the CDC, R54 was eligible for shared decision making with their provider to decide if PCV20 or PCV21 should be administered as it was more than five years since the PPSV23 dose. R54's record didn't shared decision making or receipt of vaccination. During an interview on 7/29/26 at 1:20 p.m., registered nurse (RN)-G, who identified as the Infection Prevention and Control nurse for the facility, was responsible for pulling the resident's Minnesota Immunization Information Connection (MIIC) report and uploaded it to Point Click Care (PCC, an electronic health record) and then entered the immunizations into the immunization section of PCC when new residents were admitted. RN-G stated they were the only person who did the vaccine review and she utilized the CDC pneumorec application to see what pneumococcal vaccines the resident may be eligible for. RN-G added two of these admissions were during a period of time where she was needing to serve as the facility's director of nursing and there were things that were behind. A policy, Resident Immunizations dated 1/21/25, identified the purpose was to provide direction to St. [NAME] Health Services of [NAME] (SFHS) employees regarding offering vaccinations. Additionally, the Adult Immunization Schedule, prepared by the CDC would be utilized to ensure residents were offered and encouraged to accept the (continued on next page)</p> |                                                                                               |                                                 |

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| F 0883<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | appropriate vaccination. The policy also identified an immunization history will be taken upon admission. This will include checking the Minnesota Immunization information Connection (MIIC) website. Any immunizations that are not current or unknown vaccination histories will be shared with the attending physician and appropriate physician orders obtained. The resident's immunization history will be documented and maintained in the resident's electronic medical record (EMR). Vaccine Information Statements (VIS) will be provided to the resident and/or representative prior to administration of the vaccination. Education will be provided, and any questions answered, prior to administration of the vaccination. resident representative identified in the record. Administered immunizations will be documented in the EMR and on the MIIC website. Record that the resident or representative was provided education regarding the benefits and side effects of the immunization administered |                                                                                               |                                                 |

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| <p>F 0895</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Have a Compliance and Ethics Program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to implement an effective compliance and ethics program with sufficient monitoring and auditing mechanisms to detect and prevent potential violations and ensure the integrity of the data reported to the Centers for Medicare and Medicaid services (CMS). The facility further failed to ensure employees could report, without fear of retaliation, a high-level personnel's suspected violations. These failures resulted in documentation and minimum data set (MDS) irregularities with unsupported or inconsistently reported diagnosis for 4 of 4 residents (R31, R39, R40, R61) reviewed. Findings include: R31's admission Record identified an admission date of 1/25/23. R31's quarterly minimum data set (MDS) dated [DATE], didn't contain diagnosis code F33.3 (Major Depressive Disorder Severe with Psychotic Symptoms) in section I. On 12/16/25, RN-A modified the 11/5/25 MDS to include diagnosis F33.3 under section I. R31's Diagnosis Audit Report identified F33.3 was added to his EMR on 1/15/25 with an effective date of 1/25/25. A progress note from R31's provider on 4/21/26, included a review of systems and diagnoses for a regulatory visit and didn't include F33.3, but did contain a diagnosis for severe Lewy body dementia with agitation, depressive disorder in remission noting resident can be very happy when alert. R31's progress notes didn't reflect supporting documentation for the F33.3 diagnosis that was added to his medical records. A provider order for R31's F33.3 diagnosis was requested but not received. R39's significant change in status assessment (SCSA) MDS dated [DATE], completed by RN-A included diagnosis F33.3. R39's history and physical dated 8/13/23, identified diagnoses of late onset Alzheimer's disease without behavioral disturbance and generalized anxiety disorder, but didn't contain diagnosis F33.3. R39's Diagnosis Audit Report identified F33.3 was added to her record on 1/15/25 with an effective date of 8/17/23. A provider order for diagnosis F33.3 was requested but not received. R61's SCSA MDS dated [DATE], didn't identify a diagnosis code F33.3 in section I. A modification was made on 12/16/25 by RN-A, and section I identified a diagnosis code of F33.3. An additional modification was made on 4/13/26 by RN-B, and section I no longer included diagnosis code F33.3. R61's Order Summary Report dated 11/25/25, didn't include a diagnosis for F33.3. A diagnosis audit report dated 7/31/26, identified R61 had diagnosis F33.3 added to her EMR by RN-A on 12/16/25 at 10:36 a.m. as an effective diagnosis beginning on 1/22/25. A document, Physician Update facsimile for R61, from the facility to the provider was timestamped and dated 6/23/25 10:59:10, identified a request for diclofenac gel for low back pain with dosing directions with a yes or no and the yes is circled, signed by medical doctor (MD)-K on 6/24/25. The facsimile from the clinic was timestamped and dated 6/24/26 10:38:17. A document, Physician Update facsimile for R61, from the facility to the provider was timestamped and dated 6/23/25 10:59:10, identified the following, OK to use diagnosis F33.3 Major Depressive Disorder Severe with Psychotic Symptoms? with a yes or no and the yes is circled, signed MD-K on 6/24/25. The facsimile from the clinic was timestamped and dated 6/24/26 10:38:17. During an interview on 7/30/26 at 9:09 a.m., RN-C stated after their case mix review the summer of 2025, she had a lot of corrections to make and as she was doing those, she noticed a couple of MDS' where it looked like she had done modifications that she didn't remember doing. RN-C investigated the audit trail histories of the MDS, and it would show that her supervisor, RN-A who was the director of nursing (DON), and two corporate nurses were making the modification. Some would be things like adding a Medicare number. RN-C stated she didn't want to report internally because it was her supervisor, and RN-C had been put on a performance improvement plan (PIP) related to the citations coming out of the case mix review and she was fearful of retaliation. Between (continued on next page)</p> |                                                                                               |                                                 |

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| F 0895<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>7/24/25 and 8/5/25, RN-C filed concerns with CMS, the Office of Health Facility Complaints (OHFC), the Minnesota Board of Nursing and the Office of the Inspector General (OIG). RN-C stated that on 2/2/26 she found a fax from June of 2026 for R61 which had a new diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms and the fax appeared to have been modified. RN-C stated she took a side-by-side photo of the two orders, and the fax time was identical down to the millisecond. RN-C stated that it appeared that a faxed order for diclofenac gel (topical medication to reduce pain and inflammation) for R61 was photocopied, and the body of the message cleared and this different order for a diagnosis, major depressive disorder severe with psychotic symptoms (diagnostic code F33.3) was in its place. RN-C e-mailed a corporate nurse (CN)-O on 2/2/26 about her concerns with R61 and R72's MDS modifications and suspicion regarding documentation. RN-C stated the facility administrator came to her that day to talk about her concerns for diagnosis changes without supporting documentation and asked for an example which she provided. RN-C stated her administrator stated he would speak with RN-A and investigate, then on 2/9/26, the administrator informed RN-C that RN-A had located fax documentation in the resident's hard chart from June 2025 showing physician approval of the diagnosis and that his investigation was complete. RN-C stated after that the corporate office had an outside party do an audit of their MDS' and found there were 136 original assessments and 136 modifications, RN-C reported RN-A was put on leave at that time. When RN-A went on leave RN-C was asked to perform the beneficiary denial forms for residents and as she was trying to learn more about this process, she looked at old forms, and for R61 specifically, she noticed the signatures on the denial forms were not what she recognized as being the residents. RN-C stated in early February RN-A made meeting notes for the weekly meetings she was supposed to be having with RN-C regarding her performance, there were supposed to have been eight meetings but only two were held. R40's SCSA MDS dated [DATE], didn't identify diagnosis code F33.3 in section I. A modification was made on 12/16/25 by RN-A, and section I identified diagnosis code F33.3. An additional modification was made on 4/13/26 by RN-B, and section I no longer included diagnosis code F33.3. A diagnosis audit report dated 7/31/26, identified R40 had diagnosis F33.3 added to his EMR by RN-A on 12/16/25 at 10:30 a.m. as an effective date of 1/15/25. R40's Physician Update facsimile dated 8/17/25, identified the following, OK to use F33.3 major depressive disorder with psychotic symptoms related to behaviors, agitation and trazadone use with a yes or no and the yes circled and an undated physician signature. R40's progress notes from provider on 3/24/26, includes a review of systems and diagnoses for a regulatory visit and didn't include F33.3, but did include a diagnosis for mild late onset Alzheimer's dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety. During an interview on 7/30/26 at 1:04 p.m., nurse practitioner (NP)-F stated all faxes go to a central system and the provider signs through that system and the system then keeps a copy of all requests for the resident record. NP-F stated they were familiar with both R40 and R39, they took over care from MD-L towards the end of 2025. NP-F was not aware either resident having the diagnosis major depressive disorder, recurrent, severe with psychotic symptoms (F33.3). NP-F reviewed both resident records and confirmed that diagnosis was not on their current or historical diagnosis list. NP-F also stated she was very familiar with MD-L's signature since they worked for the same organization. NP-F reviewed the diagnoses order for R40 dated 8/17/25 and stated the provider signature on the order did not look like MD-L's signature. During an interview on 7/30/26 at 3:33 p.m., RN-I stated on 2/10/26, RN-C had shown her the two faxed orders for R61 and they had the exact same time stamp down to the millisecond of 10:38:17. During an interview on 7/31/26 at 11:48 a.m., the administrator stated they had an internal complaint related to an MDS issue and began reviewing inappropriate documentation inconsistent with providers (continued on next page)</p> |                                                                                               |                                                 |

