*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
June 21, 2023

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

RE: CCN: 245052
Cycle Start Date: May 11, 2023

Dear Administrator:

On May 26, 2023, we notified you a remedy was imposed. On June 20, 2023 the Minnesota Department(s) 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 June 16, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 10, 2023 be discontinued as of June 16, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of May 26, 2023, 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 10, 2023. 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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308  Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

June 21, 2023

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

Re: Reinspection Results
Event ID: F9ZH12

Dear Administrator:

On June 20, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

PLEASE NOTE, LIFE SAFETY CODE (LSC) SURVEY RESULTS WE BE POSTED SEPERATELY AT A LATER DATE.

Electronically delivered
May 26, 2023

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

RE: CCN: 245052
Cycle Start Date: May 11, 2023

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 May 11, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. 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. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 10, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective June 10, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 10, 2023.

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.

This Department is also recommending that CMS impose:

- 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 10, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Moorhead Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 10, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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 an "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 Rd., Suite 300
Fergus Falls, Mn. 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 - Health Regulation Division 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 November 11, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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 electronic 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.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
May 26, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: F9ZH11

Dear Administrator:

The above facility was surveyed on May 8, 2023 through May 11, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

REVISED LETTER TO INCLUDE LIFE SAFETY CODE SURVEY. NO CHANGES TO REMEDIES PREVIOUSLY IMPOSED. DISREGARD LETTER RECEIVED ON 5/26/23.

Electronically delivered
May 26, 2023

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

RE: CCN: 245052
Cycle Start Date: May 11, 2023

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 May 11, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. 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. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 10, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 10, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 10, 2023.

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.

This Department is also recommending that CMS impose:

- 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 10, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Moorhead Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 10, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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 an "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 Rd., Suite 300
Fergus Falls, Mn. 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 - Health Regulation Division 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 November 11, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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 electronic 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

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

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.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 _____ B. WING _____ | C 05/11/2023 |

| 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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 5/8/23, to 5/11/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained. | E 000 | | |
| E 041 SS=C | Hospital CAH and LTC Emergency Power<br>CFR(s): 483.73(e)<br><br>§482.15(e) Condition for Participation:<br>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.<br><br>§483.73(e), §485.625(e), §485.542(e)<br>(e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.542(e)(1), | E 041 | | 6/13/23 |

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

Electronically Signed | 06/05/2023

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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| | 245052 | A. BUILDING _____ B. WING _____ | C 05/11/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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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 |
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| E 041 | Continued From page 1<br>§485.625(e)(1)<br>Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)<br>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):]<br>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the | E 041 | | |

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| E 041 | Continued From page 2<br>material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. | E 041 | | |

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| E 041 | Continued From page 3<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2, 8.4.2.3, and 8.4.9.5.1. This deficient finding had the potential to affect all 35 residents residing in the facility.<br><br>Findings include:<br><br>On 5/09/2023 at 11:15 a.m., a review of available documentation of the monthly generator testing log revealed there was missing information regarding a cool down and the load in which the generator was currently running at during the monthly test. In addition, the monthly documentation did not have the 30% of the nameplate rating documented.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery.<br><br>During an interview on 5/11/23, at 1:20 p.m. maintenance director (MD) indicated he was unsure if he had been testing and documenting the generators correctly. | E 041 | 1. Cool down, load, and 30% of rating have been added to the generator logs.<br>2. All generator testing logs have been updated as necessary.<br>3. Audit will be done to ensure all generator information is being documented according to code.<br>4. Maintenance Director or designee will audit compliance weekly x 4 weeks, monthly x 3 months and results will be brought to qapi<br>5. 6/13/23 | |
| F 000 | INITIAL COMMENTS<br><br>Moorhead Restorative Care Center is a Special Focus Facility (SFF). On 5/8/23, to 5/11/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, | F 000 | | |

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| F 000 | Continued From page 4<br>Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed:<br>H50522094C (MN00090790), with a deficiency issued at F684.<br>H50522098C (MN00092475), with a deficiency issued at F686.<br>H50522093C (MN00090271), with a deficiency issued at F812.<br>H50522097C (MN00091915), with a deficiency issued at F550.<br>H50522096C (MN00091913), with a deficiency issued at F550.<br><br>The following complaints were reviewed with no deficiency issued.<br>H50522095C (MN00091652),<br>H50522099C (MN00093043),<br>H50522100C (MN00093044),<br>H50522101C (MN00093045).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights. | F 550 | | 6/15/23 |

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| F 550 | Continued From page 5<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. | F 550 | | |

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| F 550 | Continued From page 6<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to promote dignity while providing cares for 1 of 1 resident (R136) who required catheterization. Further, the facility failed to promote dignity while utilizing a gait belt for an extended period of time, for 1 of 1 resident (R3) reviewed for extended use of a gait belt. In addition, the facility failed to ensure a resident was treated in a dignified manner for 1 of 4 residents (R3) reviewed for dignified dining. Further, the facility failed to promote dignity by initiating unnecessary transmission based precautions (TBP) for 1 of 1 residents (R186) who was restricted from leaving his room and using the facility common areas.<br><br>Findings include:<br><br>R136's Admission Record dated 5/10/23, identified R136 had diagnoses which included: age related physical disability, acute respiratory failure with hypoxia, and neuromuscular dysfunction of the bladder unspecified.<br><br>R136's care plan revised on 5/9/23, indicated R136 was cognitively intact and required limited staff assistance with activities of daily living (ADL's) and staff were to meet his needs. Identified R136 would use a disposable catheter for straight cath himself independently while laying on the floor.<br><br>R136's Nursing Aid Kardex dated 5/10/23, indicated R136 required limited staff assistance with ADL's and staff were to meet his needs. Identified R136 would use a disposable catheter for straight cath himself independently while | F 550 | 1. Orders were obtained for nursing to assist R136 with cath. Cathing was offered to R136 by nursing, R136 refused. Staff was educated that gait belt must be removed after ambulation unless specified otherwise on care plan. Education to staff was given on responding to requests in a timely manner.<br>2. The deficient practice has the potential to impact all residents that require assistance with ADL's. All resident's requiring ADL assistance have been reviewed to ensure proper assistance is provided.<br>3. ADL/Care education provided to all staff. Policy's reviewed to ensure continued compliance.<br>4. Social Services or designee will audit ADL/care weekly x 1 month, monthly x 3 months. Audit results will be presented at QAPI<br>5. 6/15/23 | |

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| F 550 | Continued From page 7<br>laying on the floor.<br><br>R136's Bowel and Bladder Program Screener dated 5/3/23, indicated R136 was alert/orientated, not aware of the need to toilet, never voided appropriately without incontinence and required staff assistance to bathroom/transfer to toilet/commode/urinal and adjust clothing and wipe.<br><br>R136's Order Summary Report dated 5/10/23, indicated R136 had an order to straight cath himself every four hours as needed for diagnosis of neurogenic bladder and nursing was to assist.<br><br>During observations on 5/10/23, at 7:24 a.m. R136's call light was on, office staff knocked on the door and R136 indicated he was ready to get up and get dressed. Office staff left the call light on and informed nursing assistant (NA)-C R136 wanted to get up.<br>- at 7:25 a.m. NA-A entered R136's room and he was seated on the edge of his bed. NA-C indicated she had to get something and immediately left the room. R136 indicated he had been at the facility for about five or six days and indicated he was not able to cath himself anywhere. R136 indicated he could not do it in the bathroom because it was too small and was not able to cath himself on his bed. R136 indicated he was pretty independent with most of his cares and had been able to empty his bladder.<br>- at 7:30 a.m. R136 continued to be seated on the edge of his bed already dressed, when NA-A re-entered his room. NA-A proceeded to wash her hands, donned gloves and assisted R136 to pick out his clothes for the day. NA-A asked R136 if he had washed up and R136 replied he had. NA-A | F 550 | | |

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| F 550 | Continued From page 8<br>assisted R136 to removed his shirt and to put on a clean one. NA-A asked R136 if he could lay down due to his shorts not being all the way up and he laid back on the bed and rolled side to side so she could pull his shorts up and applied suspenders to his shorts. During his time she had called for a nurse on her walkie to apply a new dressing to the back of his right leg.<br>- at 7:35 a.m. licensed practical nurse (LPN)-C entered R136 room, donned a pair of gloves, applied a dressing to the back of his right leg and immediately left the room. NA-A applied R136 braces to his legs and assisted R136 into his wheel chair and placed his feet on his foot peddles. NA-A told R136 she was going to have to change his shorts due to them being wet/soiled with urine. During this time, R136 asked NA-A if she could assist him with his cathing, NA-A told R136 she could not do that and called for LPN-C to assist R136 with cathing. R136 indicated he could not cath himself while he was in the bed and he got back into his bed and sat on the edge of the bed.<br>- at 7:44 a.m. NA-A called LPN-C again for assistance while she got a brief out of the drawer.<br>- at 7:45 LPN-C entered R136's room and indicated she had never catheterized R136 before and would have to ask another nurse to assist her. LPN-C left the room, while NA-A raised the bed to working level, asked R136 if he could lay down and he did. The entire front of R136's gray shorts were wet and soiled. NA-A removed R136's wet shorts, his wet underwear and removed his incontinent brief which was saturated with urine. NA-A placed a clean incontinent brief on R136 while he rolled side to side and indicated he did not know the last time he had catheterized himself. R136 indicated staff had come in early this morning and changed his | F 550 | | |

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| F 550 | Continued From page 9<br>brief when he was sleeping. NA-A assisted R136 to put clean underwear on and a pair of pants. NA-A asked R136 if his bladder felt full and he indicated he did not know. NA-A called for LPN-C again on the walkie talkie, lowered his bed and assisted R136 to put his shoes back on.<br>- at 7:53 a.m. NA-C entered R136's room asking NA-A if she needed help with a transfer and told NA-C R136 was waiting to get catheterized. NA-C and NA-A collected the garbage and the linen and NA-C left the room. R136 indicated he just wanted to get up.<br>- at 7:56 a.m. NA-A raised the head of the bed for R136, clipped his call light to his shirt and left the room to get LPN-C.<br>- at 7:57 a.m. R136 remained in bed and indicated he was to get catheterized every 3 to 4 hours. The quality nurse (QN) dropped off cathing supplies on the bed side table next to the door while she walked by. R136 had a very stern voice and stated he was very frustrated while he waited for staff to come and assist him.<br>- at 7:59 a.m. NA-A re-entered R136's room and informed him she was still looking for LPN-C. R136 stated he was upset as they were not coming to assist him.<br>- at 8:04 p.m. R136 continued to wait for the nurse to assist him with cathing, while the director of nursing (DON) walked by his room several times looking in his door.<br>- at 8:06 a.m. R136 continued to wait for staff assistance, when NA-A entered his room and informed R136 the DON said he catheterized himself. R136 stated back to NA-A "normally yes, but here I cannot in bed", and said, " lets get the show on the road."<br>- at 8:08 a.m. LPN-C entered R136's room, had him roll over to his belly and she applied a new dressing to the back of his right leg due to the | F 550 | | |

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| F 550 | Continued From page 10<br>other dressing falling off. R136 stated to the LPN-C in a very angry and frustrated voice "forget about the cathing" and LPN-C said, "they haven't come to do that yet." LPN-C stated "normally he catheterized himself and they brought the stuff for him (meaning cath supplies) on the table" and she immediately left the room. NA-A assisted R136 to his wheel chair and he asked for another shirt. NA-A assist R136 with putting on another shirt and he said in a frustrated voice, " forget it", while NA-A collected the linen.<br>- at 8:13 a.m. R136 wheeled himself out of his room via wheel chair propelling with his hands and into the dining room for breakfast.<br>- at 8:38 a.m. R136 was seated in his wheel chair in his room and indicated staff still had not come in to cath him and the cathing supplies remained on the bed side table by the door.<br>- at 8:53 a.m. R136 remained the same.<br>- at 9:02 a.m. R136 remained the same.<br>- at 9:08 a.m. R136 waited in the hallway in his wheelchair waiting for LPN-C to give him his medications. His catheter supplies remained on the bedside table by the door.<br>-at 9:12 a.m. LPN-C administered R136 his medications and he took them independently with water. LPN-C did not offer to assist R136 to cath as he continued to wait.<br>- at 9:21 a.m. R136 wheeled himself independently around the nursing home using his hands and his cath supplies remained on the table next to the door in his room.<br>- at 9:30 a.m. R136 was seated in his wheel chair in his room looking around. At 9:31 a.m. R136 indicated staff still had not assisted him with cathing and stated in a stern voice, "I don't know what happened to the supplies." R136 had a slight odor of urine noted.<br>- at 10:00 a.m. R136 remained the same and still | F 550 | | |

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| F 550 | Continued From page 11<br>had not been assisted with cathing.<br><br>During an interview on 5/10/23, at 9:25 a.m. NA-A confirmed staff assisted R136 with his ADL's and indicated R136 was incontinent of bowel and bladder. NA-A stated she had not seen R136 cath himself before and he had asked for assistance with it today. NA-A indicated R136 would refuse incontinent cares once in while, however staff were able to redirect him and he usually was compliant with the cares after that. NA-A stated nursing staff still had not assisted R136 with being catheterized.<br><br>During an interview on 5/10/23, at 12:02 p.m. LPN-C confirmed staff assisted R136 with ADL's and indicated he would normally cath himself. LPN-C indicated she was confused that morning since she had never assisted R136 with cathing and was not comfortable competing the task as she had never cathed R136 before. LPN-C said she had asked the QN to assist R136 and went back to passing her morning medications. LPN-C verified she had not assisted R136 that morning with cathing and neither did the QN. LPN-C indicated R136 had "kicked the DON out of his room" when she entered his room as he was upset he had asked for assistance and did not receive the help he requested. LPN-C stated it was not dignified for R136 to become incontinent in his brief while he waited for assistance from staff. LPN-C indicated the residents should be treated with dignity and verified R136 had not been assisted as he requested.<br><br>During an interview on 5/10/23, at 12:17 p.m. the QN confirmed the above findings and indicated R136 required staff assistance with some of his ADL's. The QN confirmed she had not assisted | F 550 | | |

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| F 550 | Continued From page 12<br>R136 to cath as she was not aware he required assistance. The QN indicated she had entered R136's room when he was in the dining room and she left the catheter supplies on his bedside table. The QN stated her expectation was for staff to assist R136 when he asked for assistance. The QN indicated staff disregarded R136 and it was not respectful or dignified for staff not so assist him as he had requested.<br><br>During an interview on 5/11/23, at 9:10 a.m. R136 indicated yesterday when he asked for help with cathing he was becoming angry and upset. R136 indicated he becomes very impatient when he has to wait a long time for assistance and verified a nurse finally came in, talked with him and assisted him however was not sure what time that was.<br><br>R3's quarterly Minimum Data Set (MDS) dated 4/13/23, identified R3 had diagnoses which included cancer, blindness, and difficulty walking. R3 was cognitively intact and required extensive assistance with activities of daily living, which included bed mobility, ambulating, and toileting. R3 was able to make himself understood and was able to understand others.<br><br>R3's care plan revised 4/12/23, identified R3 had impaired vision, required assist of one with transfers, ambulation. R3's care plan did not identify R3 required the use of a gait belt.<br><br>During an observation on 5/8/23, at 4:52 p.m. R3 was seated at a table alone in the dining room in an armed chair, he wore a pair of bleach stained sweat pants, a gait belt was around his waist and his walker was positioned to his left side. At that time, nursing assistant (NA)-B approached R3, | F 550 | | |

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| F 550 | Continued From page 13<br>asked him what he wanted to eat and took his order.<br><br>- at 4:59 p.m. R3 remained seated on a chair in the dining room, he was served a plate of food, he had a large cup of pink liquid and had taken a large drink from the cup. R3 reached to his plate with his bare hands, took a piece of dinner roll and ate a bite. R3 had a frown on his face, he sat in the chair, did not continue to eat and remained wearing a gait belt around his waist.<br><br>-at 5:14 p.m. R3 remained seated on a chair in the dining room, he continued to wear a gait belt around his waist, his head was tilted downwards in a chin to chest position. R3 was approached by licensed practical nurse (LPN)-B, she leaned down, asked him if he was going to eat, R3 replied he was not hungry and was done eating. LPN-B was observed not to respond to R3, and she walked away.<br><br>- at 5:20 p.m. R3 remained seated alone at a table in the dining room, at that time, NA-I approached him told him he needed to eat, removed his gait belt, draped it across the walker positioned to R3's left, walked behind R3 and pushed his chair towards the table. R3 was observed to tell NA-I he wasn't hungry, she stood to his right side, donned a clothing protector around his neck, took his spoon, placed it into his food, and attempted to feed R3. He stated he was not hungry, wanted to go back to his room, he continued to speak to NA-I as she walked away. R3 frowned, his head bent forwards and he remained seated at the table alone.<br><br>-at 6:00 p.m. R3 had remained seated in the dining room, at that time, NA-I approached him, | F 550 | | |

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| F 550 | Continued From page 14<br>asked if he was ready to go back to his room, which he accepted, donned the gait belt around R3's waist and walked with him back to his room. R3 sat on the side of his bed as NA-I placed his call light within his reach and left his room.<br><br>R3 was observed seated in the dining room forty-six minutes after he had verbalized not being hungry, and had requested to go back to his room.<br><br>During an interview on 5/9/23, at 9:51 a.m. R3 stated he typically had to wait to be assisted out of the dining room when he was done with his meals. R3 stated he was not able to walk without staff assistance as he was blind, indicated he was usually one of the first ones in the dining room and usually the last one out. R3 stated he felt he had no control over what the facility staff did with him and did not complain as some of the staff were not always nice. R3 frowned, his forehead was furrowed, he placed his head in his hands, shook his head and indicated he no longer wished to talk about the facility.<br><br>R3 declined subsequent attempt at a follow up interview.<br><br>During an interview on 5/10/23, at 11:14 a.m. NA-C stated R3 required extensive assistance with bed mobility, walking with a gait belt and walker, limited assistance with transfers and typically used his wheelchair for most of his locomotion. NA-C indicated R3 was blind, felt he did not really verbalize his needs or wishes and was typically withdrawn. She indicated R3 was assisted to/from meals by staff, typically was one of the first residents to the dining room and one of the last ones to leave the dining room. NA-C | F 550 | | |

