STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Living Center	619 West Sixth Street Park Rapids, MN 56470

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure fall prevention strategies were assessed and fall interventions were implemented to protect from accidents for 1 of 3 residents (R1) who was at risk for falls and had a fall with injuries. This resulted in actual harm to R1 who fell and sustained a scalp laceration, a tibial (shin bone) fracture, femur (the longest, strongest, and heaviest bone in the human body, extending from the hip to the knee) fracture and a bimalleolar (a severe, unstable ankle injury involving fractures to both the medial malleolus (inner tibia) and lateral malleolus (outer fibula) fracture of right lower leg. The facility implemented corrective action prior to the investigation, so the deficiency was issued at Past Noncompliance.Findings Include: R1's admission Record indicated she admitted to the facility on [DATE]. R1's diagnoses included dementia, vertebral and sacral fractures and age-related osteoporosis. R1's annual Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment. The MDS identified lower extremity impairments on both sides and frequent urinary incontinence. The MDS indicated R1 had sustained one fall since the previous assessment. R1's Fall Risk assessment dated [DATE], indicated predisposing diseases that included arthritis, osteoporosis, dementia, unsteadiness and muscle spasm. The assessment identified frequent incontinence, inability to independently come to a standing position and the need for hands on assistance to move from place to place. Fall precautions and devices included high/low bed, call light in reach, and mechanical stand for transfer. At the time of assessment, most recent fall occurred 1/26/26. Staff to use a mechanical stand and total assist of one for all transfers. R1's care plan updated 2/4/26, identified a risk for falls related to impaired mobility, history of falls, impaired cognition, poor safety awareness and a history of fractures. The care plan identified the following interventions: 12/30/23, keep call light in reach and encourage use. 12/30/23, Bed in lowest position and fall mat on floor next to bed when R1 was in bed. 2/3/26, Gripper socks to be worn at all times. Nursing Home Internal Report submitted to the State Agency on 2/4/26, indicated on 2/3/26, R1 was found on the floor in her room. Staff report that she was laying between her bed and recliner, on her side. She had a head laceration and was laying with one leg in a twisted position underneath her. Her bed was in high position without fall mat in place. Ambulance was called and resident not moved due to pain when staff touched lower extremities. Hospital returned patient last evening with Urinary Tract Infection (UTI) and head laceration. R1 returned to emergency room (ER) on 2/4/26 at 0300 am due to severe pain with movement or when touched. ER reported at this time indicated she had two fractures found in right leg. Resident has dementia and is impulsive. Resident attempted to self-transfer and fell. Resident stated she was trying to get up. Staff heard a quiet help coming from her room. R1's Progress Notes indicated the following: 1/26/26, R1 sustained a fall in her room at 3:45 p.m. R1 was seen in the supine (lying horizontally on the back with the face and torso facing upward) position on the floor near her bed. R1 tried to ambulate independently (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Living Center	619 West Sixth Street Park Rapids, MN 56470

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	wearing compression stockings. 1/28/26, R1 had been seen at dining area in her wheelchair. R1 appeared confused and verbalized that she needed to go out as she had no place to stay and kept looking for her wheelchair. 2/2/26, R1 was reviewed for falls. R1 had been found alongside her bed on 1/26/26. R1 had compression socks on but no Gripper socks. Root cause of fall indicated slipping on the floor. Intervention included to encourage and place gripper socks over compression stockings. 2/3/26, R1 fell at 2:35 p.m. R1 stated she was trying to get out of bed and fell. R1 was laying on her left side, right leg was twisted and [NAME] under her left leg. Left arm was pinned under her left side. Large pool of blood around R1's head. R1 stated her leg and head hurt. R1's Bed was in the raised position and fall mat was not in place. R1 was in stocking feet. 2/3/26, R1 returned from the emergency department (ED) at 8:15 p.m. R1 had significant head and right leg pain. Head laceration, bruising to left hand and arm and swelling below right knee. 2/4/26, R1 complained of much pain in right leg. Noted leg to be swollen and firm to touch from knee to foot. When leg was touched R1 complained of pain. When repositioning leg on pillow R1 winced and complained of pain. R1 stated she did not get an x-ray on her legs. Confirmed with ED. R1 was in severe pain and sent back to the ED. 2/4/26, Staff spoke with ED nurse. R1 had scan of head along with x-ray of right leg. R1 was found to have a femur fracture and right tibial fracture. 2/5/26, Staff placed call to hospital to inquire if x-ray of right ankle had been performed. Hospital nurses confirmed x-ray completed with result of malleoli fracture. Also informed R1 was not a candidate for surgery due to her bones. R1 was non-weight bearing. 2/6/26, R1 returned from hospital. Primary diagnosis included right tibial plateau fracture, right femur fracture, acute head injury, laceration to left forehead and urinary tract infection. R1's hospital Discharge summary dated [DATE], indicated she admitted for management of multiple fractures involving the right leg and inability to bear weight. Discharge diagnosis included tibial plateau fracture, femur fracture, bimalleolar fracture and scalp laceration. R1 had been stable and was ready for discharge with hospice services. Terminal diagnosis was severe Alzheimer's dementia, Secondary diagnosis includes femur fracture, tibial plateau fracture and ankle fracture. During observation on 2/9/26 at 12:13 p.m., R1 was lying on bed in her back. R1 had sutures and bruising on the left side of her forehead, bruising surrounding her left eye and extending down below her cheek bone. R1 was covered to her chest with her left arm outside the blanket. R1's left arm had purple bruising extending down to her left hand. When spoken to, R1 did not respond, only stared. During interview on 2/9/26 at 12:47 a.m., nursing assistant (NA)-A stated on 2/3/26, she had been floating between hallways on the unit. NA-A said it had been busy and when she had laid R1 down in bed, she had forgotten to put the bed down and had not placed the fall mat next to the bed. NA-A said the interventions were listed on the care plan and said after R1 fell, she had received education related to following the care plan. NA-A stated R1 always wanted to be in bed after lunch and stated it had been unusual for her to attempt to get up until a few weeks prior to the fall. NA-A said R1 had made a few attempts to get out of bed in the past few weeks. During interview on 2/9/26 at 1:02 p.m., NA-B stated the few weeks preceding R1's fall, she would kind of stare but could tell staff what she wanted. NA-B said R1 was typically content when she was lying down but said a few times she had gone into her room and found her seated on the side of the bed. NA-B said since R1's recent fall, she was on full bed rest and said she had a lot of pain when she was touched or repositioned. During interview on 2/9/26 at 2:15 p.m., registered nurse (RN)-A stated at the time of R1's fall on 2/3/26, care planned fall interventions included bed in lowest position, fall mat in place and gripper socks. During interview on 2/9/26 at 2:02 p.m., the administrator stated she felt the root cause of R1's fall was related to her attempt to self-transfer and felt the injuries were a result of her bone condition and the way R1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Living Center	619 West Sixth Street Park Rapids, MN 56470

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	had twisted when she fell. The administrator said after the incident she created a policy related to following the plan of care, educated staff to the policy, audited care plans for all residents at risk for falls. The administrator further stated care plan audits had been implemented. The Past Noncompliance began on 2/3/26. The deficient practice was corrected by 2/3/26, after the facility developed a policy related to following the care plan, initiated education related to following the care plan and completed an audit of care plans to ensure accuracy.The education was verified through interview and document review.