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| F 0895<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>orders and suspended RN-A pending investigation. After a full investigation, including an external audit of MDS, they didn't substantiate RN-A provided any type of forgery, but did see inconsistencies that they needed to work through. The facility did go through and amend those MDS' to remove the diagnoses F33.3. The administrator stated through the course of this survey he could see there may be more resident signatures in question on the beneficiary notices. The administrator stated the facility did not report this issue to the Minnesota Board of Nursing, he assumed the former MDS coordinator did, and the facility had complied with the requests for documentation submission. The administrator also said they have increased additional auditing and oversight of the MDS submissions. In a timeline received from the facility administrator on 8/3/26, the administrator documented he spoke with RN-A on 2/2/26 about the concern of not having the physician documentation. The administrator also documented RN-A provided him with four copies from the hard charts later this week, one of them was the R61 example from RN-C. The administrator also noted he had met with MD-K, the primary care provider for R61, on 2/24/26 and reviewed the two faxes from 6/24/25. MD-K stated that R61 did have a diagnosis of F33.3. MD-K stated she found it unusual her signature would be exact as she signed everything individually and did not use a copy for her signature. MD-K also found it unusual on the F33.3 diagnosis fax she didn't circle the yes completely as she always made sure when circling it was a clear circle so that it showed up when faxed. MD-K was going to have her office review the fax timestamps to see how many were sent to the facility. MD-K stated it was not unusual to send multiple faxes at the same time. MD-K's office was unable to locate either fax in her system but stated it was possible her team did not scan them in. On 2/9/26, (approximate date), the administrator documented he let RN-C know he was able to find the physician forms and they looked fine and had signatures, but he wasn't able to find supporting documentation so RN-C did the right thing to not code it on the MDS. On 2/17/26, the administrator documented that he met with RN-A and reviewed what he had found with the F33.3 issue without supporting documentation. During this meeting, RN-A discussed that one of the forms were brought up during RN-A's Board of Nursing call about concerns of a discrepancy of physician signatures. On 2/18/26, he obtained faxes for R61 from the pharmacy and noted one of the forms to be on a similar form as the physician update for the major depression diagnosis (F33.3), then suspended RN-A pending investigation for possible discrepancies in documentation and MDS diagnoses. The administrator notified the medical director and senior leadership of the concern and suspension. On 4/2/26 the administrator received the results of the external MDS audit and the VP of HR's investigation. These results indicated that a limited subset of documentation reviewed was directly submitted or associated with the RN-A. Based on the available evidence and audit findings, there was no conclusive determination that the RN-A engaged in fraudulent documentation practices. The concerns identified relate more appropriately to process oversight, documentation standardization, and system-level controls. As a result of these findings, the organization has focused on implementing corrective actions, including strengthening documentation standards, enhancing staff education, improving workflow processes, and increasing audit and oversight mechanisms to ensure ongoing compliance and integrity of the MDS process. An undated consultant report for an MDS integrity audit identified during the review, certain irregularities, including signature inconsistencies on select documents, were identified and appropriately escalated for further independent review. These findings should be evaluated separately to determine scope and impact. Overall, the audit supports the need for systematic process improvement, staff education, and enhanced oversight controls to ensure sustained compliance and documentation integrity. St. [NAME] Health Services leadership could address these findings proactively through targeted corrective action and strengthened governance structures. On 7/31/26 at 11:34 a.m., independent consultant (continued on next page)</p> |                                                                                               |                                                 |

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| F 0895<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>(IC)-M clarified what was meant in the MDS Integrity Audit where it was indicated under the section titled, Identification of Additional Irregularities, the findings were documented and reported through appropriate external channels in accordance with the consultant's professional and ethical obligations and are formally included in this report as material findings requiring further independent review was that reports were made to the corporate office who had requested the audit and outside of this facility. IC-M stated they didn't elevate this further because they knew they were making a report. The facility's Quality Improvement Incentive Payment (QIIP) for payment year 2027, identified a baseline for resident antipsychotics at 16.76% with a goal of 10.19% for full incentive. Quarter two notes identified review of antipsychotic medication documentation shows facility in compliance with appropriate diagnosis with supporting documentation. Trending downward from Q1 from 19.65% to 13.02%. The facility's corporate compliance and ethics training was requested but not received.</p> |                                                                                               |                                                 |

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| <p>F 0552</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to ensure residents were informed of and consented to medications prescribed and given for mental health intervention for 2 of 5 residents (R7, R33) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R7:</p> <p>R7's significant change in assessment (SCSA) minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of Parkinsons, anxiety, insomnia, and bipolar disorder.</p> <p>R7's care plan dated 4/9/26, identified a focus statement for behavior related to bipolar disorder and anxiety. Interventions include target behaviors, non-pharmacological interventions, to administer medications per order and monitor for side effects.</p> <p>R7's provider order on 7/21/26, Depakote 250 milligrams (mg) by mouth two times per day for bipolar disorder. And an order on 5/31/26, gabapentin 300 mg by mouth three times per day for anxiety.</p> <p>R7's electronic medical record (EMR) didn't contain evidence of R7 having been educated on the risks, benefits, side effects, and alternatives for Depakote or gabapentin which were both treating mental health diagnoses.</p> <p>R33:</p> <p>R33's significant change Minimum Data Set (MDS) dated [DATE], identified R33 had diagnoses which included Parkinson's disease, polyneuropathy, depression, and anxiety. In addition, R33's MDS identified he was severely cognitively impaired, was dependent on staff for activities of daily living, and received antianxiety medications, opioids, and anticonvulsants.</p> <p>R33's Order Summary Report identified he had orders for the following medications:</p> <p>Celexa 20 milligrams (mg) one time a day for major depressive disorder</p> <p>Hydroxyzine 10 mg two times a day for hallucinations/delusions related to Parkinson's disease</p> <p>Risperidone 0.25 mg at bedtime for hallucinations related to major depressive disorder.</p> <p>A review of R33's electronic medical record (EMR) identified R33 had a consent for Celexa, but not for hydroxyzine or risperidone.</p> <p>During an interview on 7/30/26 at 12:12 p.m., the director of nursing (DON) stated it was important for residents and/or their families to know the side effects and the risk for taking the medication to (continued on next page)</p> |                                                                                               |                                                 |

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| F 0552<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | decide if the risk was worth taking the medication.<br><br>Psychotropic Medications dated 5/21/25, identified care center nursing staff would review the psychotropic medication informed consent with the resident and/or representative and then would obtain a signature for use of the medication(s). Psychotropic medications were defined as anti-anxiety, hypnotic/sedative, antipsychotic, anticonvulsant, antihistamine, and antidepressant classes of drugs. |                                                                                               |                                                 |