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| F 550 | Continued From page 15<br>indicated she felt R3 did not complain or voice his needs and felt it did bother him to stay in the dining room for a long period of time.<br><br>During an interview on 5/10/23, at 12:18 p.m. NA-A stated R3 required extensive assistance with bed mobility, ambulation with front wheeled walker, gait belt and was able to verbalize his needs and wishes. She indicated R3 was blind and did have times when he had difficulty navigating his environment while he used his wheelchair. NA-A stated she worried about R3 when she was not working as she felt he was overlooked by some of the staff. NA-A indicated she felt R3 would not say if something was bothering him, and he was often one of the first residents in the dining room and the last one out. She indicated R3 ate well for breakfast, lunch and did not typically eat much for dinner. NA-A indicated R3 had once mentioned sitting for a long time in the dining room, though could not recall how long ago.<br><br>During an interview on 5/10/23, at 12:24 p.m. trained medication aid (TMA)-A indicated R3 required assistance with his cares and was assisted to/from meals by staff. She indicated R3 did not verbalize his needs typically and would need to be asked what he wanted. TMA-A indicated R3 was usually one of the first ones in the dining room for meals, one of the last ones out, and felt it was due to R3 not verbalizing his needs or wishes.<br><br>During an interview on 5/10/23, at 2:45 p.m. NA-B stated R3 required assistance with ambulation to/from meals with a walker and gait belt. NA-B indicated R3's gait belt should have been removed when he was in the dining room during | F 550 | | |

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| F 550 | Continued From page 16<br>his meals, though at times it was left on. She indicated R3 was often one of the first residents to the dining room and one of the last ones out, oftentimes waiting long past his meal was done, as he was an "easy" resident. NA-B indicated she was not aware if it bothered R3 if his gait belt was left on or that he was left in the dining following his meals. She stated she did not feel R3 advocated for himself and would not verbalize his wishes or needs.<br><br>R3's quarterly Minimum Data Set (MDS) dated 4/13/23, identified R3 had diagnoses which included cancer, blindness, and difficulty walking. R3 was cognitively intact and required extensive assistance with activities of daily living, which included bed mobility, ambulating, and toileting. R3 was able to make himself understood and was able to understand others.<br><br>R3's care plan revised 4/12/23, identified R3 had impaired vision, required assist of one with transfers, ambulation. R3's care plan did not identify R3 required the use of a gait belt.<br><br>During an observation on 5/8/23, at 4:52 p.m. R3 was seated at a table alone in the dining room in an armed chair, he wore a pair of bleach stained sweat pants, a gait belt was around his waist and his walker was positioned to his left side. At that time, nursing assistant (NA)-B approached R3, asked him what he wanted to eat and took his order.<br><br>- at 4:59 p.m. R3 remained seated on a chair in the dining room, he was served a plate of food, he had a large cup of pink liquid and had taken a large drink from the cup. R3 reached to his plate | F 550 | | |

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| F 550 | Continued From page 17 | F 550 | | |

with his bare hands, took a piece of dinner roll and ate a bite. R3 had a frown on his face, he sat in the chair, did not continue to eat and remained wearing a gait belt around his waist.

-at 5:14 p.m. R3 remained seated on a chair in the dining room, he continued to wear a gait belt around his waist, his head was tilted downwards in a chin to chest position. R3 was approached by licensed practical nurse (LPN)-B, she leaned down, asked him if he was going to eat, R3 replied he was not hungry and was done eating. LPN-B was observed not to respond to R3, and she walked away.

- at 5:20 p.m. R3 remained seated alone at a table in the dining room, at that time, NA-I approached him told him he needed to eat, removed his gait belt, draped it across the walker positioned to R3's left, walked behind R3 and pushed his chair towards the table. R3 was observed to tell NA-I he wasn't hungry, she stood to his right side, donned a clothing protector around his neck, took his spoon, placed it into his food, and attempted to feed R3. He stated he was not hungry, wanted to go back to his room, he continued to speak to NA-I as she walked away. R3 frowned, his head bent forwards and he remained seated at the table alone.

-at 6:00 p.m. R3 had remained seated in the dining room, at that time, NA-I approached him, asked if he was ready to go back to his room, which he accepted, donned the gait belt around R3's waist and walked with him back to his room. R3 sat on the side of his bed as NA-I placed his call light within his reach and left his room.

R3 was observed seated in the dining room

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| F 550 | Continued From page 18<br>forty-six minutes after he had verbalized not being hungry, and had requested to go back to his room.<br><br>During an interview on 5/9/23, at 9:51 a.m. R3 stated he typically had to wait to be assisted out of the dining room when he was done with his meals. R3 stated he was not able to walk without staff assistance as he was blind, indicated he was usually one of the first ones in the dining room and usually the last one out. R3 stated he felt he had no control over what the facility staff did with him and did not complain as some of the staff were not always nice. R3 frowned, his forehead was furrowed, he placed his head in his hands, shook his head and indicated he no longer wished to talk about the facility.<br><br>R3 declined subsequent attempt at a follow up interview.<br><br>During an interview on 5/10/23, at 11:14 a.m. NA-C stated R3 required extensive assistance with bed mobility, walking with a gait belt and walker, limited assistance with transfers and typically used his wheelchair for most of his locomotion. NA-C indicated R3 was blind, felt he did not really verbalize his needs or wishes and was typically withdrawn. She indicated R3 was assisted to/from meals by staff, typically was one of the first residents to the dining room and one of the last ones to leave the dining room. NA-C indicated she felt R3 did not complain or voice his needs and felt it did bother him to stay in the dining room for a long period of time.<br><br>During an interview on 5/10/23, at 12:18 p.m. NA-A stated R3 required extensive assistance with bed mobility, ambulation with front wheeled | F 550 | | |

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| F 550 | Continued From page 19<br>walker, gait belt and was able to verbalize his needs and wishes. She indicated R3 was blind and did have times when he had difficulty navigating his environment while he used his wheelchair. NA-A stated she worried about R3 when she was not working as she felt he was overlooked by some of the staff. NA-A indicated she felt R3 would not say if something was bothering him, and he was often one of the first residents in the dining room and the last one out. She indicated R3 ate well for breakfast, lunch and did not typically eat much for dinner. NA-A indicated R3 had once mentioned sitting for a long time in the dining room, though could not recall how long ago.<br><br>During an interview on 5/10/23, at 12:24 p.m. trained medication aid (TMA)-A indicated R3 required assistance with his cares and was assisted to/from meals by staff. She indicated R3 did not verbalize his needs typically and would need to be asked what he wanted. TMA-A indicated R3 was usually one of the first ones in the dining room for meals, one of the last ones out, and felt it was due to R3 not verbalizing his needs or wishes.<br><br>During an interview on 5/10/23, at 2:45 p.m. NA-B stated R3 required assistance with ambulation to/from meals with a walker and gait belt. NA-B indicated R3's gait belt should have been removed when he was in the dining room during his meals, though at times it was left on. She indicated R3 was often one of the first residents to the dining room and one of the last ones out, oftentimes waiting long past his meal was done, as he was an "easy" resident. NA-B indicated she was not aware if it bothered R3 if his gait belt was left on or that he was left in the dining following | F 550 | | |

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| F 550 | Continued From page 20<br>his meals. She stated she did not feel R3 advocated for himself and would not verbalize his wishes or needs.<br><br>R186's medical record identified R186 was admitted to the facility on 5/1/23, and had diagnoses which included unspecified dementia, nicotine dependence, bipolar disorder, major depressive disorder, and claustrophobia.<br><br>R186's care plan dated 5/8/23, identified R186 had potential for ineffective coping related to reported history of traumatic events, with interventions that included encourage resident to resume normal activities and begin new ones, and provide a safe therapeutic environment where R186 could regain control as needed. Indicated R186 required extensive assistance of one staff for dressing, toilet use and transfers. Identified R186 had potential for ineffective coping related to history of traumatic events with interventions to encourage R186 to resume normal activities and begin new ones and provide a safe therapeutic environment where he could regain control as needed. Instructed staff to ask to attend activities of his choice.<br><br>R186's Order Summary Report dated 5/15/23, identified the following order:<br><br>-COVID Isolation times 10 days due to unvaccinated status, every shift for 10 Days. Start | F 550 | | |

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| F 550 | Continued From page 21<br>date 5/1/23, end date 5/11/23.<br><br>On 5/8/23, at 12:26 p.m. R186's door was closed, with two signs on his door; one identified droplet precautions, and the other instructed to report to the nurse before entering the room. There was a plastic two drawer bin next to his door labeled isolation, with personal protective equipment (PPE) inside the drawers.<br><br>On 5/9/23, at 9:20 a.m. R186's door was closed, and the signage and plastic drawer bin with PPE remained outside his door.<br><br>During an interview on 5/10/23, at 12:44 p.m. registered nurse infection preventionist (IP)-A stated TBP were initiated on residents newly admitted to the facility based on their vaccination status. IP-A indicated she was not aware of the current CDC guidelines for new admissions to the facility or what the facility policy instructed. IP-A and surveyor reviewed the facility policy titled Coronavirus Disease (COVID-19)-Testing residents, revised 9/22. IP-A verified the policy identified empiric use of TBP was generally not implemented for admissions or for residents who left the facility for less than 24 hours, and did not meet criteria for empiric TBP. IP-A stated the facility currently had three residents on TBP only due to their vaccination status and newly admitted.<br><br>On 5/10/23, at 12:58 p.m. IP-A entered R186's room and informed him he could be out of isolation now. R186 stated "thank God!" After IP-A left the room, R186 stated he had felt like he ,"was in prison", and stated he had a history of being in prison and jail and it brought back old feelings to him. R186 indicated he had post | F 550 | | |

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| F 550 | Continued From page 22<br>traumatic stress disorder. R186 stated when he was on TBP it made him feel like he could not breath, depressed, sad, and he felt like he had to fight to get out of there. R186 indicated he liked to socialize, so he would feel better now when he was able to leave his room.<br><br>During an interview on 5/10/23, at 12:32 p.m. the DON confirmed the above findings and indicated R136 was able to complete several tasks himself however still required some assistance from staff. The DON indicated she thought R136 was able to lay on the floor and self cath himself. The DON stated she was not impressed by what happened that morning and indicated her expectations would be for staff to assist F136 with cares as requested. The DON stated R136 had not been treated with respect or dignity that morning and would expect staff to follow the facility policy.<br><br>During an interview on 5/11/23, at 9:45 a.m. the DON confirmed R3 was blind, did not typically voice his needs or wishes, required assistance with ambulation, and locomotion in/out of the dining room. She indicated she would have expected staff to remove his gait belt once he was seated in the dining room. The DON indicated she expected staff to listen to R3 when he was speaking, and to inform R3 when the staff member walked away due to his inability to see. She indicated she would have expected staff to offer to bring R3 back to his room when he was done eating, or if they were unable due to helping other residents, she would have expected staff to let R3 know they would help him back to his room when they were able.<br><br>During an interview on 5/11/23, at 11:48 a.m. DON confirmed she was not aware of the CDC | F 550 | | |

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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 |
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| F 550 | Continued From page 23<br>recommendations or the facility policy related to new admissions during COVID-19. After review, DON confirmed the facility did not follow CDC recommendations or the facility policy. DON stated it was important to not place a resident in TBP when it was not required, as the isolation could cause depression.<br><br>Review of facility policy titled, Quality of Life-Dignity undated, indicated each resident would have been cared for in a manner that promoted and enhanced quality of life, dignity, respect and individuality.<br><br>Review of a facility policy titled, Dignity of the Resident, reviewed 4/12/18, identified all residents would be treated in a manner and in an environment that maintained and enhanced residents dignity and respect in full recognition of his or her own individuality. The purpose of the policy identified treating residents with dignity and respect maintained and enhanced each residents self-worth and improved his/her psychosocial well-being and quality of life. Assuring resident is comfortable in the facility and treated like a person. The policy identified the following types of staff interactions with residents which maintained their dignity; promoting independence and dignity in dining, assisting residents with daily cares in a dignified manner, and focusing on a resident when they are speaking.<br><br>The Centers for Disease Control and Prevention (CDC) Interim Infection Control And Prevention Recommendations For Healthcare Personal During The Coronavirus Disease 2019 (COVID-19) Pandemic dated 9/23/22, identified empiric use of (TBP) was generally not implemented for admissions or for residents who | F 550 | | |

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| F 550 | Continued From page 24<br>left the facility for less than 24 hours, and did not meet the criteria for empiric TBP.<br><br>The facility policy titled Coronavirus Disease (COVID-19)-Testing Residents, dated 9/22, identified empiric use of transmission-based precautions was generally not implemented for admissions or for residents who left the facility for less than 24 hours and did not meet criteria for empiric TBP.<br><br>The facility policy titled Infection Control Policy and Procedure Manual dated 10/21/22, identified TBP should have the least restrictive possible for the resident based on his/her clinical assessment and used for the least amount of time, and once the resident was no longer at risk for transmitting the pathogen, removing TBP was required to avoid unnecessary involuntary seclusion. The policy identified boredom, anger, withdrawal and depression were just some of the mood changes that could occur. | F 550 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for | F 565 | | 6/16/23 |

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| F 565 | Continued From page 25<br>providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to act promptly and respond timely on concerns brought up in the resident council for 4 of 4 residents (R13, R23, R17 and R12) who had attended resident council meetings in the facility.<br><br>Findings include:<br><br>On 5/9/23, at 1:57 p.m. a resident council meeting was held with surveyors and four residents which included R13 who regularly attended meetings, R23 who had attended a few meetings, R17 who regularly attended , and R12 who was the resident council president. During the resident council meeting, residents expressed | F 565 | 1. Food preferences will be discussed with R12, R23, R13, R17 to ensure satisfaction. The prior month resident council minutes added to the form.<br>2. All resident's with concerns have the possibility of being affected. All residents with concerns interviewed to ensure they will be addressed promptly.<br>3. Resident council form will be updated to include prior month's concerns. All concerns will be followed up on after resident council to ensure satisfactory resolution.<br>4. Activity director or designee will will conduct an audit of resident concerns weekly x 4 weeks, monthly x 3 months. | |

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| F 565 | Continued From page 26<br>concerns with the facility when an item was brought to the staff's attention, there was not always a response provided as to why something could not be fixed, or changes made. Residents verbalized concerns with several areas of food service. The residents provided examples of food being cold when served, not being offered choices when they ate in their rooms, food not covered, staff touching their food/beverage tops, a lot of processed foods and poor taste. The residents indicated the facility had hired a new dietary manager and had hoped there would be changes noted in the future. R23, R13 and R17 indicated they ate in their rooms due to medical conditions and felt they should have been served the same food at the same temperature as the residents who ate in the dining room.<br><br>Review of resident council meeting minutes from January 2023, to April 2023, revealed the following;<br><br>- January 17, 2023, the form revealed eight residents attended the meeting, which included R12. The form identified the following food issues; food was always cold, residents asked for further variety such as pasta, ethnic foods such as Spanish beans/rice, soft shell tacos, waffles and eggs prepared in ways other than scrambled.<br><br>- March 1, 2023, the form revealed eight residents attended the meeting, with the activity director, dietary manager and activity aid present. The form revealed the DM reported changes in food service would be coming in the future and the residents voiced their suggestions on food items such as fresh fruit, ice cream, polish sausage and brats. The form did not review any specific concerns that were brought up in the | F 565 | Results will be presented at QAPI.<br>5. 6/16/2023 | |

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| F 565 | Continued From page 27<br>prior meeting.<br><br>- March 21, 2023, the form revealed nine residents attended the meeting, with the activity director and the director of nursing present. The form revealed the following dietary concerns; not enough variety, getting the same foods repeatedly, specifically scrambled eggs, requests for ice cream, lighter lunches of soup, sandwiches and requested more butter be served with meals. The form revealed the DON had indicated the facility was working on menu rotation and having two options for meals. The form did not review any specific concerns that were brought up in the prior meeting.<br><br>- April 18, 2023, the form revealed 14 residents attended the meeting, with the activity director, quality nurse, occupational therapist and the dietary manager present. The form revealed the following dietary concerns; staff did not know how to cook, too much processed foods, residents requested more choices, snacks to be offered between meals, and food not being hot when it was delivered to resident rooms. The form revealed the dietary manager had indicated he would be making changes in the future and suggested residents come to the dining room "if they wanted a hot meal." The form did not review any specific concerns that were brought up in the prior meeting.<br><br>During an interview with the social service designee (SSD) she indicated she had no involvement with resident council and would follow up on resident concerns that were directed to her.<br><br>During an interview with the activity director on | F 565 | | |

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| F 565 | Continued From page 28<br>5/11/23, at 10:03 a.m. she identified she arranged the facility's resident council meetings monthly and would attend with the residents. She indicated the residents had several concerns regarding dietary/food services at the facility and the concerns had been presented to the dietary manager. The director stated she would often bring in a representative of various disciplines to discuss concerns voiced by the residents. She indicated she had the DON, quality nurse and dietary manager attend the meeting to discuss resident concerns directly with the residents. She indicated any follow up would have been the responsibility of the discipline, such as food concerns would be addressed and any concerns followed up on by the dietary manager. She indicated at that time, the residents continued to have concerns with several areas of food services such as food being served cold (out of temperature) no variety, choices not offered, no fresh fruits and no seasonal foods.<br><br>Review of a facility policy titled Resident Council, revised February 2021, identified a resident council response form would be used for any concerns brought up in resident council, and would be addressed by the department responsible for the concern. The policy identified resident council concerns would be addressed with the facility quality assurance, performance improvement committee. | F 565 | | |
| F 572<br>SS=C | Notice of Rights and Rules<br>CFR(s): 483.10(g)(1)(16)<br><br>§483.10(g) Information and Communication.<br>§483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and | F 572 | | 6/15/23 |

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| F 572 | Continued From page 29<br>responsibilities during his or her stay in the facility.<br><br>§483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.<br>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.<br>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.<br>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the resident bill of rights (BOR) were provided verbally for residents of the facility. This deficient practice had the potential to affect all 35 residents residing in the facility.<br><br>Findings include;<br><br>On 5/9/23, at 1:57 p.m. four residents were present at a resident council meeting held by surveyors. When questioned if the residents' (BOR) had been reviewed, all four residents present stated they were not aware of their BOR, and were not aware of where to find them in the facility.<br><br>During an interview on 5/11/23, at 10:03 a.m. the activity director confirmed the residents' BOR had not been reviewed with the residents during resident council meetings. She indicated a copy | F 572 | 1. Resident bill of rights have been reviewed with these 4 patients.<br>2. Resident bill of rights have been reviewed with all patients<br>3. Resident bill of rights will be reviewed with all patients verbally during their stay.<br>4. Activity director or designee will audit compliance with verbally informing patient's of their bill of rights weekly x 4 weeks, monthly x 3 months. Results from this audit will be reviewed at QAPI<br>5. 6/15/2023 | |

