DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 1, 2022

Administrator
Moorhead Restorative Care Center
2810 Second Avenue North
Moorhead, MN 56560

RE: CCN: 245052
Cycle Start Date: June 16, 2022

Dear Administrator:

On July 5, 2022, we notified you a remedy was imposed. On August 25, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 15, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 20, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 5, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 16, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD RESTORATIVE CARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

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E 000	Initial Comments On 6/12/22, to 6/16/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS Moorhead Restorative Care Center is a Special Focus Facility (SFF). A recertification survey was conducted on 6/12/22, to 6/16/22. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility failed to follow the facility's abuse prevention policies and procedures, the facility failed to timely report observed resident to resident abuse and immediately initiate an investigation including protection of residents for 1 of 1 resident (R15) reviewed for resident to resident abuse which resulted in psychosocial harm. The IJ began on 6/14/22, and the immediacy was removed on 6/16/22. The above findings constituted substandard quality of care, and an extended survey was conducted from 6/14/22, to 6/16/22. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/08/2022

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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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have	F 576		7/12/22

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F 576	Continued From page 2 reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident mail was delivered on Saturdays for 2 of 2 residents (R10, R26) who voiced concerns with mail delivery. This had the potential to affect all 25 residents residing in the facility. Findings include: During a resident council meeting on 6/14/22, at 1:57 p.m. held with four residents, R10 confirmed mail had not been consistently delivered to her on Saturdays at the facility. R10 indicated she had canceled her subscription to the Fargo Forum newspaper since it had not been delivered to her on Saturdays, and at times other residents would read it before she received it. Additionally, R26 confirmed mail was not consistently delivered on Saturdays. During an interview on 6/14/22, at 2:35 p.m. activities director (AD)-A stated the facility practice was for mail to be delivered to the business office every day for business office manager (BOM)-A to review and then provided to staff to deliver the mail to the residents. AD-A stated the mail was delivered to the business office on Saturdays additionally, however since	F 576	1. Residents R10 and R26 were identified to not be receiving their mail on the weekend. These resident's will be included in the audit process to ensure they are receiving their mail on the weekends. All staff meeting was held on 7/7/22 to discuss the importance of mail delivery during the course of a weekend and within 24 hours of receipt from the post office. 2. All residents have the potential to be affected by this deficient practice. All residents were interviewed to ensure mail is delivered in a timely manner. Education was provided at an all staff meeting regarding mail delivery to all residents on 07/7/2022. Charge Nurse will be responsible on weekends and when activity staff are not present. Policy was reviewed and updated on 6/24/22. 3. Audits will be performed on mail delivery specifically on weekends weekly x8 weeks, then monthly for 4 months, or until 100% compliance is achieved. 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

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F 576	Continued From page 3 BOM-A did not work on Saturdays the mail had not been delivered to the residents. During an interview on 6/15/22, at 1:59 p.m. director of rehabilitation (DR)-A stated BOM-A was on leave and DR-A was filling in for her. DR-A stated the mail was delivered everyday, and BOM-A or DR-A would sort through it prior to delivery to ensure residents who had power of attorneys or guardians did not receive any bills. DR-A stated the mail delivered on Saturdays was placed in her or BOM-A's mailbox to review on Mondays when they returned to work and confirmed the mail had not been delivered to residents on Saturdays. During an interview on 6/15/22, at 2:15 p.m. administrator confirmed BOM-A or DR-A sorted the residents' mail for the facility before it was distributed. Administrator indicated he was unable to answer what the facility process on Saturdays was to assure residents received their mail. The facility policy titled Mail Service Delivery dated 4/24/22, identified residents would have the opportunity to stay in contact with family/friends/community through mail services. The policy indicated the facility would provide a mail service delivery within 24 hours of receipt of mail, which included Saturdays.	F 576		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and	F 577		7/12/22

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F 577	Continued From page 4 (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure three years of survey results were readily accessible for residents or visitors. This had the potential to affect all 25 residents currently residing in the facility. Findings include: During an observation on 6/12/22, at 1:10 p.m. the facility survey results were located in a plastic pocket holder affixed to the wall, approximately three feet from the ground next to the bulletin board. The last survey results noted in the plastic pocket holder was for a standard abbreviated survey dated 10/13/21. A paper sign placed on the outside of the pocket holder stated the	F 577	1. There were no individual residents identified. MHRCC was noted to not have previous 3 years of survey results posted at the front for public viewing. 2. All residents have the potential to be affected in this area. Education provided to nursing management team on importance of having last 3 years of survey results available. Survey results printed and placed at the front desk 3. Audits will be conducted quarterly for 12 months 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

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F 577	Continued From page 5 following; Survey results, last 3 years of survey results, certifications and complaint investigations including plan of corrections are available for your review. The facility lacked the survey results for the following surveys completed from 11/05/21, to 5/4/22. -11/5/21, an abbreviated survey was completed. -11/10/21, an abbreviated survey was completed. -11/22/21, an abbreviated survey was completed. -12/13/21, a revisit survey was completed. -12/22/21, a recertification survey was completed. -2/23/22, a revisit survey as completed. -3/4/22, an abbreviated survey was completed. -4/6/22, a revisit survey was completed. -4/8/22, an abbreviated survey was completed. -5/4/22, a revisit survey was completed. During an observation on 6/13/22, at 2:37 p.m. the survey results in the plastic pocket holder on the wall remained the same. During an interview on 6/15/22, at 2:15 p.m. administrator confirmed the survey results after 10/13/21, were not included in the pocket holder on the wall and were not readily accessible for residents or visitors to review. Administrator indicated he was not aware all the survey results were not made available for review. During an interview on 6/16/22, at 10:21 a.m. corporate director of nursing (CDON) stated she was not aware of the requirement each survey was to be made available. CDON confirmed all surveys were not readily accessible for residents or visitors to review.	F 577		

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F 577	Continued From page 6 The facility policy titled Resident Right To Examine Survey Results, revised 3/1/22, identified the resident had the right to examine the results of the three most recent annual surveys of the facility, conducted by federal or state surveyors, certification visits if applicable and complaint visits, and any plan of correction in effect with respect to the facility. The policy further identified the survey results would be available to residents without having to ask a staff person in a place where individuals wishing to examine survey results do not have to ask to see them. The policy indicated a copy of the three most recent survey reports as well as their plan of correcting the identified problems would be kept in a three-ring binder in the facility's main lobby.	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		7/12/22

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F 578	Continued From page 7 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents' current wishes for resuscitation status were accurately documented in the clinical record for 1 of 1 resident (R25) reviewed for advanced directives. Findings include: R25's significant change Minimum Data Set (MDS) assessment dated 6/4/22, identified R25 had diagnoses which included chronic obstructive pulmonary disease (COPD), anxiety disorder and failure to thrive. R25's Provider Orders for Life Sustaining Treatment (POLST) form located in R25's electronic medical record (EMR) dated 6/7/22,	F 578	1. R25 was identified as not having her advanced directive order match her POLST. Resident□s advanced directive order was updated to match her POLST on 6/13/22. 2. All resident□s have potential to be affected in this area. Education was provided to all staff involved in code status on 07/7/22. All resident POLST and advanced directive orders were reviewed for accuracy. Policy was reviewed on 7/7/22. 3. Audits will be performed to ensure the POLST, and advanced directive order are accurate weekly x 8 weeks, then monthly for 4 months, or until 100% compliance is achieved.	

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F 578	Continued From page 8 indicated R25 was DNR (do not resuscitate.) Review of R25's EMR revealed the current Physician Orders dated 5/9/22, indicated R25 was a full code (cardiopulmonary resuscitation CPR attempt resuscitation). Further, R25's profile in the EMR indicated R25 was a full code. Review of R25's care plan dated 6/7/22, indicated R25 was a DNR code status. R25's clinical record did not accurately reflect R25's current wishes for advance directives. During an interview on 6/13/22, at 2:25 p.m. nursing assistant (NA)-A indicated her usual routine to verify a resident's current advance directive was to look at the code status located in the EMR under profile. During an interview on 6/13/22,at 2:35 p.m. registered nurse(RN)-B confirmed R25's code status was identified differently in various locations of the clinical record. RN -B indicated her usual routine to verify a resident's current advance directives was to look at the code status located in the EMR under profile which pulled from the physician orders. During an interview on 6/13/22, at 2:38 p.m. trained medication aide (TMA)-D indicated her usual routine to verify a resident's current advance directives was to look at the code status located in the EMR under profile. (TMA)-D stated she also had a paper copy of the care plan which contained the code status. During an interview on 6/13/22, at 2:40 p.m. social worker (SW) confirmed she had completed	F 578	4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

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F 578	Continued From page 9 a new POLST with R25 which included a DNR code status on 6/7/22. SW confirmed she had sent a text that same day to the director of nursing (DON) and RN-B stating R25's code status had changed to DNR. SW further confirmed on 6/13/22, R25's physician's orders had still indicated R25 was a full code so she sent another text to the DON and RN-B and had asked them to change the code status in the physician orders. During an interview on 6/13/22, at 3:05 p.m. DON stated the usual practice when a POLST changed was for SW to inform DON and DON would ensure a new physician order was obtained to reflect the change. DON confirmed R25's POLST was changed to DNR on 6/7/22, however indicated she had not been notified to update R25's code status until 6/13/22. A policy on advance directives was requested however was not received.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		7/12/22

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F 580	Continued From page 10 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician for elevated blood sugars for 1 of 5 residents (R18) who was	F 580	1. R18 was found to have a blood sugar outside of the parameters set by the provider. Staff did not notify the MD	