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| F 0554<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to follow a self-administration of medication (SAM) form which indicated the resident should not self-administer medications. This affected 1 of 1 (R54) residents reviewed for self-administration of medications. Findings include: R54's quarterly Minimum Data Set (MDS) dated [DATE], indicated R25 had no cognitive impairment. Diagnoses included anemia, multiple sclerosis, and seizure disorder. R54's Active Order Summary Report dated 7/30/26, lacked orders to keep any medications at bedside. R54's care plan dated 9/3/25, indicated R54 was unable to self-administer medications. Interventions included nursing responsibility to document, administer, and store all medications. R54's Self Administration of Medication (SAM) Evaluation form dated 8/21/25, indicated R54 could not self-administer medications and could not keep medications at bedside. On 7/27/26 at 4:18 p.m., medications including a tube of Diclofenac muscle cream, Biotin mouth wash, and Systane eye drops were observed on R54's bedside table. No staff were in the room. On 7/30/26 at 9:02 a.m., the same medications were again observed on R54's bedside table and there were no staff present. During an interview on 7/30/26 at 9:05 a.m., licensed practical nurse (LPN)-A stated a SAM assessment and orders from the provider to keep at bedside are needed prior to leaving medications at bedside. LPN-A confirmed Diclofenac, Biotin, and Systane were left in R54's room, but was unsure if R54 should have them left at bedside. During an interview on 7/30/26 at 9:29 a.m., registered nurse (RN)- D stated the RN did the SAM assessments. Once completed, the RN would let licensed staff know who could keep medications at bedside. RN-D reviewed R54's SAM assessment and acknowledged R54 should not have medications left at bedside. During an interview on 7/30/26 at 9:40 a.m., the director of nursing (DON) stated an expectation staff would make sure all appropriate paperwork, such as the SAM assessment, were completed and accurate prior to leaving medication at bedside. Facility policy Self-Administration of Medication by Residents last revised 2/27/24, indicated the SAM assessment would be completed and reviewed by the interdepartmental team (IDT). A decision would be made by the IDT prior to keeping medications at bedside. |                                                                                               |                                                 |

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| F 0578<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review the facility failed to ensure 1 of 1 resident's (R5) Provider Orders for Life Sustaining Treatment (POLST) was completed timely. Findings include: R5's admission Minimum Data Set (MDS) dated [DATE], identified R5 had diagnoses which included heart failure (a medical condition where the heart does not pump blood effectively), dementia, diabetes mellitus, hyperlipidemia, and heart disease. In addition, R5's MDS identified they were moderately cognitively intact and required partial to moderate assistance with activities of daily living. R5's POLST identified R5 signed their POLST document on 5/6/26, R5's provider did not sign the document until 7/30/26, after it was brought to the facility's attention that the document had not been signed by the provider. During an interview on 7/30/26 at 1:02 p.m., the director of nursing (DON) stated the admission coordinator would fill out the form with the resident or their decision maker and then it would go into the chart as an order. The DON could not say why the POLST had not been signed by the provider on admission. Advance Care Planning dated 6/25/24, identified on admission the resident and/or their legal representative would be notified of the need for an order for cardiopulmonary resuscitation. The policy identified the POLST would become a medical order.</p> |                                                                                               |                                                 |

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| F 0582<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on interview and document review, the facility failed to ensure residents received notice of Medicare non-coverage for 1 of 4 residents (R78) reviewed for beneficiary denials. Findings include: A Medicare notice of non-coverage is required to be given to residents in advance of non-coverage for services covered under Medicare so that they have an opportunity to appeal the decision. R78's admission Record identified and admission date of 8/21/25, and a discharge date of 9/10/25. A review of R78's Financial Questionnaire from admission, identified R78's signature on the financial form. R78's Medicare denial form (CMS-10123) dated 9/5/25 and a managed care denial form (U Care) dated 9/7/25, contained R78's signatures, the signatures on each form didn't look similar to each other, and the signature on the 9/7/25 U Care form didn't look similar to the Financial Questionnaire form. R78's progress notes didn't reflect R78 had received their Medicare or U Care denial forms. During an interview on 7/31/26 at 10:44 a.m., R78 stated she did not recall signing any papers about Medicare denial and the right to appeal. R78 stated she was at the facility 21 days and is home and doing well. Beneficiary denial forms for additional residents more recently receiving beneficiary denials were requested but not received. Based on interview and document review, the facility failed to ensure residents received notice of Medicare non-coverage for 1 of 4 residents (R78) reviewed for beneficiary denials.</p> |                                                                                               |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to immediately report incidents of potential resident-to-resident abuse to the state agency (SA) within two hours, as required for 1 of 1 residents (R71) reviewed for abuse. In addition, the facility failed to ensure potential sexual abuse were reported to the state agency (SA), within 2 hours, for a resident with unexplained laceration of perineum for 1 of 1 resident (R43) reviewed for injuries of unknown cause.</p> <p>Findings include:</p> <p>R71:</p> <p>R71's admission Minimum Data Set (MDS) dated [DATE], indicated R71 was cognitively intact. Diagnoses included osteoarthritis of the right hip and major depressive disorder.</p> <p>R71's care plan dated 12/24/25, indicated R71 was a vulnerable adult related to physical condition. Goals included the resident would be free abuse, neglect, or financial exploitation. Interventions lacked interventions to protect from abuse.</p> <p>R71's progress notes from 12/25/25 to 12/30/25, were reviewed and showed the following:</p> <p>12/27/25 at 2:28 p.m., R71 approached nurse and reported R72 was in her room multiple times the night before and scared R71. R71 stated R72 had grabbed some belongings and left the room. Director of Nursing (DON) was notified of the situation.</p> <p>12/30/25 at 1:00 a.m., R71 two nights in a row placed a walker in front of the door to barricade R72 from entering room. R71 stated I'm scared to death of him. R71 had put the call light on at the beginning of the shift to report R had already attempted to enter R71's room</p> <p>R72's admission MDS dated [DATE], indicated R72 had moderate cognitive impairment. Diagnoses included vascular dementia with agitation and Alzheimer's disease. The MDS indicated R72 paced and wandered daily and significantly disrupted the care or living environment of other residents.</p> <p>R72's progress notes from 12/25/25 to 12/30/25, were reviewed and indicated frequent roaming into other resident rooms and frequent agitation towards staff and residents.</p> <p>During an interview on 7/29/26 at 11:27 a.m., licensed practical nurse (LPN)-A stated R71 came to her on the morning of 12/26/25, and reported R72 had come into the room several times the night before. When R71 told R72 to leave the room, R72 snarled at R71, grabbed R71's blanket, and then left the room. LPN-A stated R71 told her R71 was very scared of R71. The DON was notified of the resident-on-resident altercation. Any nursing staff can file the vulnerable adult (VA) report but when reported the DON did not tell her to go ahead and file a VA report with the state agency (SA) or that the DON was going to file the VA with the state agency.</p> <p>(continued on next page)</p> |                                                                                               |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>During an interview on 7/29/26 at 11:39 a.m., the DON stated on 12/26/25, she was not the DON, but the evening charge nurse. She had been made aware of the situation but was unsure if the DON at the time had filed a VA with the SA. The DON stated a resident-on-resident altercation with concerns of abuse should be reported to the SA within two hours of finding out about it.</p> <p>During an interview on 7/30/26 at 9:40 a.m., the administrator stated a VA had not been filed with the SA because the facility did not feel the concern reached the level of resident-on- resident potential abuse.</p> <p>Facility policy Maltreatment Investigation and Reporting dated 3/10/26 indicated any employee who observed, suspected, or had knowledge of maltreatment or suspicious injury involving a Vulnerable Adult must immediately report their concerns. All alleged violations that involved abuse would be reported to the SA within 2 hours.</p> <p>R43:</p> <p>R43's quarterly Minimum Data Set (MDS) dated [DATE], identified R43 had diagnoses which included ulcerative colitis, cirrhosis of liver, depression, hypothyroidism, hypertension, edema, osteoarthritis, and history of malignant neoplasm of other parts of the uterus. In addition, R43 was cognitively intact, had no behaviors, required substantial to maximum assistance with activities of daily living, and was frequently incontinent of bladder.</p> <p>R43's care plan was reviewed on 7/29/26, (the document was requested but not provided). R43's care plan identified she had a self-care deficit and required assistance every four hours and as needed for check and change. The care plan further identified she required help to clean peri area with each incontinence episode.</p> <p>R43's progress note dated 7/25/26 at 6:47 a.m., identified the facility received a call from an emergency room nurse and identified the following, She doesn't have active bleeding, but when you wipe her there is a small amt of blood on the wipe. Informed Nurse res has been having bleeding for a couple of days and has had this issue in the past. Res returned to facility at 0005. The note went on to identify the following, . Spoke with resident about cares and asked if anyone has ever been rough when washing her up, providing cares, or abusive in any way. Res loudly stated, NO! Res understood it is this writer's job to ask these questions to be sure someone did not cause her any type of injury that may have caused her to have bleeding. Res again so no. Res AVS (after visit summary) listed a dx (diagnosis) of laceration to perineum.</p> <p>A review of the emergency room encounter dated 7/27/26, for the visit on 7/24/26, identified a complicated urinary tract infection, laceration of perineum in female, fecal occult blood test positive, swelling of right upper extremity. The physical exam identified the following, Does have very minor labial tear abrasion at the 12 o'clock position with minimal blood present. The summary identified the need for Good perineal care for laceration.</p> <p>During an interview on 7/28/26 at 3:01 p.m., nursing assistants (NA)-E and NA-F stated they had not been told anything specific about cares for R43 after her emergency room (ER) visit with the (continued on next page)</p> |                                                                                               |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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No. 0938-0391