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| F 572 | Continued From page 30<br>of the residents' BOR were provided to them upon admission with their admission packet, however she was unaware if they had been verbally reviewed with the residents or their representative. The activity director indicated the BOR were posted in the activity room however were hidden behind several items.<br><br>Review of monthly resident council meeting minutes from January 2023, to April 2023, lacked any evidence the residents' BOR had been reviewed with residents.<br><br>Review of an undated facility policy titled, Resident Rights, identified federal and state laws guaranteed certain basic rights to all residents of the facility, and included the right to be informed about what rights and responsibilities she/he had. | F 572 | | |
| F 577 SS=C | Right to Survey Results/Advocate Agency Info<br>CFR(s): 483.10(g)(10)(11)<br><br>§483.10(g)(10) The resident has the right to-<br>(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<br>(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.<br><br>§483.10(g)(11) The facility must--<br>(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.<br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding | F 577 | | 6/16/23 |

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| F 577 | Continued From page 31<br>years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure residents (R13, R23, R17 and R12) who routinely attended resident council, were made aware of the state agency (SA) survey results. This deficient practice had the potential to affect all 35 residents who resided in the facility.<br><br>Findings include:<br><br>On 5/9/23, at 1:57 p.m. a resident council group interview was held with R13, R23, R17, and R12, who routinely attended the facility resident council monthly meetings. R13, R23, R17, and R12 stated they were not aware of what the SA survey results were or where the information was posted in the facility.<br><br>During an interview on 5/11/23, at 10:03 a.m. the activity director indicated she had not informed the residents of where the SA results were and indicated she was unaware the residents were required to be notified and have access to them. She indicated she facilitated the resident council meetings, however was not aware of any requirements of the meetings.<br><br>Review of an undated facility policy titled, Resident Rights, identified federal and state laws | F 577 | 1. R13, R17, R12, R23 were made aware of where the recent survey results are kept.<br>2. Resident's will be made aware of where survey results can be located.<br>3. Notice of availability of survey results will be posted in the facility.<br>4. DON or designee will audit the availability of survey results to ensure they are accessible weekly x 4 weeks, monthly x 3 months and the results will be presented at qapi.<br>5. 6/16/23 | |

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| F 577 | Continued From page 32<br>guarantee certain basic rights to all residents of the facility. | F 577 | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature | F 584 | | 6/16/23 |

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| F 584 | Continued From page 33<br>levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure housekeeping services and a clean environment were provided for 2 of 2 residents (R13) who had soiled wheelchair cushions without a cover and (R 29) whose bathroom toilet seat was visibly soiled.<br><br>Findings include:<br><br>R13's quarterly Minimum Data Set (MDS) dated 4/25/23, identified R13 was cognitively intact and had diagnosis which included: hypertension (elevated blood pressure) (HTN), anxiety disorder and depression. Identified R13 required supervision with activities of daily living (ADL's) which included bed mobility, transfers, and toileting.<br><br>R13's care plan revised 9/29/22, identified R13 had ADL deficits and required extensive assistance with cares and transfers. R13's interventions identified staff assistance in all areas of ADL's with set up assistance for eating.<br><br>R29's admission MDS dated 4/25/23, identified R29 had moderate cognitive impairment and had diagnosis which included: cancer, HTN, and hyperlipidemia (elevated cholesterol). R29 required supervision with ADL's which included bed mobility, transfers, and toileting. | F 584 | 1. R13's wheelchair was cleaned, and R29's toilet was cleaned.<br>2. A full house inspection was completed to ensure cleanliness.<br>3. Ambassador rounds will be completed weekly to ensure cleanliness is upheld within all resident rooms.<br>4. Director of Housekeeping or designee will audit weekly x 4 weeks, Monthly x 3 months and results will be brought to qapi.<br>5. 6/16/23 | |

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| F 584 | Continued From page 34 | F 584 | | |

R29's care plan revised 4/20/23, identified R29 had ADL deficits and required limited assistance in all areas of ADL's with the exception of R29 being independent with eating.

On 5/8/23, at 4:11 p.m. R13 was lying in bed and his wheelchair was positioned next to his bed and had two cushions which were both visibly soiled with large white and brown stains and neither cushion had a cover on it. R13 stated he would prefer the cushions had covers on them so they were easier to wash.

On 5/8/23, at 1:42 R29's toilet seat in her bathroom was noted to have a thick, brown substance on the back and right side of the seat.

During an interview on 5/8/23, at 8:41 p.m. family member (FM)-A stated R29 would not have appreciated sitting on a dirty toilet seat.

On 5/9/23, at 9:29 a.m. R29's toilet seat continued to have a thick, brown substance on the back and right side of the seat.

On 5/10/23, at 7:16 a.m. R29's toilet seat continued to have a thick, brown substance on the back and the right side of the seat.

On 5/10/23, at 8:01 housekeeper (H)-A confirmed there was a brown, thick substance on R29's toilet seat. H-A indicated all bathrooms were supposed to be cleaned on a daily basis and when visibly soiled. H-A verified it had been a few days since R29's bathroom had been cleaned.

During an interview on 5/10/23, therapy director (TD) stated she was responsible for resident's wheelchair cushions. TD verified R13's cushions

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

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| F 584 | Continued From page 35<br>in his wheelchair were visibly soiled and did not have a cover on them. TD stated she was unsure why R13's cushions in his wheelchair were not covered. TD stated her expectation would have been all wheelchair cushions would have been covered so they were able to be cleaned.<br><br>During an interview on 5/11/23, at 11:01 a.m. director of nursing (DON) stated her expectation would have been all toilet seats were cleaned when visibly soiled and all wheelchair cushions would have had covers on them so they were easy to clean.<br><br>A facility policy titled Cleaning and Disinfection of Environmental Surfaces revised 10/17, identified environmental surfaces would have been cleaned on a regular basis e.g., daily, three times per week, or when visibly soiled. | F 584 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.<br>The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders. | F 655 | | 6/16/23 |

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| F 655 | Continued From page 36<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide a summary of the baseline care plan to the resident or resident representative for 1 of 1 residents (R136) recently admitted who was reviewed for admission.<br><br>Findings include:<br><br>R136's Admission Record dated 5/10/23, identified R136 was admitted to the facility on 5/3/23, and had diagnoses which included: age | F 655 | 1. Social worker educated that baseline care plan is to be completed within 48 hours of admission.<br>2. All residents have the ability to be affected by this practice. All resident baseline care plans reviewed to ensure completion within 48 hours of admission.<br>3. 48 hour baseline care plan will be included on admission checklist for all departments.<br>4. DON or Designee will audit Resident | |

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| F 655 | Continued From page 37<br>related physical disability, acute respiratory failure with hypoxia, and neuromuscular dysfunction of the bladder unspecified.<br><br>Review of R136's baseline care plan, indicated R136 signed and dated the care plan on 5/8/23. In addition, the form lacked any documentation R136 or R136's representative had received a copy of the care plan. R136 had not received a copy of his baseline care plan within 48 hours.<br><br>Review of R136's progress notes from 5/3/23, to 5/10/23, revealed the following:<br>- 5/3/23, R136 admitted from the hospital related to shunt revision. R136 was alert, oriented, able to verbalize his needs and required straight cathing every four hours related to neurogenic bladder. R136 was in the facility for physical and occupation therapy and planned to return home.<br><br>R136's progress notes lacked any documentation R136 had received a copy of his base line care plan and reviewed it with staff.<br><br>During an interview via telephone on 5/10/23, at 1:06 p.m. the director of social services (DSS) indicated she believed the initial baseline care plan was to be completed with in 72 hours of admission. The DSS stated once the care plan had been completed by nursing staff and herself, a copy was to be printed out and provided to the resident for to sign.<br><br>During a follow up interview via telephone on 5/11/23, at 10:29 a.m. the DSS confirmed the above findings and indicated she thought she had 72 hours to compete the initial care plan.<br><br>During an interview on 5/11/23, at 9:06 a.m. the | F 655 | chart's to ensure baseline care plan is complete weekly x 4 weeks, monthly x 3 months and results presented at QAPI.<br>5. 6/16/23<br>6. Additional was emailed to MDH | |

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| F 655 | Continued From page 38<br>director of nursing (DON) confirmed the above findings and indicated she would expect staff to complete the baseline care plan within 48 hours, review it with the resident or resident representative and provide them with a copy. The DON stated she would expect staff to follow the facility policy as well.<br><br>Review of facility policy titled, Care Plans-Comprehensive reviewed on 6/2022, indicated all new admits would have a baseline care plan in the admission pack and would be started by staff upon admission. The care plan would be completed and reviewed within 48 hours and a copy provided to the resident and power of attorney for review and the original care plan would be placed in the chart. | F 655 | | |
| F 660 SS=D | Discharge Planning Process<br>CFR(s): 483.21(c)(1)(i)-(ix)<br><br>§483.21(c)(1) Discharge Planning Process<br>The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-<br>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.<br>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. | F 660 | | 6/16/23 |

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| F 660 | Continued From page 39<br>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.<br>(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.<br>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.<br>(vi) Address the resident's goals of care and treatment preferences.<br>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.<br>(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.<br>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.<br>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.<br>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that | F 660 | | |

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| F 660 | Continued From page 40<br>the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.<br>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure appropriate discharge planning was developed and implemented for 1 of 1 resident (R32) who was discharged to home.<br><br>Findings include:<br><br>R32's admission Minimum Data Set (MDS) dated 2/8/23, indicated R32 had diagnoses which included hypertension, pneumonia, other inter-vertebral disc displacement of the lumbo-sacral region and was cognitively intact.<br><br>R32's discharge MDS dated 3/3/23, indicated R32 was discharged to the community on 3/3/23.<br><br>Review of R32's care plan revised on 2/8/23, indicated R32's discharge plans were to go home to his apartment when ready.<br><br>Review of R32's Order Details dated 3/2/23, indicated R32 was to discharge home with home | F 660 | 1. Provider was educated on medication ordering at discharge.<br>2. All residents can be affected by this practice. Discharge checklist including recap of stay as well as discharge summary to be completed by all departments.<br>3. Checklist implemented. Discharge assessment to be completed by all depts.<br>4. Nurse manager or designee will audit discharges weekly x 4 weeks, monthly x 3 months and will present audits at QAPI<br>5. 6/16/23<br>6. Additional info was submitted to MDH | |

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| F 660 | Continued From page 41<br>care for nursing, physical/occupational therapy to increase mobility and strength, follow up with primary care provider in two to three weeks and medication refill for 30 days.<br><br>Review of R32's Progress Notes from 2/2/23, to 3/9/23, revealed the following:<br>- on 2/2/23, R32 was admitted to the nursing home with lower extremity pain with herniated nucleus at L5 and L4. Recommendations included Celebrex twice a day for pain and physical and occupational therapy, ice packs and Lidocaine.<br><br>- on 2/7/23, R32 had arrived from hospital, had been living by himself in his apartment and the plans were to return to his apartment. R32 was cognitively intact, had no behaviors and had mild depression.<br><br>-on 2/26/23, R32 required staff assistance with transfers, bathing, used a wheel chair independently within facility and would let staff know if he needed assistance. R32 would be discharged home soon with assistance from his family.<br><br>-on 3/3/23, R32 would be discharged to his parents home where they would assist him, R32 was cognitively intact and had minimal symptoms of depression.<br><br>-on 3/9/23, R32 called the nursing home today and indicated he did not receive three of his medications from the pharmacy. A script for Hydrocodone 5/325 milligrams (mg) one tablet every six hours as needed for pain- 30 day supply, Gabapentin 100 mg twice a day- 30 day supply and Cyclobenzaprine 10 mg every eight | F 660 | | |

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| F 660 | Continued From page 42<br>hours was sent to the pharmacy for R32 to pick up.<br><br>R32's medical record lacked documentation regarding follow up services for home care, therapy and medications upon discharge to ensure continuity of care.<br><br>During a telephone interview on 5/10/23, at 1:01 p.m. the director of social services (DSS) indicated R32's discharge had been planned and he had been discharged to his parent's place. The DSS stated she was responsible for assessing the resident's cognition and depression score upon discharge. The DSS indicated the nurse manager NM-A was responsible for obtaining the discharge orders from the provider and to ensure services were in place. In addition, the NM-A completed the recapitulation of the resident's stay in the medical record. The DSS indicated the nurse practioner (NP)-A would normally send the medication orders to the pharmacy. The DSS stated she was not aware R32 had not received his prescriptions from the pharmacy and indicated he should have.<br><br>During an interview on 5/10/23, at 1:37 p.m. the NM-A indicated when a resident was to be discharged, the social worker would usually ask for an order from the provider and nurses would be responsible for completing a recapitulation of the stay which included: discharge destination, medications and services/referrals needed. NM-A confirmed the above findings and indicated the facility did not have a process in place for when residents were discharged. The NM-A indicated she would expect staff to ensure all necessary tasks were completed before discharging a resident. | F 660 | | |

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| F 660 | Continued From page 43<br><br>During an interview on 5/10/23, at 2:17 p.m. the director of nursing (DON) confirmed the above findings and indicated she would expect staff to ensure they obtained proper orders for discharge, provide education, ensure referrals/services were in place and medication prescriptions were sent to pharmacy. The DON stated she would expect staff to follow through with the discharge process and to follow the facility policy.<br><br>Review of the facility policy titled, Transfer or Discharge Documentation undated, indicated when a resident was transferred or discharged, the reason for the transfer or discharge would be documented in the medical chart. The documentation must include: the reason, appropriate notice provided, date and time, location, mode of transportation, a summary of resident's overall medical, physical and mental condition, deposition of personal effects, disposition of medications and signature of person recording the data. | F 660 | | |
| F 661 SS=D | Discharge Summary<br>CFR(s): 483.21(c)(2)(i)-(iv)<br><br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with | F 661 | | 6/16/23 |

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| F 661 | Continued From page 44<br>the consent of the resident or resident's representative.<br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to complete a discharge summary with a recapitulation of stay, medication reconciliation, and discharge plan of care for 1 of 1 residents (R32) who was discharged home with services.<br><br>Findings include:<br><br>R32's admission Minimum Data Set (MDS) dated 2/8/23, indicated R32 had diagnoses which included hypertension, pneumonia, other inter-vertebral disc displacement of lumbo-sacral region and was cognitively intact. Identified R32 required supervision for activities of daily living (ADL's). Indicated a discharge plan for R32 was to return to the community and no referral was made to local contact agency.<br><br>Review of R32's Order Details dated 3/2/23, indicated R32 was to discharge home with home | F 661 | 1. Discharge checklist including recap of stay as well as discharge summary to be completed by all departments.<br>2. All residents can be affected by this practice. Discharge checklist including recap of stay as well as discharge summary to be completed by all departments.<br>3. Checklist implemented. Discharge assessment to be completed by all depts.<br>4. Nurse manager or designee will audit discharges weekly x 4 weeks, monthly x 3 months and will present audits at QAPI<br>5. 6/16/23<br>6. Submitted additional info to MDH | |

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| F 661 | Continued From page 45<br>care for nursing, physical/occupational therapy to increase mobility and strength, follow up with primary care provider in two to three weeks and medication refill for 30 days with no refills.<br><br>Review of R32's Progress Notes from 2/2/23, to 3/9/23, revealed the following:<br>- on 2/7/23, R32 admitted from hospital, had been living independently in his apartment and the plans were to return to his apartment. R32 was cognitively intact, had no behaviors and had mild depression.<br><br>-on 2/26/23, R32 required staff assistance with transfers, bathing, used a wheel chair independently within facility and would inform staff when he needed assistance. R32 would be discharged home soon with assistance from his family.<br><br>-on 3/3/23, R32 would be discharged to his parents home where they can assist him, R32 was cognitively intact and had minimal symptoms of depression.<br><br>R32's medical record lacked documentation of a discharge summary, recapitulation of R32's stay, heath status, medication reconciliation of all pre/post discharge medications, and discharge plan of care had been completed at the time of discharge to ensure continuity of care.<br><br>During a telephone interview on 5/10/23, at 1:01 p.m. the director of social services (DSS) indicated R32's discharge was planned and he had been discharged to his parent's place. The DSS stated the the nurse manager NM-A was responsible for obtaining the discharge orders from the provider and to ensure services were in | F 661 | | |

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| F 661 | Continued From page 46<br>place, and completed a recapitulation of the resident's stay in the medical record.<br><br>During an interview on 5/10/23, at 1:37 p.m. the NM-A confirmed the above findings and indicated the social worker would initiate the discharge process such as: discharge destination, medication refills needed and services/referrals needed. NM-A indicated nursing was responsible for completing the recapitulation of the resident's stay. confirmed the above findings and indicated the facility did not have a process in place for when residents were discharged. The NM-A stated she would expect staff to ensure the tasks were completed as needed for discharges.<br><br>During an interview on 5/10/23, at 2:17 p.m. the director of nursing (DON) confirmed the above findings and indicated nursing staff were responsible for completing a recapitulation/summary of the resident's stay at the nursing home. The DON indicated she would expect staff to follow through with the discharge process and to follow the facility policy.<br><br>Review of the facility policy titled, Transfer or Discharge Documentation undated, indicated when a resident was transferred or discharged, the reason for the transfer or discharge would be documented in the medical chart. The documentation must include: the reason, appropriate notice provided, date and time, location, mode of transportation, a summary of resident's overall medical, physical and mental condition, disposition of personal effects, disposition of medications and signature of person recording the data. | F 661 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents | F 677 | | 6/16/23 |

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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 |
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| F 677 | Continued From page 47<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide assistance with facial hair removal for 1 of 1 resident (R3) who was dependent on staff for activities of daily living (ADL's) and requested to be clean shaven.<br><br>Findings include<br><br>R3's quarterly Minimum Data Set (MDS) dated 4/13/23, identified R3 had diagnoses which included cancer, blindness, and difficulty walking. R3 was cognitively intact and required extensive assistance with ADL's, which included dressing, personal hygiene and bathing. R3 had no refusals of care during the assessment period.<br><br>R3's Significant Change of Status Assessment (SCSA) MDS dated 1/11/23, identified R3 had diagnoses which included cancer, blindness, and difficulty walking. R3 was cognitively intact and required extensive assistance with ADL's, which included dressing, personal hygiene and bathing. R3 had no refusals of care during the assessment period.<br><br>R3's SCSA Care Area Assessment (CAA) 1/11/23, identified R3 was cognitively intact, had severely impaired vision, and required assistance with ADL's of dressing, personal hygiene and bathing. R3 was able to verbalize his needs, required verbal cues due to visual impairment. | F 677 | 1. R3 will be shaved daily per his choice. Staff educated on resident cares.<br>2. All residents that receive ADL cares can be affected. All patient's reviewed to ensure cares are provided as necessary.<br>3. Policy and procedure reviewed to ensure compliance. Staff educated on ADL cares and resident choice.<br>4. DON or designee will audit ADL compliance weekly x 4 weeks, monthly x 3 months. Audit results will be presented at QAPI.<br>5. 6/16/23 | |