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F 580	Continued From page 11 reviewed for unnecessary medications. Findings include: R18's significant change Minimum Data Set (MDS) dated 5/11/22, identified R18 was cognitively intact and had diagnoses which included: diabetes mellitus, end stage renal disease and heart failure. R18's MDS identified R18 required limited assistance with eating, bed mobility, transfers and R18 received insulin injections seven days of the last seven days. R18's care plan revised 6/14/22, identified R18 had diabetes mellitus and had interventions which included; medication as ordered, monitor/document for side effects and effectiveness, and to educate resident/family/caregivers as to the correct protocol for glucose (blood sugar)monitoring and insulin injections and obtain return demonstrations. Continue until comfort level with procedures were achieved. Review of R18's Order Summary Report dated 6/20/22 signed 6/23/22, revealed the following: -Monitor blood sugars four times a day related to Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (peripheral nerve damage, which affects nerves in skin, muscles and organs). Call primary care provider (PCP) if blood sugar is greater than 300 or less than 65, ordered 5/4/22. Review of R18's treatment administration record from 5/4/22, to 6/15/22, identified the following: -5/10/22, R18's blood sugar at 8 p.m. was 334. -5/12/22, R18's blood sugar at 8 p.m. was 318. -5/17/22, R18's blood sugar at 8 p.m. was 349.	F 580	despite there being an order to contact the provider. Provider was sent resident's blood sugars to review. Staff were educated on informing provider when vital signs or lab values are out of range on 07/08/2022. Audits will be performed as listed below. 2. All sliding scale residents have the potential to be affected in this area. A review of all residents on a sliding scale were reviewed to ensure parameters were met. Education provided to nursing staff regarding notifying the provider if outside their blood glucose parameters on 07/08/2022. An audit will be preformed on physician notification for blood glucose monitoring parameters. Orders were also reviewed to ensure that accurate parameters were in place. 3. Audits ensuring parameters are followed will be performed weekly x 8 weeks, then monthly for 4 months, or until 100% compliance is achieved. 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

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	245052	A. BUILDING _____ B. WING _____	06/16/2022

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F 580	Continued From page 12 -5/18/22, R18's blood sugar at 8 a.m. was 413. -5/19/22, R18's blood sugar at 5 p.m. was 313. -5/19/22, R18's blood sugar at 8 p.m. was 301. -5/21/22, R18's blood sugar at 8 p.m. was 318. -5/22/22, R18's blood sugar at 8 p.m. was 336. -5/24/22, R18's blood sugar at 8 a.m. was 308. -5/24/22, R18's blood sugar at 5 p.m. was 303. -5/28/22, R18's blood sugar at 8 p.m. was 345. -6/1/22, R18's blood sugar at 8 p.m. was 321. -6/2/22, R18's blood sugar at 8 a.m. was 331. -6/3/22, R18's blood sugar at 8 a.m. was 308. -6/9/22, R18's blood sugar at 12 p.m. was 333. -6/9/22, R18's blood sugar at 5 p.m. was 355. -6/9/22, R18's blood sugar at 8 p.m. was 325. -6/11/22, R18's blood sugar at 5 p.m. was 312. -6/11/22, R18's blood sugar at 8 p.m. was 312. -6/13/22, R18's blood sugar at 8 p.m. was 312. -6/14/22, R18's blood sugar at 12 p.m. was 303. -6/14/22, R18's blood sugar at 8 p.m. was 424. Review of R18's progress notes from 5/11/22, to 6/16/22, lacked documentation notifications were made to the primary care provider for elevated blood sugars over 300 as ordered. During an interview on 6/16/22, at 5:43 p.m. registered nurse (RN)-A indicated she was not aware R18 had an order to notify the primary care provider when R18's blood sugar was over 300. RN-A stated the usual facility practice was to notifiy the primary care provider when a resident's blood sugar was over 400. RN-A confirmed the primary care provider had not been notified of R18's elevated blood sugars over 300. During an interview on 6/16/22, at 5:45 p.m. corporate director of nursing (CDON) stated she would expect staff to follow the primary care providers orders regarding notification of elevated	F 580		

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F 580	Continued From page 13 blood sugars. CDON confirmed R18's primary care provider had not been notified when R18's blood sugars were over 300. The facility policy titled Administering Medications, reviewed 12/13/21, identified medications were administered in a safe and timely manner, and as prescribed. The policy identified the director of nursing services supervised and directed all personnel who administer medication and/or have related functions. The policy lacked interpretation or implementation instructions related to monitoring of blood sugars as ordered.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		7/12/22

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F 582	Continued From page 14 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Medicare A beneficiaries received the skilled nursing facility advanced beneficiary notice (SNFABN) form, for 2 of 2 residents (R25, R17) remaining in the facility and 1 of 1 residents (R233) did not receive the Notice of Medicare Non-coverage-Form (NOMNC) who was discharged from the facility.	F 582	1. Residents R25, R17, and R233 were identified to not have proper notice given to them regarding their Medicare coverage ending. Residents R17 and R233 were discharged from the facility. R25 was served the NOMNC on 7/8/2022. 2. This has the potential to affect any resident on Medicare Insurance. An audit	

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F 582	Continued From page 15 Findings Include R25's skilled nursing facility (SNF) Beneficiary Protection Notification Review form completed by the facility identified R25's Medicare Part A Skilled services Episode Start date was 5/9/22, and last covered day of part A service was 5/27/22. R25's form lacked documentation the SNFABN form was provided. R17's skilled nursing facility (SNF) Beneficiary Protection Notification Review form completed by the facility identified R25's Medicare Part A Skilled services Episode Start date was 3/24/22, and last covered day of part A service was 5/2/22. R17's form lacked documentation the SNFABN form was provided. R233's skilled nursing facility (SNF) Beneficiary Protection Notification Review form completed by the facility identified R233's Medicare Part A Skilled services Episode Start date was 3/11/22, and last covered day of part A service was 3/21/22. R233's form identified R233 was not provided a SNFABN form CMS-10055 form since R233 was discharged from the facility and had received non-covered services. During an interview on 6/16/22, at 9:19 a.m. registered nurse (RN)-A confirmed she was responsible to complete beneficiary forms for residents in the facility. RN-A indicated she was new to the process and had not received instruction on how and when to complete the forms. RN-A confirmed R25 and R17 did not have SNFABN CMS-10055 forms completed and RN-A indicated she was not aware the form existed. Further, RN-A confirmed she had not completed	F 582	will be performed to ensure the advanced beneficiary notice and the notice of Medicare non coverage is given. Staff member was educated on completing the form in its entirety on 6/27/2022. Policy was reviewed and updated on 6/27/2022. All staff meeting was held, and staff were informed and educated on this process on 7/7/22. 3. Audits will be performed on completion of the forms when Medicare ends weekly x 8 weeks, then monthly for 4 months, or until 100% compliance is achieved 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

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F 582	Continued From page 16 any beneficiary forms for R233. On 6/16/22, at 10:23 a.m. corporate director of nursing (CDON) indicated all beneficiary forms had previously been completed by therapy staff, however that responsibility had now been transferred to RN-A. CDON confirmed the beneficiary forms were not completed as required and stated she had expected the forms to be completed as required. A policy from the facility on beneficiary notices was requested however not provided.	F 582		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their abuse prevention policies and procedures when the facility failed to immediately report witnessed resident to resident abuse, immediately initiate an	F 600	1. R15 was identified as having experienced emotional abuse that was not properly identified. Staff identified the emotional abuse and have implemented interventions to help support resident	7/12/22

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F 600	Continued From page 17 investigation including protection of residents for 1 of 1 resident (R15) reviewed for resident to resident abuse. This deficient practice resulted in an immediate jeopardy (IJ) for R15 which resulted in psychosocial harm for R15. The IJ began on 6/5/22, when R15 was kicked in the leg by another resident (R8) which triggered symptoms of post traumatic stress disorder (PTSD) for R15 which included verbalization of fear, hypervigilance, an increase in crying and isolation. The IJ was identified on 6/14/22, and the facility administrator, corporate director of nursing (DON) and interim DON were informed of the IJ on 6/14/22, at 4:50 p.m. The IJ was removed on 6/16/22, at 4:00 p.m. when the facility initiated safety checks for R8 and R15, daily check-ins with R15 and had scheduled appointments with mental health for R15 and R8, however noncompliance remained at the lower scope and severity level of D, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R15's quarterly Minimum Data Set (MDS) dated 5/6/22, identified R15 had diagnoses which included: depression, anxiety, end stage renal disease (ESRD,) and heart failure. The MDS identified R15 was cognitively intact and was independent with activities of daily living (ADL's) of bed mobility, transfers and locomotion with use of a wheelchair. The MDS identified R15 had symptoms of depression which included, trouble concentrating, feeling tired/having little energy 12-14 days, poor appetite/overeating seven (7) to eleven days, and feeling down and depressed two (2) to six (6) days out of a 14 day assessment	F 600	emotionally. Social worker will do a psychosocial assessment on resident's mood weekly until resolved. 2. All resident's have the potential to be affected in this area. All resident's were interviewed to determine whether they felt safe in the facility. All staff were initially educated via mass communication, and the staff who were onsite working when IJ was cited were provided with education as well. Post tests were obtained to ensure comprehension. Education was also provided at the all-staff meeting on 07/07/22 regarding abuse, neglect, and rules for reporting abuse/neglect, and what constitutes abuse. 3. Audits will be performed on compliance on preventing and addressing abuse/neglect via interviews with residents including R15 weekly x 8 weeks, then monthly for 4 months, or until 100% compliance is achieved. 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

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F 600	Continued From page 18 period. R15's Significant Change of Status Assessment (SCSA) MDS dated 2/5/22, identified R15 had diagnoses of ESRD, depression, anxiety and heart failure. The MDS identified R15 was cognitively intact and required supervision with bed mobility, locomotion and used a wheelchair. The MDS identified R15 had symptoms of depression which included, feeling tired/having little energy 12-14 days, feeling down and depressed one day out of a 14 day assessment period. R15's SCSA Care Area Assessment dated 2/5/22, identified R15 was cognitively intact, had minimal depression and was independent with ADL's of dressing, toileting, ambulation, transfers and eating. The CAA's identified R15 had diagnoses which included borderline personality disorder, major depressive disorder and generalized anxiety disorder. The CAA indicated R15 routinely received psychiatric services for medication management and psychotherapy. The CAA revealed R15 was at risk for changes in her mood or behavior which may be indicative of worsening depression. R15's psychiatric provider visit summary dated 3/15/22, identified R15 had diagnoses which included severe anxiety with panic, Post Traumatic Stress Disorder (PTSD) and insomnia. R15's Social Service - Resident Vulnerability and Susceptibility to Abuse Quarterly assessment dated 3/24/22, revealed a checklist form used to assess a resident's risk for maltreatment. The assessment identified R15 had the following conditions of alcohol/substance abuse and	F 600		