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| <p>F 0609</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>exception to be more gentle.</p> <p>During an interview on 7/30/26 at 10:00 a.m., NA-G stated she had not received any education about<br/>peri cares for R43 after her emergency room visit.</p> <p>During an interview on 7/30/26 at 12:18 p.m., the director of nursing (DON) stated the registered<br/>nurse (RN) called her the night R43 returned from the ER, the DON stated she called the administrator<br/>and they discussed the concern. They determined it was not reportable based on a similar situation in<br/>May or June but stated it was a different area. The DON stated that one had been investigated. They<br/>stated when R43 returned from the ER someone asked her if she had been abused and she said no,<br/>based on this information they determined this was not reportable and they decided they did not need<br/>to do an investigation. The DON stated they did not do any education or training for staff and stated in<br/>retrospect maybe they should have reported and investigated the labial tear/abrasion.</p> <p>During an interview on 7/30/26 at 1:32 p.m., the administrator stated abuse, neglect, injuries of<br/>unknown origin should be reported and investigated. He stated they did not feel R43's injury of<br/>unknown origin needed to be reported or investigated.</p> <p>Maltreatment Investigation and Reporting dated 3/10/26, identified staff needed to report within 24<br/>hours if the allegation did not involve abuse and did not result in bodily injury.</p> <p>Maltreatment Prohibition Definitions dated 6/16/26, injuries of unknown source should be reported<br/>when the source of the injury was not observed by any person or the source of the injury could not be<br/>explained and if the injury was suspicious or the location of the injury was not generally vulnerable to<br/>trauma.</p> |                                                                                               |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to conduct a formal investigation into the allegations of resident-on-resident mental abuse for 1 of 4 residents reviewed (R71) for abuse. The facility also failed to investigate a possible sexual abuse when a resident had unexplained laceration of perineum. This affected 1 of 4 residents (R43) reviewed for abuse.</p> <p>Findings include:</p> <p>R71:</p> <p>R71's admission Minimum Data Set (MDS) dated [DATE], indicated R71 was cognitively intact. Diagnoses included osteoarthritis of the right hip and major depressive disorder.</p> <p>R71's care plan dated 12/24/25, indicated R71 was a vulnerable adult related to physical condition. Goals included the resident would be free abuse, neglect, or financial exploitation. Interventions lacked interventions to protect from abuse.</p> <p>R71's progress notes from 12/25/25 to 12/30/25, were reviewed and showed the following:</p> <p>12/27/25 at 2:28 p.m., R71 approached nurse and reported R72 was in her room multiple times the night before and scared R71. R71 stated R72 had grabbed some belongings and left the room. Director of Nursing (DON) was notified of the situation.</p> <p>12/30/25 at 1:00 a.m. R71 two nights in a row placed a walker in front of the door to barricade R72 from entering room. R71 stated I'm scared to death of him. R71 had put the call light on at the beginning of the shift to report R had already attempted to enter R71's room</p> <p>R72's admission MDS dated [DATE], indicated R72 had moderate cognitive impairment. Diagnoses included vascular dementia with agitation and Alzheimer's disease. The MDS indicated R72 paced and wandered daily and significantly disrupted the care or living environment of other residents.</p> <p>R72's progress notes from 12/25/25 to 12/30/25, were reviewed and indicated frequent roaming into other resident rooms and frequent agitation towards staff and residents.</p> <p>During an interview on 7/29/26 at 11:27 a.m., licensed practical nurse (LPN)-A stated R71 came to her on the morning of 12/26/25, and reported R72 had come into the room several times the night before. When R71 told R72 to leave the room, R72 snarled at R71, grabbed R71's blanket, and then left the room. LPN-A stated R71 told her R71 was very scared of R71. The DON was notified of the resident-on-resident altercation. The facility process is once the DON is notified of alleged physical, sexual, or mental abuse administration is notified, and management will perform any investigations that would occur. LPN-A stated the DON or any other member of the management team came in that weekend to start an investigation.<br/>(continued on next page)</p> |                                                                                               |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>During an interview on 7/29/26 at 11:39 a.m., the DON stated on 12/26/25, she was not the DON, but the evening charge nurse. She had been made aware of the situation but was unsure if the DON at the time had performed any kind of investigation into the alleged resident on resident mental abuse concerns.</p> <p>During an interview on 7/30/26 at 9:40 a.m., the administrator stated a VA had not been filed with the SA because the facility did not feel the concern reached the level of resident-on- resident potential abuse. For that reason, there was no investigation, other than discussed in the Inter-departmental team (IDT).</p> <p>The IDT notes for the week of 12/26/25 to 12/30/25 were requested but not provided.</p> <p>R43:</p> <p>R43's quarterly Minimum Data Set (MDS) dated [DATE], identified R43 had diagnoses which included ulcerative colitis, cirrhosis of liver, depression, hypothyroidism, hypertension, edema, osteoarthritis, and history of malignant neoplasm of other parts of the uterus. In addition, R43 was cognitively intact, had no behaviors, required substantial to maximum assistance with activities of daily living, and was frequently incontinent of bladder.</p> <p>R43's care plan was reviewed on 7/29/26, (the document was requested but not provided). R43's care plan identified she had a self-care deficit and required assistance every four hours and as needed for check and change. The care plan further identified she required help to clean peri area with each incontinence episode.</p> <p>R43's progress note dated 7/25/26 at 6:47 a.m., identified the facility received a call from an emergency room nurse and identified the following, She doesn't have active bleeding, but when you wipe her there is a small amt of blood on the wipe. Informed Nurse res has been having bleeding for a couple of days and has had this issue in the past. Res returned to facility at 0005. The note went on to identify the following, . Spoke with resident about cares and asked if anyone has ever been rough when washing her up, providing cares, or abusive in any way. Res loudly stated, NO! Res understood it is this writer's job to ask these questions to be sure someone did not cause her any type of injury that may have caused her to have bleeding. Res again so no. Res AVS (after visit summary) listed a dx (diagnosis) of laceration to perineum.</p> <p>A review of the emergency room encounter dated 7/27/26, for the visit on 7/24/26, identified a complicated urinary tract infection, laceration of perineum in female, fecal occult blood test positive, swelling of right upper extremity. The physical exam identified the following, Does have very minor labial tear abrasion at the 12 o'clock position with minimal blood present. The summary identified the need for Good perineal care for laceration.</p> <p>During an interview on 7/28/26 at 3:01 p.m., nursing assistants (NA)-E and NA-F stated they had not been told anything specific about cares for R43 after her emergency room (ER) visit with the exception to be more gentle.<br/>(continued on next page)</p> |                                                                                               |                                                 |