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| F 677 | Continued From page 48<br><br>R3's care plan revised 4/12/23, identified R3 had impaired vision, required assistance of one staff with dressing, personal hygiene and bathing. R3's care plan revealed he preferred to be clean shaven, staff were to offer assistance with shaving three times weekly and as needed in the morning.<br><br>R3's nursing assistant (NA) care guide printed 5/11/23, revealed R3 required extensive assistance with dressing and preferred to be clean shaven.<br><br>During an observation on 5/8/23, at 4:52 p.m. R3 was seated at a table alone in the dining room in an armed chair, he wore a pair of bleach stained sweat pants, a gait belt was around his waist and his walker was positioned to his left side. R3's cheeks, chin, upper lip were covered with white, thick, course stubble approximately five (5) to six (6) millimeter (mm) long and his neck was covered with thick, white course hair approximate 10-12 mm long. At that time, nursing assistant (NA)-B approached R3, leaned towards him, and took his order for the evening meal.<br><br>-at 6:00 p.m. R3 had remained seated in the dining room, at that time, NA-I approached asked if he was ready to go back to his room, which he accepted, donned the gait belt around R3's waist and walked with him back to his room. R3 sat on the side of his bed as NA-I placed his call light within his reach and left his room. R3's cheeks, chin, upper lip were covered with white, thick, course stubble approximately 5-6 mm long, and his neck remained covered with thick, course, white facial hair approximately 10-12 mm long. | F 677 | | |

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| F 677 | Continued From page 49<br>During an observation on 5/9/23, at 12:22 p.m. R3 was seated in a chair alone at a table in the dining room. R3's cheeks, chin, upper lip continued to be with covered with white, thick, course stubble approximately 5-6 mm long, and his neck remained covered with thick, course, white facial hair approximately 10-12 mm long.<br><br>-at 12:38 p.m. R3 remained seated in a wheelchair at a table in the dining room, had eaten a few bites of his food, at that time, nursing assistant (NA)-C approached R3, offered to walk him him back to his room, she donned a gait belt, assisted him to stand with a front wheeled walker and proceeded to assist R3 back to his room. NA-C assisted R3 onto a wheelchair, wheeled him next to his bed, provided his call light and left the room. R3 remained unshaved.<br><br>During an observation on 5/10/23, at 7:12 a.m. R3 was lying in bed, his mouth was opened, his eyes were closed, he was covered with a blanket from his feet to his upper chest. R3's cheeks, chin, upper lip continued to be with covered with white, thick, course stubble approximately 5-6 mm long, and his neck remained covered with thick, course, white facial hair approximately 10-12 mm long.<br><br>-at 7:21 a.m. R3 was seated in a wheelchair next to his bed, at that time NA-A obtained a wash basin, washed his face and proceeded to shave R3's face, neck and upper lip. NA-A stated she felt R3 had not been shaved since the weekend when she had shaved him last. NA-A was unable to remove all of R3's facial hair, indicated she would have to shave him again after he eats his breakfast. NA-A stated R3 preferred to be clean shaven and he did not refuse cares. | F 677 | | |

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| F 677 | Continued From page 50<br><br>During an interview on 5/9/23, at 9:51 a.m. R3 stated he typically liked to be clean shaven, however he felt he had no control over what the facility staff did with him and did not complain as some of the staff were not always nice. R3 frowned, his forehead was furrowed, he placed his head in his hands, shook his head and indicated he no longer wished to talk about the facility.<br><br>R3 declined a subsequent attempt at a follow up interview.<br><br>During an interview on 5/10/23, at 11:14 a.m. NA-C stated R3 required extensive assistance with dressing, grooming and did not typically voice his needs or wishes. NA-C indicated she was not aware what R3's preferences for shaving were, however indicated she would look at his care plan.<br><br>During an follow up interview on 5/10/23, at 12:18 p.m. (NA)-A stated R3 required extensive assistance with dressing, bathing and personal hygiene. She indicated R3 was blind and was not able to see himself, but would feel his face with his hands to check to see if he was shaved. NA-A indicated she worried about R3 when she was not working as she felt he was overlooked by some of the staff. NA-A indicated she felt R3 would not say anything if something was bothering him, nor would he ask for help with shaving.<br><br>During an interview on 5/11/23, at 9:45 a.m. the director of nursing (DON) confirmed R3 was blind, did not typically voice his needs or wishes, and required assistance dressing, and grooming, which included shaving. She confirmed R3's care | F 677 | | |

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| F 677 | Continued From page 51<br>plan identified he preferred to be clean shaven. The DON stated she expected R3 to be clean shaven and staff to follow his care plan.<br><br>A facility policy titled, Activities of Daily Living reviewed 4/2/18, identified it was the purpose of the policy to preserve ADL function, promote independence and increase self esteem and dignity. The policy identified residents who required assistance with ADL's including grooming, would be assisted per their plan of care.<br><br>An undated facility policy titled, Shaving the Resident identified it was the purpose of the policy to promote cleanliness and to provide skin care. The policy revealed a step by step procedure for shaving a resident which included reviewing the residents care plan to identify his/her shaving needs/preferences. | F 677 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to routinely administer an anti-Parkinson's medication timely for 1 of 1 resident (R22) who reported increased jerky | F 684 | 1. Nurses were educated that all blood sugar results should be recorded. Nurses educated that Parkinsons med must be given within 15 minutes of scheduled | 6/16/23 |

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| F 684 | Continued From page 52<br>movements and was reviewed for quality of care. In addition, the facility failed to routinely check/monitor blood sugars routinely for 1 of 1 (R24) resident reviewed for use of insulin. Further, the facility failed to ensure proper positioning for 1 of 1 resident (R2) reviewed for positioning.<br><br>Findings include:<br><br>R22's admission Minimum Data Set (MDS) dated 3/8/23, identified R22 had diagnoses of Parkinson's disease, cirrhosis (liver scarring/damage) anxiety and depression. The MDS identified R22 had moderately impaired cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, dressing and personal hygiene.<br><br>R22's admission Care Area Assessment (CAA) dated 3/8/23, identified R22 had a diagnosis of Parkinson's disease, had weakness and jerky movements. R22 required extensive assistance with his ADL's and was at risk for falls due to his jerky movement related to Parkinson's disease.<br><br>R22's care plan revised 4/10/23, revealed R22 had Parkinson's disease, required assistance from staff for his ADL's, was at risk for injury/falls related to Parkinson's disease and identified R22's needs were to be addressed timely.<br><br>Review of R22's undated physician orders, printed 5/11/23, identified R22 had an order dated 3/27/23, for Carbidopa-Levodopa (Interment) 25-100 milligrams (mg), give one tablet by mouth five times a day for Parkinson's disease - MUST BE GIVEN WITHIN 15 MINUTES OF SCHEDULED TIME. | F 684 | time.<br>2. Residents on insulin, blood sugar checks, or time sensitive meds can be affected by this practice. These patient's have been reviewed to ensure compliant practice is in place.<br>3. Progress note will be written for reason of late med administration.<br>4. DON or designee will audit compliance weekly x 4 weeks and monthly x 3 months. Results will be brought to QAPI.<br>5. 6/16/23 | |

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| F 684 | Continued From page 53<br><br>Review of R22's May Medication Administration Record (MAR) revealed R22 was scheduled to receive his Interment at the following times, 4:00 a.m., 8:00 a.m., 11:30 a.m., 4:00 p.m., and 8:00 p.m.<br><br>Review of R22's medication administration history audit form, dated 4/26/23, to 5/10/23, identified R22 did not receive his scheduled Interment within 15 minutes of it's scheduled 59 times out of 73 administrations of the medication.<br><br>During an interview on 5/8/23, at 1:26 p.m. R22 stated he had Parkinson's disease, had significant shakiness/jerking type movements as a result of the disease symptoms. He indicated he was supposed to receive his Interment five times daily, within 15 minutes of the scheduled times, which were 4:00 a.m., 8:00 a.m.,. 11:30 a.m., 4:00 p.m., and 8:00 p.m. R22 stated he did not routinely receive his Interment on time, and at times the medication was given up to an hour or two later. R22 stated it had occurred most recently that morning. R22 stated when he did not receive the medication in a timely manner, his shakiness was worse and his head felt like a Zombie, indicated it was very uncomfortable for him. He stated he regularly reminded nursing staff he needed the medication timely, reported his concerns to the facility nurse practioner (NP)-A and nursing leadership. R22 indicated he could not function properly without his Interment and felt the facility did not take his concerns seriously and did not understand how important it was to give his medication routinely on time. R22 was observed to have upper body jerking type movements during the interview. | F 684 | | |

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| F 684 | Continued From page 54<br>During an interview on 5/10/23, at 12:01 p.m. nursing assistant (NA) -A indicated R22 required assistance with transfers, bed mobility and dressing. She indicated R22 oftentimes had shaky/jerky movements from his Parkinson's and had good days and bad days. NA-A indicated R22 would ask for assistance when needed, used his call light and was able to verbalize his needs and wishes. She stated R22 had reported the nurses were not administering one of his Parkinson's medications to him as he needed and he had reported being frustrated with them. She stated she had reported to the nurse at the time, and felt the nurse had spoken with R22, however was not certain.<br><br>During an interview on 5/10/23, at 1:12 p.m. NA-C stated R22 was able to verbalize his needs, used his call light and required assistance with his ADL's of bed mobility, transfers, dressing and ambulation. She indicated R22's self performance fluctuated, at times requiring extensive assistance and other times supervision to limited assistance. NA-C indicated R22 had jerking/shaking type movements which were more prevalent at times. She indicated R22 had reported to her most recently on that day, he was not receiving his medication for Parkinson's when he was supposed to receive it. NA-C stated she reported R22's concerns to the nurse and was not sure what had been done afterwards.<br><br>During an interview on 5/10/23, at 12:58 p.m. licensed practical nurse (LPN)-G stated R22 was able to verbalize his needs with clear speech and felt he was very aware of when he was supposed to receive his medications, specifically his Interment. LPN-G indicated R22 was supposed to be given his Interment within 15 minutes of it's | F 684 | | |

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| F 684 | Continued From page 55<br>scheduled time in order to be the most effective to help ease the symptoms of Parkinson's disease, of shakiness/jerking movements and brain fog. She stated R22 had reported to her on several occasions he had not received his Interment as it was ordered and had increased symptoms of jerky movements/shakiness. She indicated R22 appeared uncomfortable when he had increased symptoms and felt R22's discomfort could be lessened if he received his medication routinely on time. LPN-G stated she had reported R22's concerns to facility leadership a few months ago, and the NP specified parameters to give the medication within 15 minutes of its scheduled dose. However, she indicated she felt there had been no improvement and there was no system of monitoring or audits in place to ensure nurses were administering it timely.<br><br>During a follow-up interview on 5/11/23, at 9:37 a.m. R22 stated he had not received his Interment that morning until after 8:30, which was an hour later than he was supposed to receive it. R22 stated he was frustrated and felt like his needs were not being taken seriously. R22 stated he felt a bit foggy and had increased jerking movements that day as a result of not receiving his Interment on time. R22 stated he felt safe at the facility, however did not feel like his needs were routinely being met in regards to his medications. R22 was observed to have upper body jerking type movements during the interview.<br><br>During an interview on 5/11/23, at 10:30 a.m. LPN-D confirmed he had not administered R22's scheduled 7:30 a.m. Interment, until approximately 8:30 a.m. that morning. He | F 684 | | |

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| F 684 | Continued From page 56<br>indicated R22 had been sleeping when he last looked and did not wake him to administer his Interment. LPN-D confirmed R22's physician orders identified R22's Interment should be given within 15 minutes of its scheduled dose. He indicated R22 was at risk for increased Parkinson's symptoms of shakiness/jerking movements when he did not receive the medication timely on a routine basis.<br><br>During an interview on 5/11/23, at 12:54 p.m. R22's nurse practitioner (NP) stated she would expect R22 to be administered his Interment within 15 minutes of the scheduled dose. She indicated she had been aware R22 had reported not being given his medication timely, he had been assessed to self administer medications in hope he would be able to give himself his Interment, however R22 was not able to safely self administer his medications. The NP stated she had then ordered the doses of his Interment to be given within 15 minutes of the administration time back in March. The NP stated it was imperative with the type of medication such as Interment to be taken at the same time every day to achieve the maximum benefit. She stated R22 was at risk for increased symptoms of Parkinson's disease such as shakiness/jerking movements, weakness and a decline in his ADL's.<br><br>During a telephone interview on 5/11/23, at 12:49 p.m. with the facility's pharmacy consultant (PC)-A, indicated a medication such as Interment, needed to be administered routinely at the same time daily in order to achieve the maximum desired effect of the medication. The consultant indicated a resident, such as R22, was at risk for increased symptoms of Parkinson's | F 684 | | |

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| F 684 | Continued From page 57<br>disease such as shakiness/jerky movements and brain fog, if they did not receive the medication timely and routinely. She indicated she was not aware R22's Interment had not been given timely with over 50% of his medication administrations. The consultant indicated, had she been aware, she would have reported it to the DON, NP and would have written a recommendation during her most recently pharmacy review.<br><br>R24's admission MDS dated 2/7/23, identified R24 had diagnoses which included diabetes, respiratory failure, cancer and heart failure. R24 was cognitively intact, had severely impaired vision and required extensive assistance with ADL's of bed mobility, transfers, dressing, and personal hygiene. R24 received daily insulin and had no refusals of care.<br><br>R24's 5-day Perspective Pavement System (PPS) MDS dated 3/10/23, identified R24 had diagnoses which included diabetes, respiratory failure, cancer and heart failure. R24 was cognitively intact, had severely impaired vision and required extensive assistance with ADL's of bed mobility, transfers, dressing, and personal hygiene. R24 received daily insulin and had no refusals of care.<br><br>R24's admission CAA dated 2/7/23, identified R24 was legally blind, required extensive to total assistance with her ADL's and relied on staff for her needs. R24 was cognitively intact, was able to make her needs known and had no behaviors. R24 had a diagnosis of diabetes was at risk for skin breakdown. The CAA did not identify R24's routine use of insulin or need to have her blood sugar monitored. | F 684 | | |

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| F 684 | Continued From page 58<br>Review of R24's care plan revised 3/9/23, revealed R22 had diabetes, was at risk for complications such as hypoglycemia (low blood sugar, can cause confusion, heart palpitations, shakiness, and anxiety), hyperglycemia (high blood sugar, can cause increased thirst, dry mouth, frequent urination, tiredness and blurred vision.) R24's care plan lacked any mention of R24's use of insulin of her need to have her blood sugars monitored.<br><br>Review of R24's unsigned physician orders printed 5/11/23, identified an order dated 3/7/23, for Accucheck (device for obtaining a drop of blood to check blood sugar levels) before meals, and HS (before bed) related to Diabetes Mellitus due to underlying condition.<br><br>R24's physician orders identified an order for Levemir (long acting insulin) Flex Touch Subcutaneous Solution Pen-injector 100 units/milliliters (ml) inject 90 units subcutaneous twice daily for diabetes.<br><br>Review of R24's March Medication Administration Record from 3/8/23, to 3/31/23, identified R24's blood sugar was documented as checked 89 out of 96 times. However, no blood sugar results were listed on the MAR.<br><br>R24's blood sugar summary report from 3/8/23, to 3/31/23, identified blood sugar values for 25 out of 96's times. R24's blood sugars ranged from 93 milligrams (mg)/deciliter (dl) to 417 mg/dl, (typical non-fasting blood sugar 125 mg/dl).<br><br>Review of R24's April MAR from 4/1/23, to 4/30/23, identified R24's blood sugars were documented as checked 119 out of 120 times. | F 684 | | |

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| F 684 | Continued From page 59<br>However, no blood sugar results were listed on the MAR.<br><br>R24's blood sugar summary report from 4/1/23, to 4/30/23, identified R24's blood sugar values for 38 out of 120 times. R24's blood sugars ranged from 98 mg/dl to 351 mg/dl.<br><br>Review of R24's May MAR from 5/1/23, to 5/10/23, identified R24's blood sugars were documented as checked 40 out of 40 times. However, R24's blood sugars were documented 21 out of 40 times and ranged from 151 mg/dl to 409 mg/dl.<br><br>R24's blood sugar summary report from 5/1/23, to 5/10/23, identified R24's blood sugar values 24 out of 40 times, and ranged from 117 mg/dl to 409 mg/dl.<br><br>During an interview on 5/8/23, at 1:43 p.m. R24 stated she was diabetic, received a high dose insulin daily and was supposed to have her blood sugars monitored a few times a day. R24 indicated she did not think her blood sugar was being checked routinely, and could not recall if she had mentioned not having her blood sugars checked regularly to anyone. R24 indicated she typically did not have any symptoms of a low blood sugar or high blood sugars and her blood sugars were typically between 150-250 mg/dl.<br><br>During an interview on 5/10/23, at 12:06 p.m. NA-A indicated R24 was blind, able to verbalize her needs and wishes, and required extensive assistance with all of her cares. She indicated R24 was diabetic and had her blood sugar monitored daily by the licensed nursing staff. She stated she was not aware of a time when R24's | F 684 | | |

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| F 684 | Continued From page 60<br>blood sugar was too high or too low, however felt R24 would let someone know if she felt off.<br><br>During a follow up interview on 5/10/23, at 1:30 p.m. R24 stated she took a lot of insulin, however could not recall a time within the past few months where her blood sugar was high enough to require additional insulin or low enough to require an intervention. R24 indicated for her, a blood sugar between 70 mg/dl to 90 mg/dl was too low for her, and she felt she would start to develop symptoms of shakiness if her blood sugar dropped too low. She stated she had her blood sugar checked that morning and before lunch that day, most recent blood sugar was in the mid 100's. R24 indicated some nurses were better at checking her blood sugar than others.<br><br>During an interview on 5/10/23, at 2:05 p.m. during an interview, LPN-G stated R24 was cognitively intact, was a diabetic, received insulin and required routine blood sugar monitoring. She indicated R24 had an order for her blood sugars to be checked before meals and before bed. LPN-G indicated R24's blood sugars were typically in the higher 100 mg/dl to mid -200 mg/dl range. She could not recall a time, R24 required additional insulin or had symptoms of a low blood sugar and required intervention. LPN-G indicated she felt R24 was at risk for hypoglycemia due to her high dose of insulin she received twice daily.<br><br>During a telephone interview on 5/11/23, at 12:50 p.m. the facility's PC-A confirmed R24 received a high dose of long acting insulin (Levemir) twice daily and should have her blood sugars checked at a minimum of twice daily due to the risk of hypoglycemia. She indicated it was imperative for | F 684 | | |