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F 600	Continued From page 19 physical impairment, was a vulnerable adult and was able to report maltreatment. R15's medical record lacked any documentation since 2020, of any past trauma, possible triggers of trauma and any identified interventions to assist R15 in coping with symptoms and triggers of past trauma. R15's care plan revised 6/13/22, identified R15 had borderline personality disorder, major depressive disorder, and generalized anxiety disorder. R15's care plan revealed interventions which included to assist R15 in developing/providing activities of interest, monitor/document/report any signs of depression and revealed R15 needed adequate rest periods. R15's care plan identified she was at risk for abuse due to anxiety, medication use, medical conditions and assistance with cares. R15's care plan revealed interventions which included anticipating her needs, do not have her near others who disturb her and to remove her from potentially dangerous situations. R15's care plan lacked any indication of R15's diagnoses of PTSD, severe anxiety with panic and insomnia or interventions. Review of a facility Grievance/Concern or Problem Resolution Form dated 6/6/22, identified R15 had submitted a grievance regarding the following; on 6/5/22, at dinner time, R8 had attempted to leave the facility by the front door, R15 had attempted to tell R8 to wait for staff, when R8 grabbed her wheelchair and kicked her in the right leg. The form revealed a Summary of Investigation which identified the following; on 6/9/22, the director of nursing (DON) had spoken to R15 about the situation, explained the resident	F 600		

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F 600	Continued From page 20 did not have any bruising/pain of her right leg, was medically stable and no medical interventions were required. The form identified the DON spoke with R15 about her memories of past abuse being triggered by the emotionally intense event and talked to her about processing emotions and healthy coping. The grievance form revealed a Plan of Resolution which indicated the DON spoke to R15 about not involving herself in staff/other resident conflicts and if a situation was triggering to R15, she was to "remove herself and let staff handle it." R15's grievance form lacked any interventions to provide protection to R15 and other residents from further abuse, an indication R15's psychosocial needs were assessed or if R15 expressed feeling fearful. Review of R15's progress note dated 6/5/22, identified R15 was involved in an altercation with another resident who had attempted to leave the facility. The note revealed the other resident was agitated with R15 for becoming involved. The note identified the other resident swung and kicked out, R15 backed away, however was brushed by the other residents foot. The note revealed R15 had no injury, was crying heavily, not because she was hurt, but because she had been in abusive relationships before. R15's medical record lacked evidence of interventions placed to protect R15 and other residents from further abuse, R15's psychosocial health and any corresponding follow-up assessments such as mood monitoring or behavioral changes following the incident of abuse were completed. On 6/12/22, at 1:25 p.m. R15 was seated in a recliner in her room, her wheelchair was in front	F 600		

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F 600	Continued From page 21 of her with a stuffed bear placed on the seat in front of her. R15 stated she kept the bear there for comfort and indicated she had been having a hard time the past week. At that time R15's eyes filled with tears, her brow furrowed, she stated she was involved in an incident the week prior, on 6/5/22, when she had been kicked by another resident, R8, in her right lower leg. R15 indicated at the time of the incident, R8 had been attempting to leave the building by the front door, she approached R8 to try to calm him down as a registered nurse (RN)-A, and a nursing assistant (NA)-B had been attempting to move R8 (who was seated in a wheelchair) away from the door. R15 stated at that time, R8 grabbed onto her wheelchair, pulled her closer and kicked her right leg. She indicated, NA-B then took a hold of R8's wheelchair and assisted him outside of the building by the front door. R15 indicated shortly after the incident, RN-A looked at her right lower leg, saw no injury and had told her to go back to the dining room to finish her evening meal. R15 indicated she was not able to eat directly following the incident, she cried a lot, she felt afraid of R8 and returned to her room for the rest of the evening. R15 stated at no time, did anyone ask her how she felt, if she was afraid or if she needed anything. With continued tears running from her eyes, R15 indicated she had a stroke about a year ago and since then she cried very easily. However, she stated since the incident with R8 on 6/5/22, she had increased crying episodes, and felt very affected by the incident emotionally and mentally. R15 indicated she had a bruise on her lower right leg, which presented a few days following the incident and felt the facility leadership, such as the administrator and DON, did nothing to protect her and dismissed her concerns. R15 lifted her right leg and on the	F 600		

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F 600	Continued From page 22 lateral aspect approximately six (6) centimeters (cm) from her ankle a nickel sized purple bruise with green bordering was noted. R15 stated she felt her PTSD had been "triggered" following the incident as she continued to feel afraid of R8 and felt she had been in a "fight or flight" mode since the incident which occurred eight days prior. R15 stated she felt very tired, she needed to be hyper aware of her surroundings and had increased memories of her past abusive relationship. Further, R15 indicated the day after the incident, she had spoken with the facility's activity director and was encouraged to file a grievance. R15 stated she had obtained a grievance form and had asked the activity director for assistance to fill out the form as she as not able to write very well. R15 stated after the grievance form was filled out, she presented the form to the facility administrator who had proceeded to "scold her" for not following facility process for filing grievances. R15 indicated the facility administrator had told her only three staff members were able to fill out a grievance with residents, that was himself, the facility social worker and DON. R15 indicated, as she tightened her jaw and furrowed her brow, tears continued to fall down her cheeks, she felt the administrator had "scolded her like a principal would a student" and indicated she did not feel as though the administrator took her concern seriously and did not feel she would be protected against R8 or any other resident in the facility by facility leadership. Additionally, R15 stated following the incident R8 had been taken out of the facility and brought out to eat at a local legion and indicated she felt R8 was rewarded for his behavior. R15 indicated a few days following the incident, the DON had met	F 600		

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MOORHEAD RESTORATIVE CARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23 with her regarding the grievance form, and had told her to stay away from R8. She stated she felt the DON had told her to mind her own business and getting kicked was her fault for trying to assist. R15 stated she contacted the state ombudsman regarding the administrator's and DON's lack of response to her grievance and her continued fear of R8. R15 indicated since the incident, R8 "looks at her in a mean manner," and felt he knew what he did and believed he would do it again. R15 stated she did not feel safe overall in the facility, she had been "tight all over" and sick to her stomach since the incident. R15 stated, with continued tears, she felt scared all the time and felt like she had to watch out for herself again and that no one would protect her. While R15 continued to have tears rolling down her cheeks, she took a hold of her stuffed bear and squeezed it tightly. R15 indicated she would be looking at scheduling another appointment with her mental health practioner due her PTSD symptoms. -at 3:22 p.m. R15 remained seated in her wheelchair near the nurses station, at that time, R15 indicated she was going to look for her nurse. She wheeled herself down the 300 wing, turned right down the 400 wing and propelled herself with her feet and the right sided hand rail in the hallways. R15 was observed to look at R8's room, while R8 was in his room, R15 lips and jaw tightened, her brow furrowed in a grimace, she shivered as she passed his room. R15 then wheeled herself back to the nurses station by the 300 wing. On 6/15/22, at 9:32 a.m. R15 was seated in her wheelchair in the activity room, she was working on a puzzle with activity aid (AA)-A, she was	F 600		

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F 600	Continued From page 24 smiling and was talking with AA-A. At that time, the door to the courtyard was opened, a female resident was wheeled in by NA-F, followed by R8. R8 wheeled himself towards the activity table, approximately two feet from where R15 and AA-A were working on the puzzle. R15's eyes widened, she straightened her posture and took a deep breath, her back upright in a fearful manner. R8 sat near her for a brief period and then wheeled himself out of the activity room. -at 11:17 a.m. R15 was seated in a wheelchair by the front entrance of the facility, and R8 was seated in a wheelchair at the entrance of the dining room, approximately five feet from R15. R8 sat in the wheelchair, looked at R15 intently and stared at her. R15's eyes were wide, darting back and forth as if she was looking for something, backed her wheelchair up towards the door. R8 wheeled out of the dining room, and down the 400 wing of the facility. R15 then entered the dining room and wheeled herself to a table in the middle of the room. During an interview on 6/13/22, at 2:36 p.m. trained medication aid (TMA)-A stated R15 was independent with all of her cares and only required assistance with showering. TMA-A indicated she felt R15 was a reliable historian and was able to communicate her needs and wishes. TMA-A stated she was working the evening during the incident on 6/5/22, and stated R8 had been attempting to leave the facility through the front door, which had set off an alarm. She indicated she observed R15 wheel herself to the entrance and spoke to R8, who then kicked her in the leg. TMA-A stated R8 was taken out of the front door by NA-B and RN-A had spoken with R15. TMA-A indicated she had not spoken with	F 600		

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F 600	Continued From page 25 R15 following the incident and was not aware if anyone had asked her if she felt safe or was afraid. She indicated R15 cried and went back to her room following the incident. TMA-A stated she was not aware of any history of R8 being aggressive towards other residents. However, she stated R8 had a history of aggression towards staff, was quick to anger and would kick and push through staff at times. TMA-A indicated she felt when R8 did not get what he requested, he would become aggressive without any warning and felt it was best to stay out of his way during those times. During an interview on 6/13/22, at 3:04 p.m. NA-B stated R15 was fairly independent with her ADL's, rarely called for assistance and felt she was reliable and truthful. NA-B stated he had been working on the evening of 6/5/22, and had witnessed the incident with R8 and had observed R15 get kicked in the leg by R8. NA-B indicated he had been attempting to keep R8 away from the entrance as he was trying to leave the facility, when R8 turned his wheelchair around and kicked at R15. NA-B stated following the incident, R15 began to cry and wheeled herself away from the front entrance. NA-B stated he was not aware if anyone had talked to R15 following the incident as he had taken R8 out of the front door and was asked by the charge nurse to bring him outside. NA-B indicated he was then directed to bring R8 out to eat at the local Legion and he had no further aggressive episodes that evening. NA-B indicated R8 had a history of being aggressive towards staff, and was not aware of any other residents, besides R15, who R8 had kicked or been aggressive towards. NA-B stated twice in the past two weeks, R8 had attempted to leave the facility and had become aggressive towards a	F 600		