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| F 0610<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>During an interview on 7/30/26 at 10:00 a.m., NA-G stated she had not received any education about peri cares for R43 after her emergency room visit.</p> <p>During an interview on 7/30/26 at 12:18 p.m., the director of nursing (DON) stated the registered nurse (RN) called her the night R43 returned from the ER, the DON stated she called the administrator and they discussed the concern. They determined it was not reportable based on a similar situation in May or June but stated it was a different area. The DON stated that one had been investigated. They stated when R43 returned from the ER someone asked her if she had been abused and she said no, based on this information they determined this was not reportable and they decided they did not need to do an investigation. The DON stated they did not do any education or training for staff and stated in retrospect maybe they should have reported and investigated the labial tear/abrasion.</p> <p>During an interview on 7/30/26 at 1:32 p.m., the administrator stated abuse, neglect, injuries of unknown origin should be reported and investigated. He stated they did not feel R43's injury of unknown origin needed to be reported or investigated.</p> <p>Maltreatment Investigation and Reporting dated 3/10/26, identified staff needed to report within 24 hours if the allegation did not involve abuse and did not result in bodily injury. In addition, an initial investigation must be conducted immediately to determine what happened and whether the incident requires reporting to the Office of Health Facility Complaints or the Minnesota Adult Abuse Reporting Center. The internal process included interviews with residents, staff, and visitors. The process also included immediate interventions taken to protect the resident(s).</p> |                                                                                               |                                                 |

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| F 0628<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide the required documentation or notification related to the resident's needs, appeal rights, or<br>bed-hold policies.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on<br>interview and document review, the facility failed to provide the required written notices before a<br>transfer to the hospital for 1 of 1 resident (R7) reviewed for hospitalization. Findings include: R7's<br>significant change in condition assessment (SCSA) minimum data set (MDS) dated [DATE], identified<br>intact cognition and diagnoses of right-side affected hemiplegia and hemiparesis, congestive heart<br>failure (CHF), and chronic obstructive pulmonary disease (COPD). R7's progress notes dated 7/27/26,<br>didn't include information regarding a bed-hold. During an interview on 7/30/26 at 1:25 p.m., registered<br>nurse (RN)-E stated they would ask the resident or representative if they would want a bed-hold and<br>then they let social services director (SS)-C know. RN-E stated the nurses didn't use a form; she<br>thought SS-C went over the form. During an interview on 7/30/26 at 1:26 p.m., SS-C stated the<br>charge nurse would ask family if they would like a bed-hold and then make a progress note regarding<br>verbal bed-hold obtained, when SS-C was back in the office she would send out the bed-hold form and<br>policy and return envelope to sign and send back to them. SS-C stated no paperwork goes to the<br>hospital with the resident, and they only did bed-holds if the resident was admitted. A policy, Bed Hold<br>Election and Hospital Transfer 9/23/25, identified its purpose was to ensure residents and their<br>representatives were informed of their right to elect a bed hold during hospitalization or a therapeutic<br>leave. For a hospital leave transfer to the emergency department, the bed hold policy will accompany<br>the resident. The resident and or representative will be contacted for verbal authorization to accept or<br>decline the bed hold. A copy of the policy and completed consent will be mailed within 24 hours. |                                                                                               |                                                 |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to ensure the minimum data sets (MDS) was completed accurately and timely for 1 of 3 residents (R25) reviewed for activities of daily living, and 1 of 4 residents (R69) reviewed for quality of care and 1 of 1 resident (R43) for oral/dental. In addition, the facility failed to ensure the integrity of MDS data submitted to the Centers for Medicare and Medicaid Services (CMS) for 4 of 4 residents (R31, R39, R40, R61) reviewed for MDS accuracy. Findings include:</p> <p>R25:</p> <p>Per the Centers for Medicare and Medicaid Services (CMS) and the resident assessment instructions (RAI) manual, a significant change in assessment (SCSA) must be completed less by the end of the 14th day following determination that a significant change has occurred or 14 days after the assessment reference date (ARD).</p> <p>R25's SCSA MDS with an ARD of 4/9/26, identified moderately impaired cognition and diagnoses of malignant neoplasm of lung, and secondary neoplasm of bone. The RN assessment coordinator signed as complete on 4/28/26. Section GG for functional limitation in range of motion was not assessed.</p> <p>During an interview on 7/30/26 at 11:24 a.m., registered nurse (RN)-H, who identified as the MDS coordinator, stated there wasn't date from the nursing staff to be able to code section GG of the MDS. RN-H stated it would be important for section GG to be completed to know the resident's baseline and for billing purposes.</p> <p>R31</p> <p>R31's admission Record identified an admission date of 1/25/23.</p> <p>R31's quarterly minimum data set (MDS) dated [DATE], didn't contain diagnosis for major depressive disorder, recurrent, severe with psychotic symptoms (F33.3) in section I. On 12/16/25, RN-A modified the 11/5/25 MDS to include diagnosis F33.3 under section I.</p> <p>R31's Diagnosis Audit Report identified F33.3 was added to his EMR on 1/15/25 with an effective date of 1/25/23.</p> <p>A progress note from R31's provider on 4/21/26, included a review of systems and diagnoses for a regulatory visit and didn't include F33.3, but did contain a diagnosis for severe Lewy body dementia with agitation, depressive disorder in remission noting resident can be very happy when alert. R31's progress notes didn't reflect supporting documentation for the F33.3 diagnosis that was added to his medical records.</p> <p>R31's medical record lacked supporting documentation for diagnosis F33.3.<br/>(continued on next page)</p> |                                                                                               |                                                 |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>A provider order for R31's F33.3 diagnosis was requested but not received.</p> <p>R39</p> <p>R39's SCSA MDS dated [DATE], completed by RN-A included diagnosis F33.3.</p> <p>R39's history and physical dated 8/13/23, identified a diagnosis of late onset Alzheimer's disease without behavioral disturbance and generalized anxiety disorder, but didn't contain diagnosis F33.3.</p> <p>R39's Diagnosis Audit Report identified F33.3 was added to her record on 1/15/25 with an effective date of 8/17/23.</p> <p>R39's medical record lacked supporting documentation for diagnosis F33.3.</p> <p>A provider order for diagnosis F33.3 was requested but not received.</p> <p>R40</p> <p>R40's SCSA MDS dated [DATE], didn't identify diagnosis code F33.3 in section I. A modification was made on 12/16/25 by RN-A, and section I identified diagnosis code F33.3. An additional modification was made on 4/13/26 by RN-B, section I didn't identify diagnosis code F33.3.</p> <p>A diagnosis audit report dated 7/31/26, identified R40 had diagnosis F33.3 added to his EMR by RN-A on 12/16/25 at 10:30 a.m. as an effective date of 1/15/25.</p> <p>R40's Physician Update facsimile dated 8/17/25, identified the following, OK to use F33.3 major depressive disorder with psychotic symptoms related to behaviors, agitation and trazadone use with a yes or no and the yes circled and an undated physician signature.</p> <p>R40's progress note from provider on 3/24/26, includes a review of systems and diagnoses for a regulatory visit and didn't include F33.3, but did include a diagnosis for mild late onset Alzheimer's dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety.</p> <p>R40's medical record lacked supporting documentation for diagnosis F33.3.</p> <p>R43:</p> <p>R43's quarterly MDS dated [DATE], identified section L oral/dental, was not completed (it was left with dashes).</p> <p>During an interview on 7/29/26 at 1:27 p.m., RN-H reviewed R43's MDS and verified section L was missing information. RN-H stated it should have been completed and stated it would be important to have the information so any changes could be reviewed at the next assessment.</p> <p>During an interview on 7/30/26 at 11:59 a.m., the director of nursing (DON) verified the MDS (continued on next page)</p> |                                                                                               |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245245                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Manor                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>321 Northeast Sixth Street<br>Chisholm, MN 55719 |                                                 |
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| <p>F 0641</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>assessments needed to be completed for coding, billing, and to develop the residents care plans.</p> <p>MDS 3.0 assessment dated [DATE], identified all MDS assessments and Discharge and Reentry records would be completed following the Resident Assessment Instrument (RAI) instructions. The RAI further identified all items should be completed and signed within the required time frames according to the RAI Manual.</p> <p>R61</p> <p>R61's SCSA MDS dated [DATE], didn't identify a diagnosis code F33.3 in section I. A modification was made on 12/16/25 by RN-A, and section I identified a diagnosis code of F33.3. An additional modification was made on 4/13/26 by RN-B, section I didn't identify diagnosis code F33.3.</p> <p>R61's Order Summary Report dated 11/25/25, didn't include a diagnosis for F33.3.</p> <p>A diagnosis audit report dated 7/31/26, identified R61 had diagnosis F33.3 added to her EMR by RN-A on 12/16/25 at 10:36 a.m. as an effective diagnosis beginning on 1/22/25.</p> <p>R61's medical record lacked supporting documentation for diagnosis F33.3.</p> <p>R69:</p> <p>R69's admission Minimum Data Set (MDS) dated [DATE], identified section C cognitive patterns, section D mood had not been assessed. Section E behavior was missing assessments.</p> <p>During an interview on 7/29/26 at 1:25 p.m., registered nurse (RN)-H reviewed R69's admission MDS and verified sections C, D, and E were missing information. RN-H stated social services would usually complete sections C, D, and E. RN-H verified it was important to have all sections completed for a baseline assessment so they could compare them at the next assessment.</p> <p>During an interview on 7/31/26 at 11:48 a.m., the administrator stated they had an internal complaint related to an MDS issue and began see inconsistencies that they needed to work through. The facility did go through and amend those MDS' to remove the diagnoses F33.3.</p> |                                                                                               |                                                 |