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| F 684 | Continued From page 61<br>R24's blood sugars to be checked/monitored routinely. The consultant indicated she was not aware R24's blood sugars were not being routinely checked and/or documented, and definitely would have made a recommendation the facility follow the physician orders and check her blood sugars routinely.<br><br>During an interview on 5/11/23, at 12:56 p.m. R24's NP confirmed R24 received a high dose of long acting insulin twice daily (Levemir) and stated she would expect nursing staff to check R24's blood sugars to ensure she did not drop too low or get too high. She indicated R24's insulin had been increased during her last hospitalization, when she returned to the facility in March, she had an order for routine blood sugar checks before meal and bed. The NP indicated she felt it was imperative to monitor R24's blood sugars, not knowing it placed her at risk for injury, hospitalization and death.<br><br>R2's significant change MDS dated 4/21/23, identified R2 had moderately impaired cognition, and had diagnoses which included dementia, anxiety, and atrial fibrillation (chronic irregular heart rate). Indicated R2 required total assistance with transfers, and extensive assistance with bed mobility and toilet use.<br><br>R2's significant change CAA, dated 4/25/23, identified R2 required total assistance with transfers and extensive assistance with bed | F 684 | | |

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| F 684 | Continued From page 62<br>mobility, dressing, and toileting due to physical limitations, weakness, limited range of motion, poor coordination, poor balance, visual impairment and pain. Indicated R2's functional status would be addressed in the care plan to slow or minimize decline and avoid complications.<br><br>R2's care plan dated 5/9/23, identified R2 had an ADL self-care performance deficit related to dementia and poor hygiene. R2's interventions included R2 was able to turn side to side independently, and required extensive assistance with dressing, toilet use, and transfer assistance with the use of the Hoyer (mechanical lift) by two staff. R2's care plan further identified R2 was at risk for pain and discomfort related to anxiety and history of migraine headaches.<br><br>On 5/10/23, at 8:42 a.m. NA-C was in R2's room with a Hoyer lift. Trained medication aide (TMA)-A entered the room. TMA-A and NA-C assisted R2 from his wheelchair to his bed using the Hoyer lift. While TMA-A guided R2 to the bed, NA-C began to lower R2 to the bed, while TMA-A stood between the window and the bed. NA-C raised R2's head of the bed up to approximately 45 degrees, and R2 was lowered onto the bed. R2's head extended 4-5 inches above the end of the mattress while the head of bed was raised. TMA-A removed R2's slippers, while NA-C lowered R2's head of bed to a flat position. R2's head then rested on top of the head board, with the top of his head extended over the board 2-3 inches. R2 stated, "you got me a little high", and NA-C responded, "yes, you will scoot down". TMA-A stated "you are a little high there". NA-C and TMA-A proceeded to turn R2 side to side, while completing incontinence cares, while R2's head remained positioned on the headboard. R2 | F 684 | | |

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| F 684 | Continued From page 63<br>was able to hold his head above the head board when he was turned to his left side, however when turned to his back and right side, his head again rested on top of the head board. NA-C and TMA-A positioned R2 onto his back after incontinence cares were completed. Surveyor intervened and asked R2 how his head felt, in which R2 responded, "like my head is on a board", TMA-A then responded, "we will move you down". NA-C and TMA-A then used the draw sheet, to reposition R2 further down his mattress, so his head was no longer resting on the head board.<br><br>During an interview on 5/10/23, at 8:57 a.m. R2 stated his head was a little sore now, from being positioned on the head board.<br><br>During an interview on 5/10/23, at 1:59 p.m. NA-A indicated R2 was totally dependent on staff for cares. NA-A stated they did not reposition R2 from his head resting on the headboard, until after surveyor spoke to R2 and he informed them he felt like his head was on a board. NA-A stated she was not aware R2's head was resting on the head board prior to that, and indicated it was important to assure R2 was positioned correctly to prevent injuries.<br><br>During an interview on 5/10/23, at 1:45 p.m. the director of nursing (DON) stated she was aware R22 had voiced concerns with not being given his Interment routinely on time. The DON stated with that type of medication (anti-Parkinson's) it was important to give it routinely at the same time every day in order to be as effective as possible. The DON indicated R22 had increased symptoms of Parkinson's disease such as jerking/shakiness when he did not receive the Interment timely. She | F 684 | | |

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| F 684 | Continued From page 64<br>confirmed R22's physician order directed nursing staff to administer R22's Interment within 15 minutes of its scheduled time, dated 3/28/23. The DON confirmed this order was put into place as a result of R22's reports of not receiving his Interment timely. She indicated she could not recall the last time she was told R22 was not receiving the Interment timely and confirmed there was no system in place such as monitoring or auditing to ensure R22's Interment was administered as ordered. The DON stated she would expect nursing staff to administer R22's medications as ordered and on time.<br><br>During an interview on 5/11/23, at 9:52 a.m. the director of nursing (DON) reviewed R24's medical record and confirmed R24's blood sugars were not routinely documented. The DON indicated she had not been aware R24's blood sugars were not being monitored, and was not sure why. She indicated she would expect R24's physician orders to be followed, have her blood sugar checked, documented and any levels abnormal for R24 should have been reported to R24's primary practitioner.<br><br>During an interview on 5/11/23, at 11:58 a.m. director of nursing (DON) stated if a resident informed staff something was not right she would expect staff to stop and fix the problem. DON indicated she would expect staff to properly position residents as it was important to prevent injuries and promote comfort.<br><br>Review of a facility policy titled, Medication Administration reviewed 5/2022, identified it was the purpose of the policy that medications should be administered in a safe and timely manner, and as prescribed. The policy identified medications | F 684 | | |

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| F 684 | Continued From page 65<br>must be administered in accordance with orders, including any required time frames.<br><br>An undated facility policy titled, Obtaining a Fingerstick Glucose Level, revealed a procedure for obtaining glucose levels. The policy identified following physician orders.<br><br>The facility policy titled Lifting Machine, Using A Portable, undated, identified two nursing assistants were required to perform the procedure. The procedure identified steps to put a resident back to bed, which included; position the lift over the bed, lower there resident into the center of the bed, and position the resident in a comfortable position that promoted good body alignment. The policy also instructed to remain with the resident until he or she was comfortable and free from any adverse effects from the transfer.<br><br>The facility policy titled Repositioning dated 4/2/18, identified the propose of the procedure was to provide guidance for evaluation of resident repositioning needs, and to aid the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with | F 686 | | 6/16/23 |

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| F 686 | Continued From page 66<br>professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure timely assistance with repositioning for 2 of 5 resident (R19, R14) with a history of pressure ulcers and at risk for further development of pressure ulcers. In addition, the facility failed to implement interventions for 1 of 5 residents (R14) who was at high risk for pressure ulcers.<br><br>Findings include:<br><br>R19's Significant Change In Status Assessment (SCSA) Minimum Data Set (MDS) dated 4/19/23, identified R19 had diagnoses which included heart failure, diabetes, renal insufficiency and was cognitively intact. Indicated R19 required extensive assistance of two staff for bed mobility and transfers. Identified R19 was at risk for the development of pressure ulcers and listed various treatments which included pressure ulcer treatment and application of ointments/medication.<br><br>R19's SCSA Care Area Assessment (CAA) dated 3/29/23, indicated R19 was at risk for developing pressure ulcers and required staff assistance with bed mobility. Identified R19 had maceration with moisture associated skin damage and was at risk | F 686 | 1. Staff was educated on using pressure relieving devices and repositioning.<br>2. All residents at risk for skin breakdown can be affected by this practice. High risk resident charts reviewed to ensure all necessary precautions in place.<br>3. Braden scale completed on everyone in facility. Care plans reviewed and revised for at risk residents.<br>4. DON or designee will audit compliance with repositioning and precautions weekly x 4 weeks, monthly x 3 months, and presented at QAPI<br>5. 6/16/23<br>6. Additional info submitted to MDH | |

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| F 686 | Continued From page 67<br>for pressure ulcers related to incontinence, poor nutrition, chronic or end stage renal, liver, heart disease, diabetes, and immobility.<br><br>R19's Braden Scale for Predicting Pressure Sore Risk form, dated 5/2/23, identified R19 was at moderate risk for the development of pressure ulcers, skin was often very moist, was chair fast, had slightly limited mobility, probably inadequate nutrition and had a problem of friction and shearing. The form indicated R19 was at risk for skin breakdown and required moderate to maximum assistance from staff for activities of daily living (ADL's), repositioning and mobility.<br><br>R19's current care plan revised on 5/10/23, identified R19 had potential for pressure ulcer development related to history of ulcers, immobility and was dependent on staff for all cares. The care plan directed staff to turn and reposition at least every two hours, or more often as needed.<br><br>Review of the Aide Kardex dated 5/10/23, indicated R19 required staff assistance to turn and reposition at least every two hours or more often as needed or requested. The Kardex instructed staff to follow the facility's policies/procedures for the prevention/treatment of skin breakdown.<br><br>During observations on 5/10/23, at 7:10 a.m. R19 was seated in her brown recliner in her room, with her feet up on the footrest and was working on a cross word puzzle book.<br>-At 7:11 a.m. trained medication aid (TMA)-A entered R19's room and began making the bed. TMA-A donned a pair of gloves, grabbed the basin of water setting on R19's bedside table and | F 686 | | |

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| F 686 | Continued From page 68<br>emptied it in the bathroom. TMA-A removed the gait belt from around R19's waist, collected the dirty linen in a bag, immediately left R19's room and sanitized her hands, while R19 remained in her recliner.<br><br>- at 7:19 a.m. R19 continued to be seated in her recliner.<br><br>- at 8:01 a.m. R19 continued to be seated in her recliner.<br><br>- at 8:15 a.m. R19 continued to be seated in her recliner.<br><br>- at 8:40 a.m. R19 continued to be seated in her recliner with her eyes closed, she was leaning slightly to the right and while resting.<br><br>- at 8:48 a.m. R19 continued to be seated in her recliner resting.<br><br>- at 8:57 a.m. R19 continued to be seated in her recliner resting and occasionally opening her eyes.<br><br>- at 9:02 a.m. R19 continued to be seated in her recliner.<br><br>-at 9:07 a.m. R19 staff entered R19's room, deliver her breakfast tray and placed on her bedside table in front of her. R19 began eating her breakfast independently while nursing assistant (NA)-C walked by her room.<br><br>- at 9:16 a.m. R19 continued to eat her breakfast independently in her room.<br><br>- at 9:21 a.m. R19 remained the same. | F 686 | | |

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| F 686 | Continued From page 69<br><br>- at 9:38 a.m. R19 continued to be seated in her brown recliner, when nurse practitioner (NP)-A and nurse manager (NM)-A entered her room and told R19 it was Wednesday, and they were going to check her skin. The NP-A closed the door, and NP-A and NM-A proceeded to donn gloves on their hands and lifted up R19's abdominal fold. The area had no open areas and was reddish/pink in color. NP-A and NM-A then checked the skin under R19's breasts, no open areas noted with skin reddish/pink in color. NM-A retrieved R19's walker and placed it in front of her. NM-A placed a gait belt around R19 waist while she sat in her recliner, NM-A gathered her supplies and she counted to three and assisted R19 to stand while holding her walker. NM-A took a picture of R19's buttocks area and R19 began to get tired of standing and NP-A and NM-A assisted R19 to sit back in her recliner.<br><br>- at 9:47 a.m. NP-A and NM-A assisted R19 to a standing position while using her walker. R19's buttocks had no open areas, with dry flaky patches of skin and was reddish/pink in color. NM-A applied a wound adhesive (Cavilon no sting barrier film) and assisted R19 to sit back down in her recliner. NP-A and NM-A removed their gloves, sanitized their hands and made sure R19 was comfortable. NP-A gave R19 her call light, placed her bed side table next to her and NP-A and NM-A immediately left the room. R19 verified this was the first time she had been up out of her recliner since this morning.<br><br>R19 had not offered to reposition every two hours as directed by her care plan and was unable to reposition herself independently. R19 had not been repositioned for a total of 2 hours and 27 | F 686 | | |

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| | 245052 | A. BUILDING _____ B. WING _____ | C 05/11/2023 |

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

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| F 686 | Continued From page 70<br>minutes and was at risk for pressure ulcers.<br><br>During an interview on 5/10/23, at 11:53 a.m. TMA-A confirmed R19 required staff assistance with her ADL's and was compliant with cares. TMA-A indicated she did not know the last time R19 had been repositioned and thought maybe it was when she had therapy sometime that morning. TMA-A indicated R19 was at risk for developing pressure ulcers and verified staff were to reposition R19 every two hours.<br><br>During an interview on 5/10/23, at 11:56 a.m. R19 confirmed she has had pressure ulcers in the past and staff assisted her with cares. R19 indicated staff had not been in to turn and reposition her since she had gotten up this morning. R19 stated she had rested until she received her breakfast tray and the nurse came in to assess her bottom.<br><br>During an interview on 5/10/23, at 1:45 p.m. NM-A confirmed R19 required staff assistance with her ADL's and was cognitively intact. NM-A indicated R19 was at risk for pressure ulcers and she would expect staff to follow her care plan and to reposition R19 every two hours. NM-A stated she did not know the last time R19 had been repositioned and had only come into R19's room to do her treatment to her buttocks. NM-A indicated she would expect staff to follow the facility policy for repositioning.<br><br>During an interview on 5/10/23, at 2:05 p.m. the director of nursing (DON) confirmed R19 required staff assistance with ADL's and was incontinent of bowel and bladder. The DON verified R19's care plan, verified she was at risk for pressure ulcers, and she would expect staff to turn and reposition | F 686 | | |

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| F 686 | Continued From page 71<br>R19 as per her schedule and to follow her care plan. The DON indicated R19 should have been repositioned every two hours.<br><br>Review of facility policy titled, repositioning undated, identified the facility was to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized call plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents.<br><br>R14's quarterly Minimum Data Set (MDS) dated 4/29/23, identified R14 was cognitively intact with diagnoses of diabetes, heart failure, and atrial fibrillation (chronic irregular heart beat). Indicated R14 required extensive assistance with bed mobility, transfers, toilet use, hygiene and dressing. R14 had no behaviors and was at risk for pressure ulcers, but had no current unhealed pressure ulcers. R14's pressure risk interventions identified included application of ointment/medication other than to feet.<br><br>R14's admission Care Area Assessment (CAA) dated 4/29/23, identified R14 was at risk for pressure ulcer development due to requiring extensive assistance with bed mobility, frequent incontinence of bowel and had scored at risk for development on nursing admission assessment. R14's CAA identified R14 was immobile, bed bound and was incontinent. Instructed staff to offer toileting and repositioning periodically. Licensed staff to do complete skin check weekly with bath/shower. | F 686 | | |

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| F 686 | Continued From page 72<br><br>R14's Braden Scale For Predication Pressure Sore Risk Assessment dated 12/22/22, identified R14 had a score of 14, which indicated high risk for pressure sores.<br><br>R14's care plan revised 5/9/23, identified R14 had ADL's self care needs due to disease process. R14's interventions included extensive assistance with toilet use and transfers, and limited assistance with hygiene and dressing. R14 was identified to be independent with repositioning and turning in bed. R14's care plan identified R14 was at risk for pressure ulcer development related to immobility and disease process. R14's interventions included to follow facility policies/protocols for prevention/treatment of skin breakdown. R14's interventions instructed staff to offer resident assistance with turning. In addition, R14's care plan identified R14 had skin impairment to bilateral lower extremities related to edema and blisters, and interventions included staff to reposition every two to three hours.<br><br>R14's Order Summary Report signed 4/26/23, included the following orders:<br>-Prevalon boots (pressure relieving boots) every shift when in bed , start date 12/12/22.<br>-wash and apply barrier cream to buttocks and perineal area to protect skin from breakdown two times a day and as needed, for skin break down prevention with a start date of 8/29/22.<br>-weekly skin review on day shift every Saturday start date 7/30/22.<br><br>On 5/8/23, at 2:05 p.m. R14 was lying on his back in his bed, with his head of bed slightly elevated, wearing a hospital gown. R14 indicated he thought he had a pressure sore on his bottom, | F 686 | | |

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| F 686 | Continued From page 73<br>which he stated the nurses assessed at times. R14 stated he was supposed to be wearing Prevalon boots, which were not on his heels and lying in his recliner.<br><br>On 5/10/23, at 7:13 a.m. to 9:00 a.m. during continuous observations:<br>-7:13 a.m. R14's door was closed, NA-F entered room 304 with a lift.<br>-7:14 a.m. NA-C left a room across the hall from R14, then re-entered the same room. NA-F left room 304, walked past R14's room and walked away.<br>-7:17 a.m. NA-F returned to hallway and entered room 304 again. R14's door remained closed.<br>-7:24 a.m. surveyor knocked, then entered R14's room. R14 was lying on his back in his bed, gown on, covered with sheet and blanket, with his head of bed slightly raised. R14's bed side table was over his bed, and he was working on a word search book. R14 had his Prevalon boots on. R14 stated he was wearing his blue Prevalon boots, then stated he was able to move around in his bed at times. R14 informed surveyor staff had been in to assist him with cares a few hours ago.<br>-7:42 a.m. two staff members walked by R14's room, NA-C entered a room across the hall from R14's room.<br>-9:00 a.m. NA-F entered R14's room, with his breakfast tray, which she set up on his bedside table. R14 used the bed controls and raised the head of his bed up to nearly 90 degrees and R14 began to eat his breakfast and remained on his back.<br><br>On 5/10/23, at 9:36 a.m. R14 remained in bed on his back, head of bed slightly elevated, continuing to work on his word search book. R14 informed surveyor no one had assisted him with | F 686 | | |

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| F 686 | Continued From page 74 | F 686 | | |

repositioning, and stated he could only move himself around in bed somewhat. R14 stated his bottom was a "little sore" and agreed to have a nurse come in and assess it.