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F 600	Continued From page 26 dietary aid, and another NA. During an interview on 6/13/22, at 3:25 p.m. NA-A stated R15 required minimal assistance with cares such as showers and assistance with undergarments. NA-A stated she felt R15 was reliable, and was able to communicate without difficulties and had good recall. NA-A stated she had noticed some changes with R15 within the last week, such as increased crying, staying in her room and wanting to have staff walk with her to the dining room. NA-A stated early last week, approximately one to two days following the incident with R8, she asked R15 if anything was wrong and R15 had told her of the incident with R8. NA-A indicated she felt R15 appeared afraid, was crying heavily during her retelling of the incident and had told NA-A she was afraid of R8. NA-A indicated she had asked R15 if staff had witnessed the incident and had been told staff was present. NA-A stated R15 had asked her for a hug, which was abnormal for R15 as she did not like physical contact. NA-A stated R15 had spoken to her about past abuse with her estranged husband and indicated R15 had felt the incident with R8 had brought up memories and feelings from her past abuse. NA-A stated she felt R15 had acted differently since the incident, such as staying in her room more often, and felt even though she had only known R15 for a short time, the change in her mood and behavior was very apparent. NA-A indicated R15 startled easily and was hypervigilance when she was out of her room. NA-A stated she had asked R15 if any leadership staff had spoken to her about the incident and was concerned no one was helping R15 with her ongoing fear and concerns with her safety. NA-A stated she had witnessed R8 glaring and looking at R15 in a	F 600		

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F 600	Continued From page 27 harsh manner in the dining room within the last few days and R15 had asked her to walk with her back to her room. NA-A indicated this was not usual for R15. She stated she was not aware of R8 being aggressive towards other residents prior to this incident, however she had observed R8 become physically aggressive towards staff and had smacked and kicked an NA the week prior to the incident with R15 on 6/5/22. During an interview on 6/13/22, at 3:41 p.m. NA-D indicated R15 was independent with her ADL's, was reliable and able to communicate without difficulty. NA-D indicated she had been made aware of the incident between R15 and R8 from another NA earlier in the week. She indicated she had not really worked with R15 since the previous weekend and had not noticed any changes in her behavior in the facility. NA-D indicated she felt R8 was very quick to anger without much warning, and staff were to stay away from him during those times. NA-D stated she had been kicked by R8 as recently as a few weeks ago, and was not aware of any interventions in place to keep residents away from R8 when he was agitated and aggressive. During an interview on 6/14/22, at 8:09 a.m. NA-C stated R15 was able to complete most of her cares independently, felt she was a reliable historian and was able to communicate her needs without difficulty. NA-C stated she had noticed R15 was hyper-alert and appeared "jumpy" for a few days following the incident on 6/5/22. NA-C stated she had not worked with R15 in the past couple of days, and was not aware if she continued to appear jumpy and more alert. NA-C indicated R15 had spoken with her in the past about previous abuse with her estranged	F 600		

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F 600	Continued From page 28 husband and indicated R15's prior abuse was extensive and felt it could affect how she felt in high stress situations. NA-C stated she felt R8 was quick to anger, he would become aggressive when he did not get what he wanted, and would kick out or hit out at staff. During an interview on 6/14/22, at 8:30 a.m. TMA-B stated R15 was alert, oriented and was able to communicate without difficulties. TMA-B indicated R15 has spoken to her about being kicked by R8, and felt R15 was very upset about the incident due to her previous abuse history. TMA-B indicated R15 had told her she was not as upset about being kicked as she was about the feelings and fear it had brought back to the surface. She indicated R15 had been more tearful and had been staying in her room more so in the last week, following the incident with R8. TMA-B indicated she had spoken to the licensed nurses regarding R15's increase in crying and isolation and had been told to just talk to R15 when she was upset. TMA-B indicated she felt R8 could become aggressive towards staff and residents. She stated when R8 became upset or was mad, it would show on his face and indicated it was best to keep a distance from R8 during those episodes. During an interview on 6/14/22, at 8:44 a.m. the activity director (AD) stated she had been made aware of the incident between R15 and R8 when R15 had approached her on Monday morning, the day following the incident. AD indicated R15 had stated she needed to have a very serious talk with her, and had a "fearful" expression on her face. AD stated R15 informed her of what had happened on 6/5/22, told her she was afraid of R8 and wanted help to file a grievance. AD	F 600		

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F 600	Continued From page 29 indicated she assisted R15 to fill out a grievance form and had assumed the facility clinical leadership had filed a vulnerable adult report with the state agency. AD stated R15 had left her office with the grievance form, indicated she was going to bring it to the facility administrator and returned approximately an hour later extremely upset. AD indicated R15 had told her the administrator had scolded her for filing out the grievance form and had told her she did not follow the facility's process for filing a grievance. AD stated she provided R15 with the states' ombudsman contact information and encouraged R15 to contact her for assistance with the grievance. She indicated the facility administrator had talked to R15's son following the incident on 6/5/22, and had told R15's son he felt she was being dramatic and was not harmed in the incident. AD stated R15 informed her the DON had spoken with her a few days after she turned in the grievance to the administrator and had been told to mind her own business and not interfere with staff and other residents. AD indicated she felt R15 was reliable, able to communicate her needs and had been significantly affected by the incident emotionally and mentally. AD stated R15 continued to be afraid of R8 and was hyper aware of her surroundings. AD indicated R8 oftentimes would lose his temper when he did not get what he wanted, such as going outside of the facility, and indicated he had been aggressive physically with staff in the past. During a telephone interview on 6/14/22, at 11:05 a.m. R15's family member (FM)-A indicated he had received a phone call from R15 the previous weekend who was very upset and crying. He stated R15 had told him she had attempted to	F 600		

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F 600	Continued From page 30 assist staff stop a resident from leaving the facility and she had been kicked by the resident. FM-A stated he came to the facility the following day to speak with R15 and the facility leadership to see what the facility was going to do to protect R15. FM-A stated R15 was alert, oriented and had no difficulty with communicating her needs and advocating for herself. He indicated R15 had told him the resident who kicked her, R8, gave her dirty looks and she was fearful of him. He stated a facility staff member, he was not aware of their title, had spoken with him about the incident, told him they had instructed R15 not to interfere with other staff and residents and told him R15 had no injuries. FM-A stated R15 had a history of significant abuse, physical, mental and emotional and felt this incident had definitely affected his mother's mental status. He stated since the incident, R15 was more anxious, called him more frequently and wanted to move to an assisted living facility. FM-A stated R15 was a friendly and helpful person who would routinely try to assist someone in need and was concerned the incident could be repeated if R15 felt staff or another resident was in danger of becoming hurt. During an interview on 6/14/22, at 11:41 a.m. RN-A indicated she felt R15 was alert, oriented, able to communicate her needs and was a reliable historian. RN-A stated she had been present during the incident on 6/5/22, when R8 had kicked R15 in the leg. She stated R8 had been attempting to leave the facility, since he had a Wanderguard (device used to lock the doors for a period of time to prevent elopement) the door locked and an alarm was sounding. She indicated R15 had come out of the dining room and attempted to calm R8 down, and R8 had turned and "brushed his leg" against R15's leg. She	F 600		

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F 600	Continued From page 31 indicated she asked R15 if she was hurt, which she denied, she looked at R15's leg and didn't notice any redness or injury. RN-A stated she was unsure of the next steps to take regarding the incident since R8 had made contact with R15 and R8 continued to be aggressive wanting to leave the facility out the front door. She indicated she contacted the facility interim DON and corporate DON, and had been instructed to have one of the NA's take R8 out of the facility to the local Legion for his evening meal. She stated R15 had returned to the dining room and was not aware if R15 was fearful or had any negative affects from the incident. RN-A stated since the incident, R15 has brought up the incident frequently, appeared more anxious, sad and had been on guard. RN-A indicated she felt since the incident, R8 may have it "out for" R15 as he has been seen giving her "dirty looks" and would stare at R15 across the dining room. RN-A stated at the time of the incident, she had asked the interim DON, corporate DON and administrator if the incident needed to be reported to the state agency and had been told since R15 had no injury, a report did not need to be made and an investigation of the incident was not required. RN-A stated she was not aware any monitoring, supervision or other interventions had been implemented for R8 or R15 following the incident to protect R15 and other residents. During a joint interview on 6/14/22, at 12:42 p.m. with the interim DON and corporate DON, the interim DON confirmed she had been notified of the incident by RN-A via telephone on 6/5/22, with R15 and R8 shortly after the incident had occurred. The interim DON indicated she had been told R8 had attempted to leave the building, which had set off the alarm for the WanderGuard	F 600		

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F 600	Continued From page 32 system. She indicated she was told R15 had attempted to intervene to assist staff when R8 was swinging out at staff and he had kicked out at R15. The interim DON stated she was under the impression no physical contact was made between R15 and R8 during the incident and had been told R15 had no injuries. The interim DON indicated when she spoke to RN-A regarding the incident, she had inquired about whether the incident would qualify to be reported to the State Agency (SA). The interim DON stated she contacted the corporate DON, and had decided no abuse had occurred to R15 due to no physical harm or injury. The interim DON confirmed she had met with R15 regarding the grievance filed on 6/6/22, and confirmed R15 identified she had been kicked by R8. The interim DON indicated she had not specifically asked R15 if she was kicked by R8 and indicated she had asked R15 if she was fearful of R8, though did not document it on the grievance form. She indicated she could not recall if she had asked R15 if she felt safe in the facility. The interim DON indicated she and R15 discussed her past abuse and how the incident could have brought up feelings associated with past abuse and trauma. Both the interim DON, and corporate DON indicated they were not aware of any changes in R15's mood or behavior such as increased crying, keeping to her room more, hypervigilance or any indication of fear of R8 since the incident. The corporate DON confirmed R15's care plan lacked any indication of a history of trauma, PTSD, triggers or interventions. She indicated residents should have a trauma assessment completed upon admisson and with any changes, and confirmed R15's medical record lacked a current trauma assessment. The corporate DON stated she would expect R15's history of abuse, PTSD, any	F 600		