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| F 0656<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to include dialysis to a resident's comprehensive care plan, who received dialysis while in the facility. This affected 1 of 1 (R2) residents reviewed for comprehensive care plans. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 was cognitively intact. Diagnoses included anemia, hypertension, and end stage renal disease. Section O: Special Treatments, Procedures, and Programs indicated R2 received dialysis while at the facility. R2's Active Order Summary Report dated 7/30/26, indicated an order to monitor perma-catheter site for pain, swelling, or signs of infection. The order summary report lacked orders related to R2's dialysis. R2's care plan lacked a care plan related to R2's dialysis and interventions to treat the dialysis, until a care plan was initiated on 7/28/26. During an interview on 7/28/26 at 12:49 p.m., R2 stated dialysis was received through the dialysis center in Hibbing, Mn on Tuesday, Thursday, and Saturday. Dialysis was received through the perma-catheter in the right chest wall. During an interview on 7/30/26 at 9:06 p.m., the licensed practical nurse (LPN)-A stated all resident specific medical conditions such as heart conditions, respiratory conditions and kidney conditions, like the need for dialysis, would have their own specific care plans so all staff would be aware of the condition and know how to provide care related to the condition. During an interview on 7/30/26 at 9:29 a.m., registered nurse (RN)-D stated the RN was responsible for building the care plan based on diagnoses and the information in the MDS assessment. RN-D reviewed R2's MDS assessment from 7/10/26, and R2's active care plan and acknowledge the MDS assessment showed R2 received dialysis but there was no active care plan related to the Dialysis is R2's current care plan. During an interview on 7/30/26 at 9:40a.m., the director of nursing (DON) stated all RN's should make sure the comprehensive care plan has all details related to what is on the comprehensive MDS assessment in the resident's active care plan. The facility policy Person Centered Care Planning dated 6/16/26 indicated a comprehensive person-centered care plan would be completed with 7 days of the MDS completion. The care plan would be based on the MDS assessment and care area assessments. The care plan would cover specialized services and include measurable goals and interventions |                                                                                               |                                                 |