On 5/10/23, at 9:52 a.m. nurse manager NM-A and surveyor entered R14's room. NA-C was in R14's room and confirmed she had not been in R14's room yet that morning, and indicated she was going to assist him with incontinence cares. NA-C instructed R14 to turn to his left side, placed her right hand on his right side then back, while she assisted him to turn, and he used the grab bar to remain in position on his left side. NA-C used a wipe to cleanse R14's buttocks and indicated R14 was dry at that time. NM-A assessed R14's buttocks. NM-A stated R14's skin had no open areas, was blanchable, with scar tissue present, pink in color, over coccyx area. NM-A applied a new brief, removed his Prevalon boots, inspected his heels, which were noted to be intact, blanchable, with no redness. NM-A confirmed staff should have assisted R14 with repositioning every two hours as R14 was high risk for developing pressure ulcers and had a history of pressure ulcers. NM-A confirmed she expected R14's Prevalon boots to be on when R14 was in bed. R14 was lying on his back, with his head of bed slightly elevated, and NM-A applied a pillow under his knees.

R14 had not been offered to reposition every two hours as directed by his care plan and was unable to fully reposition himself independently. R19 had not been repositioned for greater than 2 hours and 36 minutes.

During an interview on 5/10/23, at 1:47 p.m. NA-C indicated she provided limited assistance to

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| F 686 | Continued From page 75<br>R14 for repositioning, however indicated R14 could move himself. NA-C stated R14 was to have his Prevalon boots on while in bed and to be repositioned every two hours. NA-C indicated she was responsible for R14's cares, confirmed she had not repositioned him prior to cares at 9:52 a.m. and stated she should have assisted him sooner.<br><br>During an interview on 5/10/23, at 2:35 p.m. LPN-G confirmed she had not assisted R14 to reposition that morning, and indicated she did not usually assist with repositioning the residents.<br><br>During an interview on 5/10/23, at 2:05 p.m. the director of nursing (DON) confirmed R19 required staff assistance with ADL's and was incontinent of bowel and bladder. The DON verified R19's care plan, verified she was at risk for pressure ulcers, and she would expect staff to turn and reposition R19 as per her schedule and to follow her care plan. The DON indicated R19 should have been repositioned every two hours.<br><br>During an interview on 5/11/23, at 11:58 a.m. director of nursing (DON) indicated she would expect staff to follow care plan interventions, such as Prevalon boots and repositioning, to prevent skin breakdown for R14.<br><br>Review of facility policy titled, repositioning undated, identified the facility was to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized call plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. | F 686 | | |

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| F 686 | Continued From page 76<br><br>The facility policy titled Pressure Ulcers-Skin Breakdown-Clinical Protocol dated 4/18, identified the nursing staff and practitioner would assess and document an individual's significant risk factors for development of pressure ulcers. The policy indicated the nurse would describe, document and report the following criteria which included; the residents mobility status, current treatments, including support surfaces and all active diagnoses. The physician would order pertinent would treatments, including pressure reduction surfaces, and help identify medical interventions. | F 686 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to complete a comprehensive assessment after a resident fell and received a major injury. Further, the facility failed to implement interventions to prevent further falls for 1 of 1 resident (R 25) who had a fall with a major injury.<br><br>Findings include:<br><br>R25 's admission Minimum Data Set (MDS), | F 689 | 1. Staff educated on fall policy and procedure. Interventions have been put in place on R25.<br>2. All resident's at risk for falls have the potential to be affected by this practice. Resident falls audited to ensure comprehensive assessment and interventions in place.<br>3. Nursing staff educated on policy and procedure for falls as well as falls checklist. | 6/16/23 |

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| F 689 | Continued From page 77<br>dated 3/15/23, identified R25 had diagnosis which included deep vein thrombus (blood clot in a deep vein), cerebral vascular accident (CVA) and chronic obstructive pulmonary disease (COPD). R25 had intact cognition and required extensive assistance with activities of daily living (ADL's) including bed mobility, transfers, and toileting. Indicated R25 had fallen in the past month.<br><br>R25's admission Care Area Assessment dated 3/23/23, identified R25 had changing cognitive status and had diagnosis which included Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA) (small strokes), and falls. Indicated R25 had impaired balance during transitions and was at an increased risk for falls.<br><br>Review of R25's most recent fall risk assessment dated 3/8/23, identified R25 was at moderate risk for falls related to prior falls and the need for assistive devices such as a cane or walker.<br><br>Review of R25's care plan revised 3/29/23, revealed R25 had limited mobility and required extensive assistance with transfers, and toileting. The care plan revealed R25 was at high risk for falls. R25's care plan listed interventions which included; bed in low position, encourage call light usage, and fall mat.<br><br>Review of R25's progress notes dated 3/22/23, at 10:10 a.m. revealed R25 was found lying on the floor near his bed in a left lateral recumbent position. R25 stated he had gotten up to go to the bathroom and his walker had gotten away from him. R25 complained of pain in his left clavicle and was sent to the emergency room (ER).<br><br>The progress note lacked documentation of a | F 689 | 4. DON or Designee will audit post fall comprehensive assessments and interventions, weekly x 4 weeks, monthly x 3 months. Results will be presented at QAPI<br>5. 6/16/23<br>6. Additional info submitted to MDH | |

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| F 689 | Continued From page 78<br>post-fall assessment and new interventions placed to prevent further falls.<br><br>Further review of R25's medical record lacked documentation a post-fall assessment had been completed to determine causative factors.<br><br>Review of R25's left shoulder X-ray dated 3/22/23, revealed R25 had a left clavicle fracture.<br><br>During an observation on 5/8/23, at 2:07 p.m. R25 was lying in bed and a fall mat was across the room placed up against the wall. R25's bed was not in a low position.<br><br>During an observation on 5/9/23, at 9:19 a.m. R25 was lying in bed and a fall mat continued to be across the room leaned up against the wall. R25's bed was not in low position.<br><br>During an interview on 5/9/23, at 9:20 p.m. R25 stated he had fallen a few months ago and fractured his shoulder. R25 stated a nurse came in a few days later and just threw a fall mat next to the bed and said it was for falls however no one discussed it with him. R25 indicated he asked a staff member to remove it the next day as his bedside table would not roll with the mat next to his bed. R25 stated no one had mentioned anything about his bed needing to be in a low position and stated "the staff are in complete control of the bed remote."<br><br>During an observation on 5/10/23, at 9:40 a.m. R25 was lying in bed and the fall mat continued to be across the room placed against the wall. R25's bed was not in a low position.<br><br>During an interview on 5/10/23, at 9:44 a.m. | F 689 | | |

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| F 689 | Continued From page 79<br>nursing assistant (NA)-A confirmed R25's fall mat was across the room against the wall and R25's bed was not in a low position. NA stated she was aware of R25's fall with a major injury and the interventions that were implemented after the fall which included the fall mat and the bed in low position. NA-A stated she thought the fall mat had been discontinued and was not sure why R25's bed was not in the low position.<br><br>During an interview on 5/10/23, at 10:37 a.m. licensed practical nurse (LPN)-C verified R25's fall mat was across the room and against the wall and R25's bed was not in low position. LPN-C stated she was unaware R25 had a fall with a major injury. LPN-C stated she was however, aware R25 was supposed to have a fall mat next to his bed but R25 did not like the fall mat. LPN-C stated she was unaware R25's bed was supposed to be in a low position.<br><br>During an interview on 5/11/23, at 11:01 a.m. director of nursing (DON) indicated she was aware of R25's fall with a major injury on 3/22/23. Don confirmed no comprehensive fall assessment had been completed after R25's fall with a major injury. DON stated her expectation would have been interventions would have been followed and a post fall assessment would have been completed after R25's fall with a major injury.<br><br>A facility policy titled Fall Prevention reviewed 5/18/22, identified a post fall assessment would have been completed after each fall and any interventions would have been noted on the form, on the residents care plan, care sheets, and the nurses notes. | F 689 | | |

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| F 740 | Continued From page 80 | F 740 | | |
| F 740 SS=D | Behavioral Health Services<br>CFR(s): 483.40<br><br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to access and provide the necessary services for the behavioral health needs for 1 of 1 resident (R186) reviewed for mood and behavior.<br><br>Findings Include:<br><br>R186's Admission Record identified R186 was admitted to the facility on 5/1/23, and had diagnoses which included unspecified dementia, nicotine dependence, bipolar disorder, major depressive disorder, claustrophobia.<br><br>R186's care plan dated 5/8/23, identified R186 had potential for ineffective coping related to reported history of traumatic events, with interventions which included encourage resident to resume normal activities and begin new ones, and provide a safe therapeutic environment where R186 could regain control as needed.<br>R186's care plan identified R186 had a mood problem related to admission and interventions included: monitor/document/report as needed, | F 740 | 1. R186 was seen for his suicidal ideations.<br>2. All resident's reviewed to determine need for psychiatric services. Any patient's in need will be seen by a provider.<br>3. Staff educated on notification to provider for behavioral services.<br>4. DON or designee will audit compliance of this practice, weekly x 4 weeks and monthly x 3 months. Results will be presented at qapi.<br>5. 6/16/23 | 6/16/23 |

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| F 740 | Continued From page 81<br>any risk for harm to self, suicidal plan, past attempt at suicide, risky actions or intentionally harmed or tried to harm self.<br><br>R186's care plan did not identify he had thoughts he would be better off dead or further appropriate interventions.<br><br>R186's Nurse Admission assessment dated 5/1/23, identified R186 was alert and orientated to person, place, time and was aware of clinical situation. R186's assessment indicated R186 was able to make his needs known verbally.<br><br>R186's Social Service Admission assessment dated 5/5/23, identified R186 had bipolar disorder, personality disorders claustrophobia, attention and concentration deficit, dementia and other behavioral disturbance, depression and insomnia. R186's assessment indicated R186 was cognitively intact and the assessment for trauma and post traumatic stress disorder (PTSD) was positive. R186's PHQ-09 (mood assessment) identified a score of 21, severe depressive disorder. R186's assessment summary included R186 had thoughts he would be better off dead, but no plan.<br><br>R186's PHQ-09 dated 5/5/23, identified R186 had a score of 21, severe depressive disorder. The assessment indicated R186 had thoughts he would be better off dead, or of hurting himself in some way, symptom present, with no frequency identified.<br><br>R186's Social Service-Trauma Informed Care History assessment completed 5/5/23, identified R186 had been through life threatening or trauma as described as being homeless in Minneapolis. | F 740 | | |

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| F 740 | Continued From page 82<br>R186's assessment indicated nothing helped him get through those difficult times, and the question what are some things you do now to help you manage consequences of having gone through tough times was left blank. R186's assessment indicated R186 did not know of any particular triggers, that made this worse for him.<br><br>Review of R186's progress notes dated 5/1/23, to 5/11/23, identified the following:<br>-5/5/23, at 1:14 p.m. -social service admission note-R186's assessment for trauma and PTSD were positive. R186's PHQ-09 score was 21, which indicated severe depression symptoms with thoughts he would be better off dead but no plan.<br><br>R186's progress notes lacked further documentation R186's thoughts of better of dead had been addressed or R186's provider had been contacted.<br><br>During an interview on 5/10/23, at 12:58 p.m. R186 confirmed he had attempted suicide before. R186 stated he had received help in the past regarding suicidal ideation. R186 informed surveyor he did not feel suicidal at that time, and felt he still had hope.<br><br>During a telephone interview on 5/10/23, at 2:33 p.m. social service designee (SSD)-A confirmed R186 had talked about suicide with her, however indicated he had no plan at that time. SSD-A indicated she had not asked him about a history of suicide attempts or thoughts, as that was not her department, however indicated she had referred him to nurse practitioner (NP)-A who would then refer him to the psychiatric NP. SSD-A indicated she was not sure when she made the | F 740 | | |

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| F 740 | Continued From page 83<br>referral, as she did not document it. SSD-A confirmed she had not initiated monitoring for R186 and stated her process was only to make the referral. SSD-A indicated she was not aware if NP-A had seen R186 since then.<br><br>During an interview on 5/10/23, at 3:08 p.m. NP-A confirmed she had been informed by SSD-A on 5/5/23, R186 had made comments about suicide and had thoughts about hurting himself. NP-A indicated R186 needed to be seen by the facility's psychiatric NP. NP-A stated she planned for R186 to be seen by herself and the psychiatric NP on 5/5/23, however he was at dialysis and she had left before he returned to the facility. NP-A confirmed she had not assessed R186 the day he made those comments, and if she would have, she would have sent him to the ER. NP-A stated she was not aware R186 had a history of suicidal attempts. NP-A indicated she would normally send residents who had suicidal ideation to the emergency room (ER) and ask staff to do 15 minute checks on them.<br><br>During an interview on 5/10/23, at 2:57 p.m. licensed practical nurse (LPN)-B indicated she had not been aware R186 had made any comments about suicide and had not seen him cry or sad. LPN-B indicated if she had been aware, she would ask if R186 had a plan and would report to the nurse and provider.<br><br>During an interview on 5/10/23, at 2:57 p.m. NA-D indicated his usual process was not to ask questions of the residents, and he had not been informed R186 made any comments of harming himself. NA-D stated he did not do any monitoring of residents' mood or behaviors, as his job was to do cares and assist with eating. NA-D | F 740 | | |

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| F 740 | Continued From page 84<br>indicated if a resident expressed thoughts of suicide to him he would inform the nurse.<br><br>During an interview on 5/10/23, at 2:58 p.m. NA-B stated R186 had been in a good mood with her, and never expressed sadness or crying or made comments to her about harming himself. NA-B stated if R186 had, she would have reported it to the charge nurse and director of nursing (DON). NA-B stated the last time they had a resident who made those comments, they were directed to do 15 minute checks, however indicated for R186 they had not received any direction.<br><br>During an interview on 5/10/23, at 3:05 p.m. nursing assistant (NA)-A stated he had not been made aware R186 had ever made suicidal comments.<br><br>During an interview on 5/10/23, at 3:09 p.m. LPN-G stated she had not witnessed R186 exhibit any signs of crying, sadness or concerns of harming self. LPN-G indicated she had not been informed of R186 making suicidal comments, and was not aware of the process at the facility if someone had made such comments.<br><br>During an interview on 5/11/23, at 9:46 a.m. NA-H stated R186 had never made comments to him about harming himself. NA-H indicated he had never been informed R186 had made these comments, and would expect it to be discussed during report and the staff to be given instructions on what to do.<br><br>During an interview on 5/11/23, at 10:22 a.m. quality nurse-educator (QN)-A indicated she was aware the usual facility process if someone made comments of suicide or harming self, was to | F 740 | | |

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| F 740 | Continued From page 85 | F 740 | | |

notify NP-A to assess the resident and then send the resident to the ER for evaluation. QN-A stated she had not been aware R186 had made any comments of suicide or harming self, and would expect R186 would have been evaluated by the psychiatric nurse or at the ER, and to follow their plan after the evaluation.

During a follow up interview on 5/11/23, at 10:49 a.m. SSD-A stated she had completed R186's assessments on 5/5/23, after he returned from dialysis. SSD-A indicated R186 had informed her he had thought about suicide in the past, had fleeting thoughts now and then, however did not have a current plan. SSD-A stated she thought she had informed NP-A in her office after her assessment of R186 and confirmed NP-A gave her no instructions. SSD-A indicated she did not report his thoughts of suicide to anyone else and stated the nurses and nursing assistants could read her progress note. SSD-A stated if she felt suicide was imminent she would have informed director of nursing (DON).

During an interview on 5/11/23, at 11:55 a.m. DON confirmed she had been informed of R186's suicidal comments on 5/10/23, when R186 had been seen by NP-A. DON stated she was not aware R186 made the comments on 5/5/23, and indicated she would have expected it to be addressed immediately at that time, to prevent harm.

The facility policy titled Suicide Threats, dated 12/07, identified staff were to report any resident threats of suicide immediately to the nurse supervisor/charge nurse. The supervisor/charge nurse would immediately assess the situation and would notify the charge nurse/supervisor and or

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| F 740 | Continued From page 86<br>director of nursing services of such threats. A staff member would remain with the resident until the nurse supervisor/charge nurse arrived to evaluate the resident. After assessing the resident in more detail the nurse supervisor/charge nurse would notify the resident's attending physician and responsible party and would seek further direction from the physician. The policy indicated all nursing personnel and other staff involved in caring for the resident would be informed of the suicide threat and instructed to report changes in there resident's behavior immediately. As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. If the resident remained in the facility, staff would monitor the resident's mood and behavior and update care plans accordingly, until a physician had determined that a risk of suicide did not appear to be present. Staff would document the details of the situation objectively in the resident's record. | F 740 | | |
| F 745 SS=D | Provision of Medically Related Social Service CFR(s): 483.40(d)<br><br>§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to comprehensively assess, monitor and implement appropriate medically related social service interventions for 1 of 1 residents (R186) who made comments of suicidal ideation.<br><br>Findings Include: | F 745 | 1. R186 was seen by psychiatry for his suicidal ideations.<br>2. All resident's reviewed to determine need for comprehensive assessments for behavioral issues. Any patient's in need will be seen by a provider.<br>3. Staff educated on notification to | 6/16/23 |

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| F 745 | Continued From page 87<br><br>R186's Admission Record identified R186 was admitted to the facility on 5/1/23, and had diagnoses which included unspecified dementia, nicotine dependence, bipolar disorder, major depressive disorder, claustrophobia.<br><br>R186's care plan dated 5/8/23, identified R186 had potential for ineffective coping related to reported history of traumatic events, with interventions which included encourage resident to resume normal activities and begin new ones, and provide a safe therapeutic environment where R186 could regain control as needed. R186's care plan identified R186 had a mood problem related to admission and interventions included: monitor/document/report as needed, any risk for harm to self, suicidal plan, past attempt at suicide, risky actions or intentionally harmed or tried to harm self.<br><br>R186's care plan did not identify he had thoughts he would be better off dead or further appropriate interventions.<br><br>R186's Social Service Admission assessment dated 5/5/23, identified R186 had bipolar disorder, personality disorders claustrophobia, attention and concentration deficit, dementia and other behavioral disturbance, depression and insomnia. R186's assessment indicated R186 was cognitively intact and the assessment for trauma and post traumatic stress disorder (PTSD) was positive. R186's PHQ-09 (mood assessment) indicated a score of 21, severe depressive disorder. R186's assessment summary identified R186 had thoughts he would be better off dead and no plan. | F 745 | provider for behavioral services.<br>4. DON or designee will audit compliance of this practice, weekly x 4 weeks and monthly x 3 months. Results will be presented at qapi.<br>5. 6/16/23 | |