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F 600	Continued From page 33 triggers to be assessed and care planned with interventions. The corporate DON and interim DON indicated they were unaware if mental anguish or psychosocial harm would constitute as abuse. The corporate DON confirmed no internal investigation was initiated or completed for the incident. The corporate DON stated she was unaware of any history of aggression with R8 towards residents or staff. Futher, both the corporate DON and interim DON confirmed following the incident, no interventions had been implemented to provide supervision and monitoring of R8 to prevent a reoccurrence of the incident. Both the corporate DON and interim DON confirmed no interventions had been implemented to monitor R15 for trauma responses, worsening mood symptoms or changes in behavior. Further, they confirmed no education or awareness had been provided to facility staff regarding the incident in order to protect R15 and other residents should R8 become aggressive again. The interim DON stated she was not immediately aware of the facility policy or federal guidelines for the definition of abuse or what is required to be reported to the state agency. The corporate DON confirmed she was not immediately aware of the facility policy or federal guidelines regarding the definition of abuse, what would qualify as resident to resident abuse, harm and what was required to be reported to the state agency. The interim DON and the corporate DON confirmed they had been following Minnesota state statues for reporting maltreatment. During an interview, on 6/15/22, at 9:32 a.m. NA-F stated R15 was alert, oriented and was able to communicate without difficulty. She stated R15	F 600		

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F 600	Continued From page 34 was very friendly towards people, liked to be helpful and felt R15 had acted differently the past week, following the incident with R8. NA-F indicated R15 was staying in her room more often then before, had been crying more and startled very easily. She indicated R15 had spoken to her about her past abuse and how the incident with R8 had brought back some feelings she had a hard time coping with. NA-F stated, she allowed R15 to talk about her feelings in hopes to make her feel safe and protected. During an interview on 6/15/22, at 9:52 a.m. the facility administrator confirmed on 6/5/22, he had been notified of the incident with R8 and R15 by phone. He indicated R15 had come to him the following day and gave him the grievance form. He stated he spoke to R15, asked if she was okay and informed her he was sorry the incident happened. The administrator indicated he gave the grievance to nursing leadership to address the problem and to come up with a resolution. The administrator stated he was not immediately aware of the federal regulations for reporting resident to resident altercations, or how abuse was defined. Further, the administrator indicated he felt the incident had been internally investigated via the grievance process. On 6/15/22, at 8:24 a.m. a telephone call was placed to R15's mental health practioner, a message was left for a return phone call. No telephone call was returned. During an interview on 6/15/22, at 10:33 a.m. the director of social services, (SS) stated she was made aware of the incident between R15 and R8 by reading a progress note in R15's medical record. SS indicated she had asked the corporate	F 600		

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	245052	A. BUILDING _____ B. WING _____	06/16/2022

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F 600	Continued From page 35 DON and interim DON for further information and whether a report to the SA was required. She indicated she had been told, the incident had not met the criteria and guidelines for reporting. SS stated she was not immediately aware of federal definitions or guidelines for reporting and investigating incidents of resident to resident altercation/abuse. She confirmed R15 had not been assessed for trauma since 2020, and her plan of care lacked any indication of R15's past abuse, and trauma. SS indicated she was not aware if R15 had any changes in her mood such as increased crying, feeling afraid or on edge. SS confirmed she had not spoken to R15 regarding the incident with R8 and had not asked R15 if she felt safe. During an interview on 6/15/22, at 3:52 p.m. RN-C stated she felt R15 had been trying to avoid being in the same place as R8 since the incident. She indicated R15 would actually leave the dining room if R8 entered or would not enter the dining room if R8 was already present. RN-C stated R15 had been eating in her room more often as well. During a follow up interview on 6/16/22, at 11:13 a.m. R15 stated she continued to feel afraid of R8 and was fearful the incident would happen again. R15's brow furrowed, her jaw tightened, relaxed and tears welled in her eyes, she indicated a staff member, whom she didn't know, asked R8 to apologize to her the other day, which he did. R15 stated she would "tried to play nice," and wanted to get along, but in her past after times when she was abused by her estranged husband, he would apologize, she would forgive him and it would happen all over again. R15 indicated she felt the situation with R8 was no different and she indicated she was so tired of being the one to	F 600		

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F 600	Continued From page 36 keep the peace and to have to be strong all of the time. During a telephone interview on 6/16/22, at 9:45 a.m. the facility medical director (MD) stated he was not aware of the incident between R15 and R8. He indicated he felt R15's diagnosis of PTSD and past trauma and abuse would certainly have been triggered following the incident. MD stated he would have expected the facility to ensure R15 was safe from residents with aggression and to ensure R15 felt safe. He indicated he would expect the facility to identify and implement interventions to supervise/monitor R8 for any aggression and to intervene as needed. MD stated he felt people who have experienced trauma, have developed coping skills and would not consistently exhibit outward appearances of fear, however that would not mean the person wasn't fearful. He indicated he would anticipate R15 would need time to work through the situation and felt she could have definitely experienced psychosocial harm as a result of the resident to resident abuse. Review of facility policy titled, Abuse Prevention Program, revised 1/22/22, revealed the facility residents had a right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The policy revealed the facility's abuse prevention program which included the following; - protocols for conducting background checks - mandated staff training/orientation programs that include such topics as abuse prevention, - identification and reporting of abuse, stress management, dealing with violent behavior or catastrophic reactions etc - identification of occurrences and patterns of	F 600		

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F 600	Continued From page 37 potential mistreatment/abuse - the protection of residents during the abuse investigations - the development of investigative protocols governing resident abuse, theft, misappropriation of resident property, resident to resident abuse, and resident to staff abuse. - timely and thorough investigation of all reports and allegations of abuse - the reporting and filing of accurate documents relative to incidents of abuse - an ongoing review and analysis of abuse incidents and - the implementation of changes to prevent future occurrences of abuse A facility policy titled, Abuse Investigation and Reporting reviewed 1/2022, identified all reports of resident abuse, neglect, exploitation, misappropriation of property, mistreatment and/or injuries of unknown source ("abuse") would be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations would also be reported. The policy identified roles of the facility administrator, which included assigning an investigator and would ensure any further potential abuse, neglect is prevented. The policy identified roles of the investigator and reporting requirements. A facility policy titled, Resident to Resident Altercation, reviewed 6/2022, identified all altercations, including those that represent resident to resident abuse would be investigated and reported to the nursing supervisor, director of nursing and facility administrator.	F 600		

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F 600	Continued From page 38 Review of a facility policy titled, Abuse and Neglect - Clinical Protocol, revised 1/2022, revealed a procedure for assessment and recognition of abuse and neglect. The policy identified abuse; mistreatment or infliction of harm by someone who has a special relationship with, responsibility for, or obligation to, an individual. The immediate jeopardy that began on 6/5/22, was removed on 6/16/22, when the facility implemented monitoring of R8's behavior, mood symptoms, provided supervision when R15 and R8 were in the same area. R15 was seen by her mental health practioner on 6/16/22, and an appointment with a mental health practioner had been made for R8 on 6/17/22, to address ongoing behavioral and psychiatric needs. The facility ensured a neutral facility leadership staff checked in with R15 daily and completed education to facility staff to ensure supervision, monitoring and ensuring R15's safety, but the noncompliance remained at the lower scope and severity level of D, no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		7/12/22

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F 609	Continued From page 39 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an alleged violation of resident to resident abuse was immediately reported to, no later than two hours, to the State Agency (SA) for 1 of 1 residents (R15) reviewed for allegations of abuse. Findings include: R15's quarterly Minimum Data Set (MDS) dated 5/6/22, identified R15 had diagnoses which included end stage renal disease (ESRD,) depression, anxiety and heart failure. The MDS identified R15 was cognitively intact and was independent with activities of daily living (ADL's) of bed mobility, transfers and locomotion with use of a wheelchair. R15's psychiatric provider visit summary dated	F 609	1. MRHCC was found to have an incident involving a reportable event of emotional abuse that was not discovered and addressed in a timely manner. Residents involved were R15 and R8. Staff have since identified the emotional abuse and have implemented interventions to help support both residents and prevent future abuse or neglect. 2. All resident's have the potential to be affected in this area. All resident's were assessed regarding abuse and neglect. Education was provided to the nurses on 07/08/22 regarding abuse, neglect, and rules for reporting abuse/neglect. Administrator and DON have been re-educated on the reporting process. 3. Audits will be performed on compliance on preventing and addressing	

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F 609	Continued From page 40 3/15/22, identified R15 had diagnoses which included severe anxiety with panic, Post Traumatic Stress Disorder (PTSD) and insomnia. R15's care plan revised 6/13/22, revealed R15 was at risk for abuse due to anxiety, medication use, medical conditions and assistance with cares. R15's care plan identified interventions which included anticipating her needs, do not have her near others who disturb her and to remove her from potentially dangerous situations. Review of R15's progress note dated 6/5/22, identified R15 was involved in an altercation with another resident who attempted to leave the facility. The note revealed the other resident was agitated with R15 when she became involved. The note identified the other resident swung and kicked out, R15 backed away and was brushed by the other resident's foot. The note revealed R15 had no injury, was crying heavily, not because she was hurt, but because she had been in abusive relationships before. Review of a facility Grievance/Concern or Problem Resolution Form dated 6/6/22, revealed R15 had submitted a grievance regarding the following; on 6/5/22, at dinner time, R8 had attempted to leave the facility by the front door, R15 had attempted to tell R8 to wait for staff, when R8 grabbed her wheelchair and kicked her in the right leg. The form indicated a Summary of Investigation which identified the following; on 6/9/22, the director of nursing (DON) had spoken to R15 about the situation, explained the resident did not have any bruising/pain of her right leg, was medically stable and no medical interventions were required. The form identified the DON spoke with R15 about her memories of	F 609	abuse/neglect via interviews regarding safety weekly x 8 weeks, then monthly for 4 months, or until 100% compliance is achieved. 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