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| F 0684<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure orders were followed as written for 1 of 1 resident (R28) reviewed for quality of care. Findings include: R28's quarterly Minimum Data Set (MDS) dated [DATE], identified R28 had diagnoses which included multiple sclerosis (a long-lasting disease of the brain and spinal cord), diabetes mellitus, persistent atrial fibrillation (a common irregular heart rhythm where the upper heart chamber beats fast and out of sync with the lower chambers), hypertension, hyperlipidemia, heart failure (a chronic condition where the heart muscle cannot pump blood and oxygen well enough to meet the body's needs). In addition, R28's MDS identified he was cognitively intact and was dependent on staff for assistance with activities of daily living. During an interview on 7/30/26 at 4:24 p.m., family member (FM)-N expressed concerns about therapies not being continued since the new physical therapy department started. FM-N stated they had talked with the facility about her concerns with lack of therapy. FM-N thought R28's provider had re-ordered the therapy, but he was not receiving any treatment. A physician's update with a date of 7/3/26, identified a family requested an order for the resident to receive lymphedema treatment. The provider responded on 7/7/26, ok for occupational therapy referral for lymphedema treatments. A review of R28's current orders on 7/30/26, (requested but not provided) identified there were no orders for lymphedema massage. During an interview on 7/31/26 at 8:24 a.m., therapy director (PTA)-A stated R28 had been getting treatment for lymphedema therapy up until May 2026, when the facility changed to a different therapy company. PTA-A stated their department had not received any orders for lymphedema therapy for R28. During an interview on 7/31/26 at 8:42 a.m., registered nurse (RN)-E confirmed the order for lymphedema order had been signed off on 7/7/26. During an interview on 7/31/26 at 10:08 a.m., the director of nursing (DON) verified when nursing received a provider order, the order should be entered as an order and not as a progress note. The DON stated if an order is entered as a progress note instead of an order the order will not be carried out. During an interview on 7/31/26 at 10:24 a.m., nurse practitioner (NP)-F stated R28 would probably benefit from lymphedema treatment. NP-F stated she would expect orders to be processed as written. |                                                                                               |                                                 |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and document review, the facility failed to ensure safe ambulation interventions were followed for 2 of 2 residents (R14, R75) reviewed. In addition, the facility failed to ensure resident equipment concerns were addressed in a timely manner to help prevent accidents for 1 of 5 residents (R9) reviewed for accident and safety concerns. Findings include:</p> <p>R14:</p> <p>R14's significant change Minimum Data Set (MDS) dated [DATE], identified R14 was severely cognitively impaired.</p> <p>R14's diagnoses included acute on chronic congestive heart failure, acute on chronic respiratory failure with hypoxia, hypertension, atrial fibrillation, difficulties in walking, abnormalities of gait and mobility, and weakness.</p> <p>R14's care plan revised 2/4/26 indicated that R14 required supervision with touching assist of 1 staff for ambulating with front wheeled walker (FWW).</p> <p>R14's physical therapy (PT) treatment encounter notes dated 6/10/26, identified R14 was doing gait training with stand by assist (SBA) without an assistive device, R14 ambulated 150 feet, and sustained a fall as R14's legs could not keep up with the rest of their body.</p> <p>R14's Incident Report Form dated 6/10/26 identified a fall in the hallway near the nurse's station on 6/10/26 at 4:15 p.m. R14 was gait training with therapy staff assist of 1. No assistive device or gait belt was identified in the report.</p> <p>R14's emergency room (ER) encounter summary dated 6/11/26 indicated R14 had an acute anterior left third rib fracture. R14 had refused to go to the ER at the time of the fall on 6/10/26.</p> <p>R14's physician encounter note dated 6/15/26 evaluated R14's fracture of left rib following a fall on 6/10/26 and indicated no new orders related to the rib fracture.</p> <p>During an interview on 7/29/26 at 1:34 p.m., the DON stated they were a charge nurse at the time of R14's fall incident on 6/10/26. They observed R14 ambulating past the nurse's station with therapy staff on 6/10/26, heard a crash, and ran into the hallway. R14 was lying in the middle of the hallway, 1 therapy staff was present, R14 had no gait belt and no FWW.</p> <p>During an interview on 7/29/26 at 2:02 p.m., physical therapy assistant (PTA)-A stated that the rehabilitation department's policy was to use a gait belt with any type of transfer or ambulation. PTA-A stated if a resident refused the use of a gait belt, they would explain the risks and benefits of its use, and if a resident continued to refuse, they would not do gait training without a gait belt. PTA-A stated gait belts were an important safety intervention to provide stability and reduce falls. (continued on next page)</p> |                                                                                               |                                                 |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>On 7/29/26 at 9:21 a.m., attempted to call the physical therapy assistant that was ambulating the resident at the time of R14's fall on 6/10/26. A voicemail was left but the call was not returned.</p> <p>R75:</p> <p>R75's 5-day Minimum Data Set (MDS) dated [DATE], identified R75 was cognitively intact.</p> <p>R75's diagnoses included fracture of left clavicle, fracture of sternum, and hypertension.</p> <p>R75's care plan revised 7/22/26, identified that R75 was able to ambulate independently with a front wheeled walker (FWW) in their resident room. The care plan did not include instructions for ambulating outside the resident room and it did not include physical therapy (PT) orders.</p> <p>R75's physician orders dated 7/10/26, instructed Physical Therapy Evaluate and Treat as Indicated.</p> <p>R75's PT orders signed 7/22/26, instructed staff to walk R75 with gait belt, FWW, and stand by assist &amp;ndash; contact guard assist (SBA-CGA) of 1 to lunch and supper in dining room daily. These orders were observed on the inside of R75's closet door on 7/29/26 at 12:28 p.m.</p> <p>During an observation on 7/29/26 at 12:01 p.m., R75 ambulated independently into the hallway with their FWW. The activities director (AD) met R75 in the hallway and asked where R75 was going. R75 stated they were headed to lunch, but they were not supposed to walk in the hallway alone. AD walked with R75 to the dining area with the FWW but no gait belt.</p> <p>During an observation on 7/29/26 at 12:27 p.m., nursing assistant (NA)-A walked with R75 from the dining table to R75's room with the FWW but no gait belt.</p> <p>During an interview on 7/29/26 at 12:28 p.m., NA-A stated R75 ambulated independently in their room but NA-A was not sure if staff were to use a gait belt when walking with R75 outside the resident's room. NA-A stated PT orders were posted inside resident closet doors, and a copy was kept at the nurse's station. After reviewing R75's PT orders on R75's closet door, NA-A confirmed R75 was SBA of 1 with a FWW and gait belt. NA-A stated they usually use a gait belt when walking with residents to reduce the risk of falls.</p> <p>During an interview on 7/29/26 at 12:34 p.m., the AD stated they forgot to use a gait belt when walking with R75 to the dining area. AD stated gait belts were important to keep hands on residents while walking to help steady them.</p> <p>During an interview on 7/29/26 at 2:09 p.m., physical therapy assistant (PTA)-A stated that each resident had a gait belt on a hook near their resident door. PTA-A expected staff to use a gait belt every time they were walking with a resident.</p> <p>During an interview on 7/29/26 at 1:34 p.m., the director of nursing (DON) stated they expected staff to use safety interventions when ambulating residents including gait belts. They stated a gait belt was important because it allows staff to give more stability to the residents and potentially reduce (continued on next page)</p> |                                                                                               |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245245                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>injury by slowing and controlling a fall.</p> <p>Transfer Belts policy, undated, instructed a transfer belt was to be used when transferring or ambulating any resident who required staff assistance.</p> <p>R9:</p> <p>On 7/27/26 at 2:27 p.m., R9 stated she fell last Saturday night (7/18/26) next to the bed because when she went to get into it the brakes on her wheelchair wouldn't lock and it rolled away. R9 stated maintenance was aware, and nursing staff had left notes and emailed the maintenance guy, but it hadn't gotten fixed. R9 added a male nursing assistant had fixed the wheelchair brake for her after she fell but it had gone bad again and wasn't working at this time. R9 was trying to demonstrate locking her right brake.</p> <p>During an interview on 7/29/26 at 1:08 p.m., NA-B stated R9 had complained about her wheelchair brakes prior to when she fell that Saturday. NA-B didn't recall if or when she put a work order in.</p> <p>During an interview on 7/30/26 at 1:06 p.m., environmental services director (EVS)-H stated he wanted work orders to come strictly from the maintenance app, but some people would leave notes, or tell him when they saw him, so he redirects them to put it on the app. EVS-H stated he prioritized work by resident things if it was affecting the resident or their equipment. EVS-H didn't recall the first time he heard about R9's wheelchair brakes; he heard there were staff who told R9 they put tickets in, but a request wasn't put in until Saturday the 18th and he went that Monday to check on it on and it was working ok at that time. EVS-H added R9 had come to the administrator on the evening of 7/27/26 about her wheelchair, and when EVS-H looked at it he decided to just replace the whole wheelchair.</p> <p>A policy, Resident Concerns dated 1/17/19, identified its purpose was to provide guidelines to staff for following up on resident or representative concerns. Resident concerns related to personal belongings, resident room, equipment, missing items, behaviors, etc. will be reported to the social services department, determined if it was a reportable incident, document on a concern form or other designated place in the medical record and routed to the appropriate department head who will document their follow up and return to social services. Environmental concerns would be reported to the maintenance department on a maintenance slip, logged by maintenance and followed up and documented by maintenance as completed.</p> |                                                                                               |                                                 |

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| F 0693<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure the tube feeding bottle was dated and timed when opened for 1 of 1 resident (R3) reviewed for tube feeding cares. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had diagnoses which included hemiplegia/hemiparesis (complete or severe paralysis on one side of the body/mild to moderate weakness on one side of the body), dysphagia (difficulty or discomfort when swallowing foods, liquids, or even saliva), hyperlipidemia, aphasia (a brain disorder that affects how one speaks, reads, writes, and understanding what other people say), hypertension. In addition, R3's MDS identified she had unclear speech, was severely cognitively impaired, and was dependent on staff for activities of daily living. R3's MDS also identified R3 received tube feedings. R3's current physician's orders reviewed on 7/28/26, identified she had orders for nocturnal feedings Jevity 1.5 at 83 milliliters (ml) per hour from 7:00 p.m. to 7:00 a.m. The orders were requested but not provided. During an observation on 7/29/26 at 7:15 a.m., R3 was resting in bed with the head of the bed at approximately 30 degrees, Jevity 1.5 was running at 83 ml per hour on a pump. The bottle had no open date or time and the tubing was not dated. During an interview on 7/29/26 at 7:53 a.m., licensed practical nurse (LPN)-A verified the tube feeding bottle was not dated or timed when opened. LPN-A also verified the tubing was undated. LPN-A stated it should be dated and timed to ensure the tube feeding doesn't hang longer than it should. During an interview on 7/30/26 at 12:29 p.m., the director of nursing (DON) stated it was her expectation that staff would date, time, and initial the tube feeding bottle and tubing to ensure the tube feeding didn't hang too long. A policy on tube feedings was requested but not provided.</p> |                                                                                               |                                                 |