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| F 745 | Continued From page 88<br>R186's PHQ-09 dated 5/5/23, identified R186 had a score of 21, severe depressive disorder. The assessment indicated R186 had thoughts he would be better off dead, or of hurting himself in some way, symptoms present, with no frequency identified.<br><br>R186's Social Service-Trauma Informed Care History assessment completed 5/5/23, identified R186 had been through life threatening or trauma as described as being homeless in Minneapolis. R186's assessment indicated nothing helped him get through those difficult times, and the question what are some things you do now to help you manage consequences of having gone through tough times was left blank. R186's assessment indicated R186 did not know of any particular triggers, that made it worse for him.<br><br>Review of R186's progress notes dated 5/1/23, to 5/11/23, identified the following:<br>-5/5/23, at 1:14 p.m. -social service admission note-R186's assessment for trauma and PTSD were positive. R186's PHQ-09 score was 21, which indicated severe depression symptoms with thoughts he would be better off dead but no plan.<br><br>R186's progress notes lacked further documentation R186's thoughts of better off dead had been addressed, interventions implemented or R186's provider had been contacted.<br><br>During an interview on 5/10/23, at 12:58 p.m. R186 confirmed he had attempted suicide in the past. R186 stated he had received help in the past regarding suicidal ideation. R186 informed surveyor he did not feel suicidal at that time, and felt he still had hope. | F 745 | | |

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| F 745 | Continued From page 89<br><br>During a telephone interview on 5/10/23, at 2:33 p.m. social service designee (SSD)-A confirmed R186 had talked about suicide with her, however indicated he had no plan at that time. SSD-A indicated she had not asked him about a history of suicide attempts or thoughts, as that was not her department, however indicated she had referred him to nurse practitioner (NP)-A who would then refer him to the psychiatric NP. SSD-A stated she was not sure when she made the referral, as she had not documented it. SSD-A confirmed she had not initiated monitoring for R186 and stated her process was only to make the referral. SSD-A indicated she was not aware if NP-A had seen R186 since then.<br><br>During an interview on 5/10/23, at 3:08 p.m. NP-A confirmed she had been informed by SSD-A on 5/5/23, R186 had made comments about suicide and had thoughts about hurting himself. NP-A indicated R186 needed to be seen by the facility's psychiatric NP. NP-A stated she planned for R186 to be seen by herself and the psychiatric NP on 5/5/23, however he was at dialysis and she had left before he returned to the facility. NP-A confirmed she had not assessed R186 the day he made those comments, and if she would have, she would have sent him to the ER. NP-A stated she was not aware R186 had a history of suicidal attempts. NP-A stated her usual process if staff informed her a resident had suicidal ideation included to send them to the emergency room (ER) and for staff to complete 15 minute checks on them.<br><br>During an interview on 5/10/23, at 2:57 p.m. licensed practical nurse (LPN)-B indicated she had not been aware R186 had made any | F 745 | | |

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| F 745 | Continued From page 90 | F 745 | | |

comments about suicide and had not seen him cry or sad. LPN-B indicated if she had been aware, she would ask if R186 had a plan and would report to the nurse and provider.

During an interview on 5/10/23, at 3:09 p.m. LPN-G stated she had not witnessed R186 exhibit any signs of crying, sadness or concerns of harming self. LPN-G indicated she had not been informed of R186 making suicidal comments, and was not aware of the process at the facility if someone had made such comments.

During an interview on 5/11/23, at 9:46 a.m. NA-H stated R186 had never made comments to him about harming himself. NA-H indicated he had never been informed R186 had made these comments, and would expect it to be discussed during report and the staff to be given instructions on what to do.

During an interview on 5/11/23, at 10:22 a.m. quality nurse-educator (QN)-A indicated she was aware the usual facility process if someone made comments of suicide or harming self, was to notify NP-A to assess the resident and then send the resident to the ER for evaluation. QN-A stated she had not been aware R186 had made any comments of suicide or harming self, and would expect R186 would have been evaluated by the psychiatric nurse or at the ER, and to follow their plan after the evaluation.

During a follow up interview on 5/11/23, at 10:49 a.m. SSD-A stated she had completed R186's assessments on 5/5/23, after he returned from dialysis. SSD-A indicated R186 had informed her he had thought about suicide in the past, had fleeting thoughts now and then, however did not

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| F 745 | Continued From page 91<br>have a current plan. SSD-A stated she thought she had informed NP-A in her office after her assessment of R186, however confirmed NP-A gave her no instructions. SSD-A indicated she did not report his thoughts of suicide to anyone else and stated the nurses and nursing assistants were able to read her progress note. SSD-A indicated if she felt suicide was imminent she would have informed director of nursing (DON). SSD-A confirmed no other social service interventions had been developed or implemented other than her referral to NP-A.<br><br>During interview on 5/11/23, at 11:55 a.m. DON confirmed she had not been informed of R186's suicidal comments by SSD-A on 5/5/23. DON stated she did not become aware of the comments until 5/10/23, after R186 had been seen by NP-A. DON stated she would have expected the concern to be addressed immediately per facility policy.<br><br>The facility policy titled Suicide Threats, dated 12/07, identified staff shall report any resident threats of suicide immediately to the nurse supervisor/charge nurse. The supervisor/charge nurse would immediately assess the situation and would notify the charge nurse/supervisor and or director of nursing services of such threats. A staff member would remain with the resident until the nurse supervisor/charge nurse arrived to evaluate the resident. After assessing the resident in more detail the nurse supervisor/charge nurse would notify the resident's attending physician and responsible party and would seek further direction from the physician. The policy further identified all nursing personnel and other staff involved in caring for the resident would be informed of the suicide | F 745 | | |

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| F 745 | Continued From page 92<br>threat and instructed to report changes in there resident's behavior immediately. As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. If the resident remained in the facility, staff would monitor the resident's mood and behavior and update care plans accordingly, unit a physician had determined that a risk of suicide did not appear to be present. Staff would document the details of the situation objectively in the resident's record.<br><br>The facility policy titled Social Services dated 3/28/18, identified each facility would have a representative responsible or the provision of social services. The policy indicated residents and their families had mental and psychosocial needs and social services staff must be able to identify the needs and implement effective interventions. The policy identified social services role to include monitoring of behavioral monitoring and interventions and to be part of review on high risk residents. | F 745 | | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility had an 8% percent medication error rate for 1 of 5 residents( R23) observed during morning medication administration. | F 759 | 1. Nurses educated on the correct policy and procedure for medication administration.<br>2. All resident's have the potential to be affected. Audit done on medication's to | 6/16/23 |

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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 |
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| F 759 | Continued From page 93<br>Findings Include:<br><br>R23's quarterly Minimum Data Set (MDS) dated 4/26/23, identified R23 was cognitively intact and had diagnoses which included: hypertension, fibromyalgia (musculoskeletal pain disorder), depression, and anxiety.<br><br>R23's Order Summary Report signed 5/15/23, identified the following:<br>-calcium-Vitamin D tablet 600-400 milligram (mg)-unit. Give one tablet by mouth one time a day for supplement, start date 1/6/23<br>-fluticasone (steroid) -umeclidinium (anticholinergic-used to block involuntary muscle movement ) -vilanterol (bronchodialtor-relaxes muscles around airways) aerosol powder breath activated 100-62.5-25 microgram one puff inhale orally one time a day related to chronic obstructive pulmonary disease, start date 2/21/23.<br><br>On 5/10/23, at 8:03 a.m. licensed practical nurse (LPN)-G stood in R23's doorway while she set up R23's medications on the medication cart, which included oral pills, a nasal spray and an inhaler. At 8:12 a.m. LPN-G entered R23's room, informed her of the medications, handed R23 the paper cup of pills and set the nasal spray and inhaler on the bedside table. R23 took her oral medications with water, and R23 administered her nasal spray and inhaler. LPN-G reminded R23 to swish and spit after her inhaler, which R23 completed. LPN-G sanitized her hands and placed the inhaler and nasal spray back in the medication cart.<br><br>LPN-G administered R23 12 medications during the observation, which included: | F 759 | ensure orders are being followed correctly<br>3. Staff retrained on medication administration, Carts were audited to ensure proper medications for each patient.<br>4. DON or designee will audit medication administration weekly x 4 weeks, monthly x 3 months, results will be presented at QAPI.<br>5. 6/16/23 | |

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| F 759 | Continued From page 94<br>- calcium 500 mg plus vitamin D3 600 international unit (IU), one tablet.<br>-Trelegy (inhaled medication to prevent inflammation)-fluticasone 200 microgram (mcg) / umeclidinium 62.5 mcg/vilanterol 25 mcg, one puff.<br><br>During an interview on 5/10/23, at 9:09 a.m. LPN-G indicated she was aware the calcium plus Vitamin D 3 medication dosage was different then R23's order and stated it was a stock medication. LPN-G stated nurse practitioner (NP)-A should have been informed, however confirmed she had not informed NP-A. LPN-G indicated she was not aware the Trelegy had a different dosage than ordered. LPN-G stated she was not aware of the facility process in place if a medication error occurred and would leave notes for director of nursing (DON) when she discovered discrepancies.<br><br>During an interview on 5/11/23, at 12:03 p.m. director of nursing (DON) indicated she expected if a dosage of a medication did not match the order, the nursing staff were expected to clarify the order, and/or obtain a new label from pharmacy. DON stated she would expect this process to be followed to assure the resident received the correct dosage of medication.<br><br>During a phone interview on 5/11/23, at 12:52 p.m. pharmacy consultant (PC)-A confirmed her usual process included reviewing residents' orders with pharmacy records to determine if medications administrated matched current orders. PC-A indicated she was not aware R23's medications did not match the orders. PC-A stated her usual process included notifying the DON of any discrepancies were found and | F 759 | | |

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| F 759 | Continued From page 95<br>discussed findings at the facility Quality Assurance meeting. PC-A indicated she expected nursing staff to assure medications were administered correctly using the rights of medication administration.<br><br>The facility policy titled Administering Medications dated 4/19, identified medications were administered in a safe and timely manner as prescribed. The policy identified if the dosage was believed to be inappropriate, the person preparing or administering the medication would contact the prescriber, the resident's attending physician or the medical director to discuss the concerns. | F 759 | | |
| F 804 SS=D | Nutritive Value/Appear, Palatable/Prefer Temp<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 2 of 3 residents (R13 and R25) reviewed for dining services.<br><br>Findings include:<br><br>R13's MDS indicated R13 had intact cognition | F 804 | 1. Food will be served on pre heated plates to R13 and R25 to ensure palatable and appetizing temperature.<br>2. Food will be served on pre heated plates to all patients to ensure palatable and appetizing temperature.<br>3. Test tray will be brought to nurse during service and temped to ensure food is being delivered at a proper temperature. | 6/16/23 |

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| F 804 | Continued From page 96<br>and was able to feed himself after staff set up his tray.<br><br>R25's MDS indicated R25 required limited assistance to eat.<br><br>During an interview on 5/8/23, at 4:17 p.m. R13 stated he enjoyed eating some of his meals in his room and indicated most of the time the hot food was not hot and the cold food was not cold by the time he received his tray.<br><br>During an interview on 5/8/23, at 1:58 p.m. R25 stated he was able to feed himself and he preferred to eat most of his meals in his room. R25 indicated most of the time hot foods were not served hot and cold foods were not served cold.<br><br>On 5/9/23 at 12:36 p.m. dietary cook DC was observed serving potato salad which was positioned next to the steam table. The potato salad was in a plastic container which was in a cardboard box with no ice. The temperature of the potato salad was 60 degrees (F). DC continued to dish up potato salad and placed a total of five more bowls of potato salad on a cart of room trays to be served to residents. Additionally, there were already 10 trays on the cart.<br><br>On 5/9/23, at 12:42 P.M. 15 residents had been served the potato salad.<br><br>At 12:55 p.m. The cart which contained the potato salad was brought into the hallway and had already been served to four residents when state agency(SA) requested the remaining 10 trays be removed from the cart. | F 804 | 4. Food service director or designee will audit to ensure compliance, weekly x 4 weeks and monthly x 3 months. Results will be brought to QAPI.<br>6/16/23 | |

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| F 804 | Continued From page 97<br>During an interview on 5/9/23, at 1:09 p.m. R25 stated I only ate 25% of my potato salad today as it wasn't very cold.<br><br>During an interview on 5/9/23, at 1:50 p.m. DC stated she had removed the potato salad from the juice refrigerator at approximately 11:55 a.m. five minutes prior to the meal service. DC indicated she had not checked the temperature of the potato salad prior to meal service and was unaware she needed to check the temperature or place the potato salad on ice while serving.<br><br>During an interview on 5/10/23, at 11:58 a.m. dietary manager (DM) stated he was unaware the temperature of the potato salad had not been checked prior to being served. DM indicated his expectation would have been all food items would be temped prior to being served and at the end of meal service.<br><br>During an interview on 5/11/23, at 9:43 a.m. registered dietician (RD) indicated her expectation would have been staff to follow the facility regarding the preparation and storage of food while being served.<br><br>During an interview on 5/11/23, at 11:01 a.m. director of nursing (DON) stated she expected staff would have checked the temperature of food prior to meal service and cold items would have been placed on ice while being served.<br><br>A facility policy titled Food Temps and Storage Policy reviewed 6/28/22, indicated all cold food would have been held at a continuous temperature of 41 degrees F. or below and cold food needed to be placed on ice while being served. | F 804 | | |

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| F 804 | Continued From page 98 | F 804 | | |
| F 812 SS=F | .<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by: | F 812 | | 6/16/23 |

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| F 812 | Continued From page 99<br>Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential for development of foodborne illness. In addition, the facility failed to ensure proper glove use and hand washing techniques were used during food preparation in the kitchen. Furthermore, the facility failed to ensure food stored in the refrigerators, freezers and dry storage were labeled, dated and discarded properly and the food was stored and served at safe food temperatures. These deficient practices had the potential to affect all 35 residents who were served food and beverages from the kitchen.<br><br>Findings include:<br><br>During an initial tour of the kitchen with the dietary manager (DM) on 5/8/23, at 11:56 a.m. the following opened items were observed in the walk in refrigerator:<br>-approximately 20 slices of turkey sandwich meat without notation of a date with a green fuzzy substance covering it.<br>-approximately 20 slices of turkey sandwich meat dated 4/29/23.<br>-large container of mayonnaise with a date of 1/18/23.<br>-large container of tomato soup prepared with milk dated 4/2/23.<br>-1 cup of french dressing dated 1/17/23.<br>-large container of thousand island dressing dated 2/17/23.<br>-two large containers of vanilla icing dated 1/17/23.<br>-one half container of pork base dated 2/10/23.<br>-one cup of chicken base dated 2/13/23.<br>-one half large tub of butter undated. | F 812 | 1. All food stored in the refrigerator has been disposed of. Any outdated/undated items have been disposed of. Refrigerator has been repaired to function properly. Staff was educated on glove use and hand washing<br>2. All residents have the potential to be affected. The refrigerator was repaired and all new items have been dated and labeled. Staff was educated on glove use and hand hygiene<br>3. Alarm was added to refrigerator to notify staff if the temperature drops below acceptable levels.<br>4. Kitchen manager will audit compliance weekly x 4 weeks, monthly x 3 months and results will be brought to qapi<br>5. 6/16/23 | |

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| F 812 | Continued From page 100<br>-one large container of pickles undated.<br>-half container of dill relish dated 1/17/23.<br>-one container of enchilada sauce dated 3/7/23.<br>There were several pickle and pickle juice noted on the floor of the walk in cooler.<br><br>The following was observed in the juice refrigerator in the kitchen:<br>-Approximately four quarts of orange juice mixed from concentrate dated 4/28/23, which contained a white fuzzy substance on top of the juice and on the side of the container.<br>-large container of lemon juice dated 2/7/23.<br>-one fourth bottle of prune juice dated 1/20/23.<br><br>The following was observed in the pantry:<br>-three- fourths of a medium sized jar of salsa dated 1/13/23.<br><br>The following was observed on a break rack on the floor:<br>-six packages of bread opened undated.<br>-one package of buns which contained a green fuzzy substance on three of the buns undated.<br><br>The following was observed in the chest freezer:<br>-chest freezer was not sealing properly<br>-four bags of potatoes wedges open undated.<br><br>During a follow up tour of the kitchen on 5/9/23, at 9:34 with DM the walk in cooler felt warm and had a strong, rancid rotten odor. The thermometer in the cooler identified the internal temperature of the cooler was 60 degrees Fahrenheit (F). DM denied smelling any odors coming from the walk in cooler.<br><br>On 5/9/23, at 9:44 a.m. director of maintenance (DOM), identified an internal temperature of 66.7 | F 812 | | |

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| F 812 | Continued From page 101<br>degrees F in the walk in cooler. DOM and director of nursing (DON) verified there was an odor coming from the walk in cooler.<br><br>During an interview on 5/9/23, at 11:04 a.m. DON stated all the food from the walk in cooler had been thrown out and the refrigeration company had been contacted to service the walk in cooler.<br><br>During an observation of the lunch meal service on 5/9/2023, the following observations were noted:<br><br>At 12:20 p.m. dietary cook (DC) did not perform hand hygiene, used her bare hands to remove a bun from a plastic bag and placed the bun on a tray.<br><br>At 12:22 p.m. DC did not perform hand hygiene, used her bare hands to remove a bun from a plastic bag and placed the bun on a tray.<br><br>At 12:27 p.m. DC did not perform hand hygiene, used her bare hands to remove a bun from a plastic bag and placed the bun on a tray.<br><br>At 12:29 p.m. the above trays were placed on a cart to be delivered to residents.<br><br>At 12:32 p.m. DC did not perform hand hygiene, entered the kitchen and proceeded to remove two slices of bread out of a bag with her bare hands and made a peanut butter and jelly sandwich. She placed the sandwich in a Ziploc bag and delivered the sandwich to a resident.<br><br>On 5/9/23 at 12:36 p.m. dietary cook DC was observed serving potato salad which was positioned next to the steam table. The potato | F 812 | | |