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F 609	Continued From page 41 past abuse being triggered by the emotionally intense event and talked to her about processing emotions and healthy coping. The grievance form identified a Plan of Resolution which revealed the DON spoke to R15 about not involving herself in staff/other resident conflicts and if a situation was triggering to R15, she was to "remove herself and let staff handle it." R15's grievance form lacked any indication if R15 felt fearful, or any other indications R15's psychosocial needs were assessed. During an interview on 6/12/22, at 1:25 p.m. R15 was seated in a recliner in her room, her wheelchair was in front of her with a stuffed bear placed on the seat in front of her. R15 stated she kept the bear there for comfort and indicated she had been having a hard time the past week. R15's eyes filled with tears, her brow furrowed, she stated she was involved in an incident the week prior, on 6/5/22, when she had been kicked by R8 in her right lower leg. R15 stated she felt her PTSD had been "triggered" following the incident as she continued to feel afraid of R8 and felt she had been in a "fight or flight" mode since the incident, eight days prior. R15 indicated she had filed a grievance and handed it to the facility administrator. She indicated she felt the administrator had scolded her for not following the process for grievances. R15 indicated a few days following the incident, the DON had met with her regarding the grievance form and had told her to stay away from R8. She stated she felt as though the DON had told her to mind her own business and getting kicked was her fault for trying to assist. R15 stated she continued to be fearful of R8 and did not feel as though facility leadership would protect her if the incident occurred again.	F 609		

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F 609	Continued From page 42 During an interview on 6/13/22, at 3:04 p.m. nursing assistant (NA)-B stated R15 was fairly independent with her ADL's, rarely rang for assistance and felt she was reliable and truthful. NA-B stated he had been working on the evening of 6/5/22, had witnessed the incident with R8 and had observed R15 get kicked in the leg by R8. He stated, following the incident R15 began to cry and wheeled herself away from the front entrance. NA-B stated he was not aware if anyone had talked to R15 following the incident. During an interview on 6/14/22, at 11:41 a.m. registered nurse (RN)-A stated she had been present during the incident on 6/5/22, when R8 had kicked R15 in the leg. She indicated R15 had come out of the dining room and attempted to calm R8 down, R8 had turned and "brushed his foot" against R15's leg. She indicated she asked R15 if she was hurt, which she denied, she looked at R15's leg and did not notice any redness or injury. RN-A stated she was unsure of what to do regarding the incident since R8 had made contact with R15 and R8 continued to be aggressive wanting to leave the facility out the front door. She indicated she contacted the facility interim DON and corporate DON, and had been instructed to have one of the NA's take R8 out of the facility and to the local Legion for his evening meal. RN-A stated she had asked the interim DON, corporate DON and administrator if the incident needed to be reported to the SA and had been told since R15 had no injury, and abuse did not occur, a report was not required. On 6/14/22, at 12:42 p.m. during a joint interview with the interim DON, and corporate DON, the interim DON confirmed she had been notified of	F 609		

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F 609	Continued From page 43 the incident on 6/5/22, with R15 and R8 shortly after the incident via telephone by RN-A. The interim DON stated she was under the impression no physical contact was made between R15 and R8 during the incident and had been told R15 had no injuries. She indicated when she spoke to RN-A, she had inquired about whether the incident would qualify to be reported to the SA. The interim DON indicated she contacted the corporate DON, and had decided no abuse had occurred to R15 due to no physical harm or injury. The interim DON confirmed she had met with R15 regarding the grievance filed on 6/6/22, and confirmed R15 identified she had been kicked by R8. Both the corporate DON and interim DON confirmed the incident had not been not reported to the SA. The interim DON stated she was not immediately aware of the facility policy or federal guidelines for the definition of abuse or what was required to be reported to the SA. Further, the corporate DON confirmed she was not immediately aware of the facility policy or federal guidelines regarding the definition of abuse, what the definition of resident to resident abuse was, what would be considered harm and what was required to be reported to the SA. The interim DON and the corporate DON confirmed they had been following Minnesota state statue for reporting maltreatment, and had identified physical harm as abuse. The corporate DON and interim DON indicated they were unaware if mental anguish or psychosocial harm would constitute as abuse. During an interview on 6/15/22, at 9:52 a.m. the facility administrator confirmed on 6/5/22, he had been notified of the incident with R8 and R15 via telephone shortly after the incident. The administrator indicated he was not immediately	F 609		

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F 609	Continued From page 44 aware of the federal regulations for reporting resident to resident altercations, or how abuse was defined. He confirmed no SA report had been filed, and was unsure if one should have been filed. A facility policy titled, Abuse Investigation and Reporting reviewed 1/2022, identified all reports of resident abuse, neglect, exploitation, misappropriation of property, mistreatment and/or injuries of unknown source ("abuse") would be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) would be reported immediately, but no later than; 2 hours if the alleged violation involved abuse OR resulted in serious bodily harm; or 24 hours if the alleged violation did not involve abuse AND had not resulted in serious bodily injury. Review of facility policy titled, Abuse Prevention Program, revised 1/22/22, revealed the facility residents had a right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The policy revealed the facility's abuse prevention program included the following; - protocols for conducting background checks - mandated staff training/orientation programs that include such topics as abuse prevention - identification and reporting of abuse, stress management, dealing with violent behavior or catastrophic reactions etc. - identification of occurrences and patterns of potential mistreatment/abuse - the protection of residents during the abuse	F 609		

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F 609	Continued From page 45 investigations - the development of investigative protocols governing resident abuse, theft. misappropriation of resident property, resident to resident abuse, and resident to staff abuse. - timely and thorough investigation of all reports and allegations of abuse - the reporting and filing of accurate documents relative to incidents of abuse - an ongoing review and analysis of abuse incidents and - the implementation of changes to prevent future occurrences of abuse	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an incident	F 610	1. R15 and R8 were the residents identified in this deficiency. Both residents	7/12/22

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F 610	Continued From page 46 of resident to resident abuse for 1 of 1 resident (R15) reviewed for abuse. In addition, the facility failed to protect 1 of 1 resident (R15) following an incident of resident to resident abuse. Findings include: R15's quarterly Minimum Data Set (MDS) dated 5/6/22, identified R15 had diagnoses which included end stage renal disease (ESRD,) depression, anxiety and heart failure. The MDS identified R15 was cognitively intact and was independent with activities of daily living (ADL's) of bed mobility, transfers and locomotion with use of a wheelchair. R15's psychiatric provider visit summary dated 3/15/22, identified R15 had diagnoses which included severe anxiety with panic, Post Traumatic Stress Disorder (PTSD) and insomnia. R15's care plan revised 6/13/22, revealed R15 was at risk for abuse due to anxiety, medication use, medical conditions and required assistance with cares. R15's care plan identified interventions which included anticipating her needs, do not have her near others who disturbed her and to remove her from potentially dangerous situations. Review of R15's progress dated 6/5/22, revealed R15 was involved in an altercation with another resident who attempted to leave the facility. The note identified the other resident was agitated with R15 when she became involved. The note continued, the other resident swung and kicked out, R15 backed away and was brushed by the other resident's foot. The note revealed R15 had no injury, was crying heavily, not because she	F 610	had their care plans updated to reflect their past histories and interventions put into place related to how to help each of them deal with the current situation. Administration team investigated and documented conversations with both residents in an attempt to resolve the issue. Both resident□s are being monitored and documented on regularly by nursing staff. Activities visits one on one with R15 daily. 2. All resident□s have the potential to be affected in this area. Education was provided to the staff starting on 07/07/22 regarding reporting, investigating any resident who has potentially experienced abuse in any form. Residents care plans reviewed to identify any other potential residents that might be affected 3. Audits will be performed on incident reporting and Investigations weekly x 8 weeks, then monthly for 4 months, or until 100% compliance is achieved. 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

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F 610	Continued From page 47 was hurt, but because she had been in abusive relationships before. Review of a facility Grievance/Concern or Problem Resolution Form dated 6/6/22, revealed R15 had submitted a grievance regarding the following; on 6/5/22, at dinner time, R8 had attempted to leave the facility by the front door, R15 had attempted to tell R8 to wait for staff, when R8 grabbed her wheelchair and kicked her in the right leg. The form indicated a Summary of Investigation which identified the following; on 6/9/22, the director of nursing (DON) had spoken to R15 about the situation, explained the resident did not have any bruising/pain of her right leg, was medically stable and no medical interventions were required. The form revealed the DON spoke with R15 about her memories of past abuse being triggered by the emotionally intense event and talked to her about processing emotions and healthy coping. The grievance form identified a Plan of Resolution which revealed the DON spoke to R15 about not involving herself in staff/other resident conflicts and if a situation was triggering to R15, she was to "remove herself and let staff handle it." R15's grievance form lacked documentation any interventions were placed to provide protection for R15 and other residents. Additionally, the grievance lacked any indication if R15 felt fearful, or any other indications R15's psychosocial needs were assessed. R15's medical record lacked evidence interventions were placed to provide protection for R15 and other residents to prevent further abuse Additionally, the medical record lacked evidence R15's psychosocial health and any corresponding follow-up assessments such as mood monitoring or behavioral changes following	F 610		