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| F 0695<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide hygienic care of oxygen and nebulizer equipment for 1 of 1 resident (R7) reviewed for respiratory care. Findings include: R7's significant change in status assessment (SCSA) minimum data set (MDS) dated [DATE], identified intact cognition and hemiplegia/hemiparesis r/t subarachnoid hemorrhage right side affected, Parkinsons, CHF, a-fib, COPD, anxiety, GERD, DM, dysphagia, insomnia, bipolar, acute pain, anemia R7's care plan dated 4/10/26 identified oxygen therapy related to acute respiratory failure and CHF. Interventions included oxygen therapy, providing medications as ordered, monitoring for signs and symptoms of respiratory distress and report, oxygen setting at two liters per minute (LPM) to keep oxygen saturations above 88%. R7's provider order dated 11/18/25 identified oxygen at 2 LPM to keep oxygen saturations above 88% every shift. An additional order on 4/2/26 identified oxygen at one to four liters for shortness of breath as needed (PRN). During an observation on 7/27/26 at 3:33 p.m., in R7's room there was a liquid oxygen container with a water bubbler attached; R7 stated he used it at night. The water bubbler was dated 4/2/26. R7 also had a nebulizer mask, chamber and tubing all connected and setting on the bedside table, there was liquid in the chamber. R7 stated he did the nebulizer himself, the nurse set it up and sometimes didn't come back. During an observation on 7/28/26 at 3:04 p.m., in R7's room a nebulizer mask, chamber and tubing were intact on bedside table with condensation in the chamber. During an interview on 7/29/26 at 1:44 p.m., registered nurse (RN)-F stated R7 was alright to administer his own nebulizer, but he needed the nurse to come back to put it back on the nebulizer machine so that was when she cleaned it. RN-F stated the nebulizer should be cleaned after every use. During an interview on 7/30/26 at 11:54 a.m., licensed practical nurse (LPN)-B stated they usually changed the bubbler and tubing when it appeared on the treatment administration record (TAR). LPN-B reviewed R7's orders and didn't find one to change the bubbler and tubing. LPN-B confirmed R7's bubbler was dated 4/2/26 and she didn't see a date on the tubing as to when it was changed. LPN-B stated it was important to do for sanitary reasons. A policy, Oxygen dated 9/23/25, identified all licensed nurses were trained in the use of oxygen and shall be responsible for its administration shall be on duty the entire time oxygen was administered. Under the Miscellaneous category, item number one identified tubing and cannula or mask should be labeled with dated and changed every week. |                                                                                               |                                                 |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and document review, the facility failed to ensure staff consistently used personal protective equipment (PPE) in resident rooms where precautions were in place to help prevent the spread of bacteria and potential for illness for 2 of 4 residents (R1, R2) reviewed for infection control. This deficient practice had the potential to cause illness for residents, staff, and visitors. In addition, the facility failed to ensure hygienic laundry practices to help minimize potential for bacteria growth. Findings include:</p> <p>R1:</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact.</p> <p>R1's diagnoses included chronic kidney disease, heart failure, hypertension, diabetes mellitus, anxiety, depression, and sleep apnea.</p> <p>R1's care plan dated 7/28/26, identified R1 was on enhanced barrier precautions (EBP) related to a history of Extended Spectrum Beta Lactamase (ESBL) infection in their urine and directed staff to follow EBP.</p> <p>R1's orders included Enhanced Barrier Precautions due to history a of ESBL dated 4/29/26.</p> <p>During an observation on 7/29/26 at 9:57 a.m., R1's door had a sign indicating R1 was on EBP. The sign instructed staff to wear gowns and gloves for high-contact resident care activities, including changing linens and providing wound care. Licensed practical nurse (LPN)-D and nursing assistant (NA)-A entered R1's room, without wearing gowns. LPN-D removed R1's bilateral lower leg stockings, removed dressings from R1's left shin and right toes, provided wound care, and redressed R1's wounds. LPN-D wore gloves and changed them appropriately, but they did not wear a gown during the wound care. At the same time, NA-A stripped R1's bed, bagged the soiled linens, and remade R1's bed with fresh linens with gloved hands but no gown.</p> <p>During an interview on 7/29/26 at 10:08 a.m., NA-A confirmed they had not gowned when entering R1's room. NA-A stated they should have worn a gown when changing R1's bed linens to keep bacteria from getting on their clothes and potentially spreading to other rooms.</p> <p>During an interview on 7/29/26 at 10:12 a.m., LPN-D confirmed they had not gowned when entering R1's room. LPN-D stated R1 did not have an active infection. After reviewing R1's electronic medical record, LPN-D confirmed R1 was on EBP and stated they should have worn a gown for the wound care.</p> <p>During an interview on 7/30/26 at 11:30 a.m., the director of nursing (DON) stated they expected staff to wear the correct personal protective equipment (PPE) when assisting residents on EBP. The DON stated staff should be wearing gowns and gloves when handling bedding and doing dressing changes for residents on EBP. They stated PPE was important to protect themselves and to prevent at-risk (continued on next page)</p> |                                                                                               |                                                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Manor                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>321 Northeast Sixth Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>residents from potential infection.</p> <p>Facility provided Enhanced Barrier Precautions sign instructed providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and wound care.</p> <p>R2:</p> <p>R2's significant change in status assessment (SCSA) minimum data set (MDS) dated [DATE], identified intact cognition and a diagnosis of clostridium difficile (an intestinal infection which can spread through contact with fecal matter, contaminated surfaces with spores. Alcohol-based hand sanitizer is not effective against spores. Special precautions, called enteric precautions must be put in place to include washing hands with soap and water and wiping environmental surfaces with a bleach-based product.) R2 was frequently incontinent of bowels and needed supervision or touch assistance with toilet transfers and hygiene.</p> <p>R2's care plan dated 6/6/26, identified a focus statement for self-care performance deficits and included interventions to provide limited assistance with toilet transfers and to assist with perineal care every shift and as needed. An additional focus statement for diarrhea related to c. difficile with interventions for contact precautions, but without necessary interventions for enteric precautions.</p> <p>R2's provider orders didn't contain orders for contact precautions.</p> <p>During an interview on 7/28/26 at 12:31 p.m., housekeeper (HK)-B stated they had infection prevention training on the computer at hire and in January every year. HK-B stated they didn't have to demonstrate to anyone how she would put on and take off her PPE.</p> <p>During an observation on 7/28/26 at 2:56 p.m., nursing assistant (NA)-C entered R2's room without isolation gown or gloves, carried an iPad, talked with R2 and took his meal order. NA-C exited the room without cleaning their hands and continued down the hall to other resident rooms.</p> <p>During an observation on 7/28/26 at 3:19 p.m., HK-A was observed entering R2's room without an isolation gown, but with gloves, and came back out with two yellow plastic trash bags and put them on top of the dumpster she was pushing. HK-A wasn't observed cleaning her hands after exiting the room.</p> <p>Laundry:</p> <p>During an interview on 7/29/26 at 8:22 a.m., during a tour of the laundry facilities with the environmental services director (EVS)-H, laundry aid (LA)-C stated they didn't leave the washer running at the end of the shift. LA-C stated they would place the wet items in the blue bins, designated for wet items, and then cover with a sheet or something and dry it in the morning.</p> <p>During an interview on 7/29/26 at 2:30 p.m., HK-A stated she received infection control training from (continued on next page)</p> |                                                                                               |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245245                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Manor                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>321 Northeast Sixth Street<br>Chisholm, MN 55719 |                                                 |
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| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>watching videos every year. HK-A stated she did see the sign outside R2's room and put gloves on because she was just going in to collect the trash.</p> <p>During an interview on 7/29/26 at 9:59 a.m., registered nurse (RN)-G, who identified as the facility's Infection Prevention nurse, stated she would expect housekeeping to wear PPE when in the contact precautions rooms, and same for the NA going in to take a meal order, nor for wet laundry to be left to be dried the next day. RN-G added the housekeeping staff were trained for infection control through EduCare (an internet-based education program) and didn't require return demonstrations for PPE use.</p> <p>During an interview on 7/30/26 at 1:12 p.m., EVS-H stated he used the paperwork from previous people in his position to train new housekeeping staff for infection control. EVS-H stated he would do this on hire before the person goes to the floor and stated he didn't ask them to demonstrate PPE use. EVS-H stated he would expect them to follow procedures for the precautions rooms no matter how long they are in there for.</p> <p>A policy, Transmission-Based Precautions dated 6/16/26, identified its purpose was to provide direction to staff related to transmission-based precautions in the prevention of infections. Contact precautions would be implemented for residents known or suspected of being infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. The policy didn't address expectations for staff usage of PPE or enteric precautions necessary for infections like c. difficile.</p> <p>A policy, Linen Handling dated 3/10/26, identified its purpose was to provide clear and consistent guidelines for the safe handling of linen to protect residents, staff, and the environment from infection and occupational exposure. The policy didn't address handling wet linen.</p> |                                                                                               |                                                 |