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F 610	Continued From page 48 the incident of abuse were completed. During an interview on 6/12/22, at 1:25 p.m. R15 was seated in a recliner in her room, her wheelchair was in front of her with a stuffed bear placed on the seat in front of her. R15 stated she kept the bear there for comfort and indicated she had been having a hard time the past week. R15's eyes filled with tears, her brow furrowed, she stated she was involved in an incident the week prior, on 6/5/22, when she had been kicked by R8 in her right lower leg. R15 stated she felt her PTSD had been "triggered" following the incident as she continued to feel afraid of R8 and felt she had been in a "fight or flight" mode since the incident, eight days prior. R15 indicated she had filed a grievance and handed it to the facility administrator. She indicated she felt the administrator had scolded her for not following the process for grievances. R15 indicated a few days following the incident, the DON had met with her regarding the grievance form, and had told her to stay away from R8. She stated she felt as though DON had told her to mind her own business and getting kicked was her fault for trying to assist. R15 stated she continued to be fearful of R8 and did not feel as though facility leadership would protect her if the incident occurred again. During an interview on 6/13/22, at 3:04 p.m. nursing assistant (NA)-B stated R15 was fairly independent with her ADL's, rarely rang for assistance and felt she was reliable and truthful. NA-B stated he had been working on the evening of 6/5/22, had witnessed the incident with R8 and had observed R15 get kicked in the leg by R8. He stated, following the incident R15 began to cry and wheeled herself away from the front	F 610		

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F 610	Continued From page 49 entrance. NA-B stated he was not aware if anyone had spoke to R15 following the incident. During an interview on 6/14/22, at 11:41 a.m. registered nurse (RN)-A stated she had been present during the incident on 6/5/22, when R8 had kicked R15 in the leg. She indicated R15 had come out of the dining room and attempted to calm R8 down and R8 had turned and "brushed his foot" against R15's leg. She indicated she asked R15 if she was hurt, which she denied, she looked at R15's leg and did not notice any redness or injury. RN-A stated she was unsure of what to do next regarding the incident since R8 had made contact with R15 and R8 continued to be aggressive wanting to leave the facility out the front door. She indicated she contacted the facility interim DON and corporate DON and had been instructed to have one of the NA's take R8 out of the facility to the local Legion for his evening meal. RN-A confirmed no immediate protection was put into place for R15 and no investigation was initiated for the incident. During a joint interview on 6/14/22, at 12:42 p.m. with the interim DON, and corporate DON, the interim DON confirmed she had been notified of the incident on 6/5/22, between R15 and R8 shortly after the incident by phone from RN-A. The interim DON stated she was under the impression no physical contact was made between R15 and R8 during the incident and had been told R15 had no injuries. The interim DON confirmed she had met with R15 regarding the grievance filed on 6/6/22, and confirmed R15 identified she had been kicked by R8. The corporate DON confirmed no internal investigation was initiated or completed for the incident.	F 610		

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F 610	Continued From page 50 R15's medical record lacked any documentation of an internal investigation completed or any interventions the facility put in place to portect R15 from further abuse. During an interview on 6/15/22, at 9:52 a.m. the facility administrator confirmed on 6/5/22, he had been notified of the incident between R8 and R15 via telephone shortly after the incident. The administrator indicated he was not immediately aware of the federal regulations for how abuse was defined. The administrator indicated he felt the incident had been internally investigated via the grievance process. During an interview on 6/15/22, at 10:33 a.m. the director of social services, (SS) stated she was made aware of the incident between R15 and R8 by reading a progress note in R15's medical record. SS indicated she had asked the corporate DON and interim DON for further information. SS stated she was not aware of federal definitions or guidelines for investigating incidents of resident to resident altercation/abuse. A facility policy titled, Abuse Investigation and Reporting reviewed 1/2022, identified all reports of resident abuse, neglect, exploitation, misappropriation of property, mistreatment and/or injuries of unknown source ("abuse") would be thoroughly investigated by facility management. Review of facility policy titled, Abuse Prevention Program, revised 1/22/22, revealed the facility residents had a right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The policy revealed the facility's abuse prevention	F 610		

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F 610	Continued From page 51 program included the following; - protocols for conducting background checks - mandated staff training/orientation programs that include such topics as abuse prevention - identification and reporting of abuse, stress management, dealing with violent behavior or catastrophic reactions etc. - identification of occurrences and patterns of potential mistreatment/abuse - the protection of residents during the abuse investigations - the development of investigative protocols governing resident abuse, theft. misappropriation of resident property, resident to resident abuse, and resident to staff abuse - timely and thorough investigation of all reports and allegations of abuse - the reporting and filing of accurate documents relative to incidents of abuse - an ongoing review and analysis of abuse incidents and - the implementation of changes to prevent future occurrences of abuse	F 610		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an as needed analgesic to ensure routine pain management for 1 of 1 resident (R2) reviewed for pain who	F 697	1. R2 was found to not be receiving her as needed pain medication per the doctor's order causing her pain to not being adequately controlled. Nursing staff	7/12/22

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F 697	Continued From page 52 experienced almost constant pain. Findings include: R2's quarterly Minimum Data Set (MDS) dated 5/31/22, identified R2 had diagnoses which included Cerebral Palsy, quadriplegia, traumatic spinal cord dysfunction (spinal cord injury that can stem from a sudden, traumatic blow to your spine that fractures, dislocates, crushes or compresses one or more of your vertebrae.) The MDS identified R2 was cognitively intact and required extensive to total assistance with activities of daily living (ADL's) of bed mobility, transfers, dressing and bathing. The MDS revealed R2 had reported almost constant, very severe, horrible pain which affected her sleep and day to day activities. The MDS identified R2 received scheduled and as needed pain medication as well as non-medication interventions for pain management. The MDS indicated R2 received opioid medications daily during the seven (7) day assessment period. R2's admission MDS dated 3/1/22, identified R2 had diagnoses which included Cerebral Palsy, quadriplegia, recent hip replacement and traumatic spinal cord dysfunction. The MDS identified R2 had intact cognition and required extensive to total assistance with ADL's. The MDS indicated R2 had reported almost constant pain, rated an eight (8) on a numeric pain scale (0- no pain,10- worst pain imaginable) which affected her sleep and limited her day to day activity. The MDS identified R2 received scheduled and as needed pain medication as well as non-medication interventions for pain management. The MDS revealed R2 received opioid medications daily during the seven (7) day	F 697	that were involved were educated on providing her the prescribed pain medication as ordered immediately after the survey. The nursing staff were educated on 7/8/2022. Staff educated on resident levels of pain is the patient's perception not the nurses, Nurse in situation educated immediately. 2. All residents have the potential to be affected in this area. All residents were assessed to determine their pain tolerance. Education was provided to the nurses and TMAs about providing pain management to adequately control resident pain. Pain assessments will be monitored to ensure pain is under control. Policy was reviewed and updated on 6/23/22. 3. Audits will be performed on resident pain management weekly x8 weeks, then monthly for 4 months, or until 100% compliance is achieved. 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

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F 697	Continued From page 53 assessment period. Review of R2's admission Care Area Assessment (CAA) dated 3/1/22, identified R2 had verbalized having severe and constant pain. The CAA revealed conditions which could have been factors in R2's pain, which included surgical incision, quadriplegia, and arthritis. The CAA identified R2 stated she had pain in her right hip and buttocks most of the time. The CAA revealed R2 had no observed non-verbal indicators of pain, however R2 verbally reported pain as constant and it interfered with her daily activities. The CAA identified R2 frequently cried, which may have been related to pain. The CAA listed various interventions in place for R2 which included repositioning, ice on affected area, and administering medications as ordered and in a timely manner. Review of R2's care plan revised 6/14/22, revealed R2 had chronic pain, received pain medication therapy and listed her goals of pain relief or ability to cope with incompletely relieved pain. The care plan listed various interventions for pain management which included, anticipate residents need for pain relief and respond timely to any complaints of pain, check with resident throughout shift for pain medication efficacy, administer analgesic medications as ordered by physician, educate resident on alternatives to pain management and offer alternatives to pain management. During an observation and interview on 6/12/22, at 7:12 p.m. R2 indicated she had constant pain, of her right side, hip, back and shoulder. R2 indicated she received scheduled pain medications (Oxycodone) twice daily and was	F 697		

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F 697	Continued From page 54 able to receive as needed Percocet every four hours for breakthrough pain. R2 stated last night, she had woken at approximately 3:30 a.m. with severe pain, had reported her pain to one of the nursing assistants (NA) and requested a prn (as needed) pain medication. R2 stated she never received any medication and had been unable to fall back to sleep until 5:30 a.m. due to pain. R2 indicated she had placed her call light on several times, and each time the NA indicated they would inform the nurse. R2 stated she had problems with receiving her prn pain medication during the night shift on several occasions, typically from a specific nurse. R2 indicated she had spoken to the facility administrator and director of nursing (DON) regarding the nurse within the last week. R2 stated she had seen some improvement, however there continued to be times, such as last night, where she did not receive her pain medication. During a follow up interview on 6/13/22, at 9:11 a.m. R2 stated she had pain throughout most of the night, and had asked for her pain medication four to five times, starting at 12:30 a.m. She stated she did not sleep, and indicated she had severe throbbing/aching pain in her right side, on her back which kept her up most of the night. R2 stated she had received her scheduled pain medication that morning and was hoping it would start to help. During an interview on 6/13/22, at 2:36 p.m. trained medication aid (TMA)-A indicated R2 was alert, oriented and was reliable and able to communicate her needs. TMA-A stated R2 reported almost constant pain, and had told her she had not received her pain medication at night when she had asked. TMA-A stated R2 allowed	F 697		

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F 697	Continued From page 55 non-medicine pain interventions such as repositioning, topical analgesic creams as well as prn medications. She indicated she felt R2 was most comfortable when she was able to receive her pain medications as she requested. During an interview on 6/13/22, at 3:04 p.m. NA-B stated R2 routinely complained of pain in her back, right hip and shoulders. He indicated R2 was able to communicate without difficulties and felt R2 was reliable. NA-B stated when R2 complained of pain, she would often allow repositioning and requested pain medication on a routine basis. He indicated he would let the medication nurse know and they would give R2 medication. NA-B stated he was not aware of R2 not receiving her medication when asked. During a follow up interview on 6/14/22, at 9:13 a.m. R2 stated she had slept a little better last night versus the previous night, and indicated she received a prn pain pill at midnight as she had requested. However, she woke around 4:30 a.m. to 5:00 a.m. in severe pain and requested a pain pill. R2 stated she was told by the nurse it was too close to the time she had received it last. She indicated she was able to receive her prn pain medication every four hours. R2 received her scheduled pain medication at 8:30 a.m. that morning, and still had a pain level of an "8" on a 0-10 pain scale. Review of R2's medication administration record (MAR) from 6/11/22, to 6/15/22, revealed the following: -an order dated 4/5/22, hydrocodone-Acetaminophen (opioid analgesic) Tablet 5-325 MG , give 1 tablet by mouth every 4	F 697		

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F 697	Continued From page 56 hours as needed for mild to moderate pain related to FUSION OF SPINE, CERVICAL REGION. The MAR revealed R2 had not received any Hydrocodone overnight, as requested by R2, on 6/11/22, 6/12/22, 6/13/22, 6/14/22, and 6/15/22. -Tylenol Extra Strength Tablet 500 MG (Acetaminophen), give 1000 mg by mouth every eight (8) hours as needed for pain The MAR revealed R2 had not received any Tylenol overnight on 6/11/22, 6/12/22, 6/13/22, 6/14/22, and 6/15/22. During an interview on 6/14/22, at 12:04 p.m. registered nurse (RN)-A indicated R2 was alert, oriented, reliable and was able to communicate without difficulty. She stated she had worked the night shift, two nights ago and had not been made aware R2 had complained of pain, or had requested pain medication. RN-A stated had she been aware R2 had requested pain medication, she would have provided her with one. RN-A stated R2 had reported to her within the last day or two, another night nurse had not been addressing her requests for pain medication. She indicated she felt there was a communication issue with some of the staff on the night shift. On 6/14/22, at 8:04 a.m. during a telephone interview, NA-I indicated R2 required extensive assistance with bed mobility and repositioning. NA-I stated R2 was alert, was reliable and was able to communicate her needs. She indicated R2 routinely woke up during the night with pain of her right hip, back and legs. She indicated, at those times, R2 would request pain medication,	F 697		

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F 697	Continued From page 57 which she would then tell the nurse on duty. NA-I indicated most of the nurses were good about giving R2 medication when needed, however she did not feel one of the licensed practical nurses (LPN)'s routinely provided R2 her pain medication as requested. NA-I indicated during those times, she would re-approach the nurse and the nurse would oftentimes pass it onto the day shift medication nurse to address. During an interview on 6/15/22, at 9:36 a.m. NA-F indicated R2 was alert, oriented, reliable and was able to communicate without difficulty. NA-F indicated R2 complained of pain daily. She indicated R2 reported pain in her back, right hip, shoulders, neck and legs. NA-F stated R2 would inform them when she was in pain and at those times NA-F would offer repositioning and would also notify the nurse. NA-F indicated oftentimes, R2 would request pain medication in addition to repositioning. During an interview on 6/16/22, at 8:26 a.m. TMA-C indicated R2 complained of pain that morning and received a prn hydrocodone approximately an hour before her scheduled pain medication. TMA-C stated R2 typically reported moderate to severe pain, and felt overall R2's pain was managed when she received her medication as requested. She stated R2 had reported to her recently she had not been receiving her pain medication on the overnight shift. TMA-B indicated she had passed the information to her charge nurse within the past few days. During an interview on 6/15/22, at 9:43 a.m. the facility administrator indicated he had spoken with R2 three to five weeks ago regarding her	F 697		

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F 697	Continued From page 58 concerns with one of the night nurses and not receiving her medications timely. He indicated he had spoken with nursing leadership and to his understanding the night nurse had been spoken to. The administrator indicated he was under the impression the situation had been resolved. During a follow up interview on 6/16/22, at 9:22 a.m. R2 stated she had woken in the middle of the night in pain and had requested pain medication from one of the NA's. R2 stated the nurse who was on duty never came to talk to her and she did not receive any medication until this morning, a few hours prior. R2 indicated her pain had been severe that morning, and had decreased to a tolerable level at that time. On 6/16/22, at 10:50 a.m. a telephone call was placed to the night nurse, licensed practical nurse (LPN)-B, left a message for a return call. No return call was received. During an interview on 6/16/22, at 4:35 p.m. the corporate DON stated she would expect R2's pain medication would have been provided to her upon request, following attempts of non-medicine interventions. The corporate DON indicated R2 should have as much pain relief as possible. A policy for pain management was requested and not received.	F 697		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD RESTORATIVE CARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 59 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate monitoring and timely removal of food stored in the facility's kitchen refrigerators to prevent food borne illness. This had the potential to affect all 25 residents receiving food prepared in the kitchen. Findings include: During an initial tour of the kitchen with the dietary aide (DA) on 6/12/22, at 1:08 p.m. the following was observed in the walk in refrigerator: -an open container which contained cheese slices without notation of the date the container was opened. -28 small containers of an unknown liquid substance without notation of the name of the substance or the date they were placed in the refrigerator. -an open carton of liquid eggs without notation of the date the carton was opened.	F 812	1. No individual resident identified. The kitchen was found to have food in the fridge that was not dated or labeled with contents. 2. All residents have the potential to be affected by this. Education was provided to the kitchen staff regarding safe food storage and dating food items on 07/12/22. Dietary management inspected all containers in the kitchen to ensure all other food was stored properly, labeled, and dated. The policy was provided to staff regarding storage of food on 7/12/22. 3. Audits will be performed on food storage and dating weekly x 8 weeks, then monthly for 4 months, or until 100% compliance is achieved. 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	06/16/2022

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F 812	Continued From page 60 -a large bag of brown lettuce with an open date of 6/3/22, with a handwritten note placed on the bag identifying "to use by 6/5/22". The following was observed in a snack cooler of the kitchen: - a large gallon container of mayonnaise which was 1/4 full without notation of a date the container was opened. - a carton of open oat milk without notation of a date the carton was opened. - 14 small containers which contained sour cream removed from a larger container without a notation of a date they were placed in the cooler. -a turkey sandwich without notation of a date the sandwich was prepared or placed in the cooler. During an interview on 6/12/22, at 1:26 p.m. DA stated staff were expected to date and label all food items once they had been opened and prior to placing the items back in the refrigerator. DA confirmed all of the above listed food items had not been dated. Further, the DA confirmed the oat milk, cheese, lettuce, and liquid eggs had been served to the residents. During a follow up tour of the kitchen with the dietary manager (DM) on 6/14/22, at 7:53 a.m. DM confirmed there were 14 small containers of sour cream in the snack cooler without a notation of a date present. During an interview on 6/14/22, at 8:13 a.m. DM stated he was not able to determine when the food present in the refrigerator and snack cooler had been opened. Additionally, DM stated staff were expected to date and label all food items once they were opened. Further, DM stated he expected staff to properly dispose of any outdated	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	06/16/2022

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F 812	Continued From page 61 food items. A facility policy titled Food Storage updated 3/22, indicated leftover food was expected to be stored in covered containers or wrapped carefully and secured. Each item would have been clearly labeled and dated before being refrigerated. Leftover food would have been used within seven days or discarded as per the 2013 Federal Food Code.	F 812		

Electronically Submitted
July 5, 2022

Administrator
Moorhead Restorative Care Center
2810 Second Avenue North
Moorhead, MN 56560

RE: CCN: 245052
Cycle Start Date: June 16, 2022

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On June 16, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 16, 2022, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

Because your facility is designated as a Special Focus Facility (SFF). CMS's policy of progressive enforcement means that your facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 20, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 20, 2022 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 20, 2022 (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Moorhead Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 16, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient

practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 16, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social

Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal

regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor

Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/15/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD RESTORATIVE CARE CENTER	**2810 SECOND AVENUE NORTH** **MOORHEAD, MN 56560**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on 06/15/2022. At the time of this survey, Moorhead Restorative Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/14/2022

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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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Moorhead Restorative Care Center was built in three stages. In 1963 the original 1-story building was constructed without a basement and was determined to be Type II (111) construction. In 1998 a 1-story addition was constructed to the northeast of the east wing of the original building and was determined to be Type V (111) construction. In 2009 a dayroom addition was constructed to the northeast corner of the original building and a dining room addition to the southeast of the original dining room was	K 000		

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K 000	Continued From page 2 constructed. These additions are Type II (000), 1-story without a basement. The building is fully sprinkler protected and has a fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 25 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.3.1, 14.4.5.3, and 14.6.2.4. This deficient finding could have a widespread impact on the residents within the facility.	K 345	1. No individual residents were identified 2. All residents who reside at MRHCC have the potential to be affected by this. Documentation showing the results of the fire alarm testing on 3-14-22 and the complete list of devices has been obtained from Allied Fire Protection on 6-15-22. Physical Plant Director (PPD) has been educated on obtaining	7/15/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 Findings include: On 06/15/2022, at 11:05 AM, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor that the facility could not provide annual fire alarm testing documentation that provided a complete listing of each individual device tested, to include device type, address, location and the test results for each individual device. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 345	documentation from testing once completed. 3. Auditing of records will be performed monthly x 11 months to ensure compliance. 4. Audits will be reviewed by administrator or designee and will be discussed at future QAPI meetings to review and recommend any changes necessary.	
K 901 SS=C	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within	K 901	1. No individual residents were identified 2. All residents who reside at MRHCC have the potential to be affected by this. The Utility Risk Assessment has been updated to reflect all of the electrical and gaseous patients/residents care	7/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/15/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD RESTORATIVE CARE CENTER	**2810 SECOND AVENUE NORTH** **MOORHEAD, MN 56560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 901	Continued From page 4 the facility. Findings include: On 06/15/2022, at 10:45 AM, during a review of available documentation and an interview with the Maintenance Supervisor, it was revealed that the facility provided a utility risk assessment document that did not contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	equipment and the associated risk categories. PPD (Physical Plant Director) was educated on 7-13-22 about what documentation is required in the utility risk assessment. 3. Audits will be performed monthly x 11 months to ensure compliance. 4. All audits will be submitted to the QAPI committee for review and to recommend any changes.	