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| F 812 | Continued From page 102<br>salad was in a plastic container which was in a cardboard box with no ice. The temperature of the potato salad was noted to be 60 degrees (F). DC continued to dish up potato salad and placed a total of five more bowls of potato salad on a cart of room trays to be served to residents. Additionally, there were already 10 trays on the cart.<br><br>At 12:42 p.m. approximately 15 residents had been served the potato salad.<br><br>At 12:55 p.m. The cart which contained the dinner rolls and the potato salad was brought into the hallway and had already been served to four residents when state agency(SA) requested the remaining 10 trays be removed from the cart.<br><br>On 5/9/23, at 1:36 p.m. a follow up visit to the kitchen revealed the walk in cooler was still not functioning and the food was still present. The following food temperatures were checked:<br>- An unopened container of potato salsa was 65 degrees F.<br>- open container of past sauce was 65 degrees F.<br>-turkey sandwich meat was 60 degrees F.<br>-container of tomato soup with a green substance on it was 60 degrees F.<br><br>During an interview on 5/9/23, at 1:11 p.m. refrigerator repairman (RR) confirmed there was a rancid odor in the walk in cooler and verified the cooler was not functioning properly. The RR stated based on his experience, he believed the walk in cooler had not been working properly for at least 24 hours and it was highly unlikely the cooler had just stopped working that morning.<br><br>During an interview on 5/9/23, at 1:50 p.m. DC | F 812 | | |

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| F 812 | Continued From page 103<br>stated she had removed the potato salad from the juice refrigerator at approximately 11:55 a.m. five minutes prior to the meal service. DC indicated she had not checked the temperature of the potato salad prior to meal service and she was unaware she needed to check the temperature or place the potato salad on ice while serving. DC confirmed she not sanitized hands and had not worn gloves while placing the buns on the tray when serving lunch. DC stated someone had told her it was not necessary to complete hand hygiene prior to dishing up food or wear gloves while touching residents' food.<br><br>During an interview on 5/10/23 at 11:58 a.m. DM confirmed the above findings. DM stated he was not certain when items should have been discarded and believed it was about five days. DM stated several of the items in the walk in cooler including the moldy sandwich meat should have been discarded. DM was unable to verify the last time any of the expired or moldy food items had been served to a resident. DM stated all food items should have been temped prior to serving to the residents and toward the end of meal service. DM indicated he expected staff to temp the food prior to service and to remove outdated and moldy food items from the coolers and refrigerators per the facility policy. DM stated he expected staff to perform hand hygiene and wear gloves when handling resident food.<br><br>During an interview on 5/11/23, at 9:43 a.m. registered dietician (RD) indicated it was the responsibility of the DM to oversee the storage of food and food prep. DM stated it had been a few weeks since she was in the walk in cooler, juice refrigerator, or pantry. DM indicated she had not been aware of the outdated or moldy food in the | F 812 | | |

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| F 812 | Continued From page 104<br>walk in cooler, juice refrigerator, or panty. DM stated she expected staff to follow the facility policy regarding the storage of food and food prep.<br><br>During an interview on 5/11/23, at 11:01 a.m. director of nursing (DON) confirmed the walk in cooler had an odor on 5/9/23, and the temperature of 60 degrees F. DON stated she expected staff to promptly dispose of outdated and moldy food. DON indicated she expected staff to discarded immediately when the walk in cooler was determined to not be functioning. DON stated she expected staff to temp food prior to meal service and cold items to be placed on ice. DON stated she expected all staff serving food to perform hand hygiene and wear gloves when handling resident food.<br><br>A facility policy titled Food Temps and Storage Policy reviewed 6/28/22, indicated all refrigerated food would have been stored at 41 degrees F in such a manner as to avoid spoilage and contamination. The policy indicated all food stored in the refrigerator would have been tabled, dated, and monitored daily for expiration dates or "use by"dates and outdated items discarded immediately. The policy identified all cold food would have been held at a continuous temperature of 41 degrees F. or below and cold foods needed to be placed on ice while being served. | F 812 | | |
| F 865 SS=F | QAPI Prgm/Plan, Disclosure/Good Faith Attmpt<br>CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)<br><br>§483.75(a) Quality assurance and performance improvement (QAPI) program.<br>Each LTC facility, including a facility that is part of | F 865 | | 6/16/23 |

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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 |
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| F 865 | Continued From page 105<br>a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:<br><br>§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;<br><br>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;<br><br>§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and<br><br>§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.<br><br>§483.75(b) Program design and scope.<br>A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: | F 865 | | |

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| F 865 | Continued From page 106<br><br>§483.75(b)(1) Address all systems of care and management practices;<br><br>§483.75(b)(2) Include clinical care, quality of life, and resident choice;<br><br>§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.<br><br>§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.<br><br>§483.75(f) Governance and leadership.<br>The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:<br><br>§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.<br><br>§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;<br>§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;<br><br>§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance | F 865 | | |

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| F 865 | Continued From page 107<br>indicator data, and resident and staff input, and other information.<br><br>§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and<br><br>§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.<br><br>§483.75(h) Disclosure of information.<br>A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>§483.75(i) Sanctions.<br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities, develop and implement appropriate plans of action to correct repeated quality deficiencies identified during the survey the facility was aware of or should have been aware of which had the potential to adversely affect all 35 residents which resided in the facility.<br><br>Findings include:<br><br>During an interview on 5/11/23, at 1:01 p.m. the director of nursing (DON) identified the quality nurse educator was fully responsible for the QAPI committee and projects the facility was working on. She indicated the quality nurse was | F 865 | 1. All repeat citations have been added to QAPI.<br>2. All repeat citations have been reviewed to ensure that they are being QAPI'd as required.<br>3. QAPI nurse will review all repeat citations and concerns as they arise and will be added to QAPI meeting accordingly.<br>4. QAPI Nurse will audit all citations and concerns weekly x 4 weeks and monthly x 3 months and will present results at QAPI.<br>5. 6/16/23 | |

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| F 865 | Continued From page 108<br>responsible for implementing and monitoring the overall QAPI process.<br><br>During an interview on 5/11/23, at 1:05 p.m. the quality nurse identified she had been in her position for two months and had held two QAPI meetings with the QA committee, in March and April of 2023. She indicated the facility was currently working on various actions items which she identified as projects during a facility walk-through and included dumpster lids, oxygen tubing, sling audits and dishwasher logs. Quality nurse stated she was not aware of a formal system in place to identify quality of life/quality of care concerns, implement QAPI projects, monitor compliance and evaluate the effectiveness of the projects. Quality nurse indicated the facility was currently looking at trends with falls, and ensuring dressing changes were completed for residents with pressure ulcers. She confirmed the facility's QA process did not include metrics for ensuring accurate, thorough assessments, and care planned interventions were routinely completed/implemented. Quality Nurse confirmed the facility had no QAPI system in place for the following current and previously identified, quality deficiencies:<br><br>- implementation of interventions for fall prevention.<br>- implementation of interventions for pressure ulcer healing/prevention.<br>- residents provided assistance with activities of daily living.<br>- residents rights.<br>- sanitary kitchen/dining services.<br>- accurate and thorough infection control surveillance, tracking and trending. | F 865 | | |

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| F 865 | Continued From page 109<br>Review of the facility form titled, QAPI, dated 4/19/23, revealed a QAPI Performance Improvement Plan (PIP) Log which identified the PIP items, date initiated, status and date resolved. The Log revealed the facility's current PIP projects included the following:<br><br>- nursing admission process, initiated 3/20/23, status for information finding.<br>- activities undated, gathering admission data.<br>- maintenance, undated, roof repair.<br>- dietary admission process, undated, diet orders.<br><br>The form identified the following QAPI Action Items of priority, required significant focus, and were initiated in February, 2023; oxygen tubing, urinal audit, sling audit, dishwasher log, dietary steam table, dumpster lids and gastric tube supplies.<br><br>The form identified a list of Quality Measures, identified percentage of residents with conditions which included, behavior, falls, incontinence, depression, pain, antipsychotics, vaccinations, weight loss and high risk pressure ulcers. The form did not identify the facility's plan for improvement in areas which were higher than average such as pain, infections and antipsychotic use.<br><br>The form listed Falls and tracked location, time and number of falls. However, the form lacked any analysis, trends or actions for fall assessment, prevention and implementation of interventions for these repeated deficiencies.<br><br>The form listed Acquired Pressure ulcers, however the form lacked any analysis, trends or actions for implementation of pressure ulcer | F 865 | | |

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| F 865 | Continued From page 110<br>interventions for these repeated deficiencies.<br><br>The facility's QA program lacked a process for reporting, investigation, in depth analysis, improvement activities, and action plans to address deficient practices. The facility lacked a system for documentation demonstrating the development, implementation and evaluation of corrective actions or performance improvement activities for identified, and repeated quality of life and quality of care deficiencies.<br><br>The facility lacked any QAPI action items or PIP's related to repeated deficiencies which include; implementation of interventions for pressure ulcers prevention/healing, falls, assisting residents with activities of daily living, ensuring and maintaining sanitary kitchen services, infection control surveillance, and ensuring resident rights were maintained.<br><br>Review of facility policy titled, QAPI program revised February 2020, identified the purpose of the policy was the facility should develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of outcomes of care and quality of life for the residents of the facility. The policy revealed interpretation and implementation objectives which would;<br>- provide means to measure current, potential indicators for outcomes of care an quality of life,<br>- provide means to establish and implement performance improvement projects to correct identified or problematic indicators,<br>-reinforce, build upon effective systems and processes related to the delivery of quality of care and services,<br>- establish systems through which to monitor and | F 865 | | |

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| F 865 | Continued From page 111<br>evaluate corrective actions.<br>The policy identified QAPI plan implementation process would include the following key components:<br>-tracking and measuring performance<br>- establishing goals and thresholds for performance improvement<br>- identifying and prioritizing quality deficiencies<br>- systemically analyzing underlying causes of systemic quality deficiencies<br>- developing and implementing corrective action/performance improvement activities, and<br>- monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. | F 865 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment | F 880 | | 6/16/23 |

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| F 880 | Continued From page 112<br>conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of | F 880 | | |

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| F 880 | Continued From page 113<br>infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to maintain an on-going infection control program, which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility, to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 35 residents who resided in the facility.<br><br>Findings include:<br><br>Review of the facility Infection Surveillance Monthly Report, dated February 2023, revealed the following:<br>-An overall Summary By Infection Category was listed at the beginning of the report which identified the type of infections and totals for each type.<br>-The log of each infection followed and identified the following headings: Residents listed in alphabetical order including their name, unit/room, infection onset, infection, signs & symptoms, status, pharmacy order-order name, order date, prescriber, and comments.<br>-For the month of January 2023; there were four infections identified; two were identified as unknown, one was cellulitis and one was candidiasis (a fungal infection caused by a yeast (a type of fungus) called Candida). One of the infections had no signs or symptoms listed. Three of the infections were treated with antibiotics and | F 880 | 1. Infection control log will be filled out to include all required information.<br>2. All resident's with infections can be affected by this practice. All patients with infections will be reviewed to ensure completion of information on infection control log.<br>3. Infection preventionist was educated on filling out log completely.<br>4. DON or designee will review infection control log to ensure completeness weekly x 4 weeks, monthly x 3 months and results will be presented at QAPI<br>5. 6/16/23 | |

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| F 880 | Continued From page 114<br>all infections were marked as closed/resolved.<br>-For the month of February 2023; there were 14 infections identified, two were urinary tract infections (UTI's), one was cellulitis and one was candidiasis. 10 of the infections were identified as unknown and no signs and symptoms were listed. 13 of the infections were treated with antibiotics and one was treated with an anti-fungal medication. 11 were marked as closed/resolved, two were marked as closed/discharged and one was marked as closed/deceased.<br>-For the month of March 2023; there were 12 infections identified, one was clostridium difficile ( a bacterium that causes an infection in the large intestine), four were cellulitis and one was a wound infection. Six of the infections were identified as unknown and one of those had no signs or symptoms listed. All of the infections were treated with antibiotics, nine were marked as closed/ resolved and three were marked as closed/discharged.<br>-For the month of April 2023, there were 14 infections identified, four UTI's, one was periodontitis ( a serious gum infection that damages the soft tissue around teeth), one was otitis media (ear infection), two were bronchitis, four were cellulitis, one was a wound infection and one was candidiasis. Four of the infections had no signs or symptoms identified. 12 of the infections were treated with antibiotics and two were treated with anti-fungal medications. All of them were marked as closed/resolved.<br><br>The facility's current surveillance log lacked necessary data which included; identification of all illnesses, identification of signs and symptoms for each infection, diagnostics performed, test dates, type of tests, specimen source, results of tests, antibiotic resistant organisms and time outs, | F 880 | | |

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| F 880 | Continued From page 115<br>(timeframe used after an antibiotic was initiated to assure appropriate use and effectiveness).<br><br>During this time frame, there were 17 of 44 resident entries which did not include signs and symptoms, however the entries included the onset dates and identified the infections had been resolved. In addition, there were 18 of 44 entries which indicated infections were identified as unknown. These entries did not include symptoms, however several identified treatment with antibiotics and resolved under the status area.<br><br>During an interview on 5/10/23, at 12:00 p.m. registered nurse infection preventionist (IP)-A stated she was responsible for overseeing the facility's infection control program and maintaining the facility's infection control surveillance log. IP-A confirmed the facility's current surveillance log lacked necessary data which included; identification of all illnesses, diagnostics performed, test dates, type of tests, specimen source, results of tests, antibiotic resistant organisms and time outs, (timeframe used after an antibiotic was initiated to assure appropriate use and effectiveness). In addition, IP-A confirmed the log had blank areas for some residents' infection types and residents' signs and symptoms. IP-A indicated some entries were made prior to her starting at the facility and confirmed she had made similar entries after she started her position when she was not certain what the infection or signs or symptoms were. IP-A stated she had not received training on the facility online program used for infection control surveillance and as a result was unable to complete all the necessary areas. IP-A indicated she had recently completed her IP training in | F 880 | | |

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| F 880 | Continued From page 116<br>March 2023, and stated she did not feel competent yet in overseeing the infection control surveillance program for the facility. If she was not aware of the symptoms she had entered unknown, or did not include any symptoms if she was unaware. In addition, the logs lacked documentation of what national criteria was used or followed prior to antibiotic use, to assure appropriate use of antibiotics. No outbreaks were noted.<br><br>During an interview on 5/11/23, at 11:48 a.m. DON stated the facility used the computer medical records program for the facility surveillance log. DON indicated IP-A was responsible for maintaining the surveillance log. DON stated she had not been aware the surveillance log lacked all the necessary components. DON indicated it was important to assure all necessary data was included to prevent infectious outbreaks in the facility.<br><br>The facility policy titled Surveillance For Infections, revised 9/17, identified the IP would conduct ongoing surveillance for healthcare-associated infections and other epidemiologically significant infections that had substantial impact on potential resident outcome and they may require transmission based precautions (TBP) and other preventative interventions. The policy further identified for residents with infections that met the criteria for surveillance, to collect the following data as appropriate: identifying information, diagnoses, infection site, pathogens, invasive procedures, and pertinent remarks. | F 880 | | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On 5/8/23, to 5/11/23, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 00938 | A. BUILDING: _____ B. WING _____ | C 05/11/2023 |

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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) COMPLETE DATE |
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| 2 000 | Continued From page 1<br>The following complaints were reviewed.<br><br>H50522094C (MN00090790), with a licensing order issued at 1545.<br>H50522098C (MN00092475), with a licensing order issued at 0900.<br>H50522093C (MN00090271), with a licensing order issued at 1100.<br>H50522097C (MN00091915), with a licensing order issued at 1805.<br>H50522096C (MN00091913), with a licensing order issued at 1805.<br><br>The following complaints were reviewed and no licensing orders issued.<br>H50522095C (MN00091652),<br>H50522099C (MN00093043),<br>H50522100C (MN00093044),<br>H50522101C (MN00093045).<br><br>Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. | 2 000 | | |

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| 2 000 | Continued From page 2<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |
| 2 255 | MN Rule 4658.0070 Quality Assessment and Assurance Committee<br><br>A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are | 2 255 | | 6/26/23 |

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| 2 255 | Continued From page 3<br><br>necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities, develop and implement appropriate plans of action to correct repeated quality deficiencies identified during the survey the facility was aware of or should have been aware of which had the potential to adversely affect all 35 residents which resided in the facility.<br><br>Findings include:<br><br>During an interview on 5/11/23, at 1:01 p.m. the director of nursing (DON) identified the quality nurse educator was fully responsible for the QAPI committee and projects the facility was working on. She indicated the quality nurse was responsible for implementing and monitoring the overall QAPI process.<br><br>During an interview on 5/11/23, at 1:05 p.m. the quality nurse identified she had been in her position for two months and had held two QAPI meetings with the QA committee, in March and April of 2023. She indicated the facility was currently working on various actions items which she identified as projects during a facility walk-through and included dumpster lids, oxygen tubing, sling audits and dishwasher logs. Quality nurse stated she was not aware of a formal system in place to identify quality of life/quality of | 2 255 | corrected | |

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| 2 255 | Continued From page 4<br><br>care concerns, implement QAPI projects, monitor compliance and evaluate the effectiveness of the projects. Quality nurse indicated the facility was currently looking at trends with falls, and ensuring dressing changes were completed for residents with pressure ulcers. She confirmed the facility's QA process did not include metrics for ensuring accurate, thorough assessments, and care planned interventions were routinely completed/implemented. Quality Nurse confirmed the facility had no QAPI system in place for the following current and previously identified, quality deficiencies:<br><br>- implementation of interventions for fall prevention.<br>- implementation of interventions for pressure ulcer healing/prevention.<br>- residents provided assistance with activities of daily living.<br>- residents rights.<br>- sanitary kitchen/dining services.<br>- accurate and thorough infection control surveillance, tracking and trending.<br><br>Review of the facility form titled, QAPI, dated 4/19/23, revealed a QAPI Performance Improvement Plan (PIP) Log which identified the PIP items, date initiated, status and date resolved. The Log revealed the facility's current PIP projects included the following:<br><br>- nursing admission process, initiated 3/20/23, status for information finding.<br>- activities undated, gathering admission data.<br>- maintenance, undated, roof repair.<br>- dietary admission process, undated, diet orders.<br><br>The form identified the following QAPI Action Items of priority, required significant focus, and | 2 255 | | |

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| 2 255 | Continued From page 5<br><br>were initiated in February, 2023; oxygen tubing, urinal audit, sling audit, dishwasher log, dietary steam table, dumpster lids and gastric tube supplies.<br><br>The form identified a list of Quality Measures, identified percentage of residents with conditions which included, behavior, falls, incontinence, depression, pain, antipsychotics, vaccinations, weight loss and high risk pressure ulcers. The form did not identify the facility's plan for improvement in areas which were higher than average such as pain, infections and antipsychotic use.<br><br>The form listed Falls and tracked location, time and number of falls. However, the form lacked any analysis, trends or actions for fall assessment, prevention and implementation of interventions for these repeated deficiencies.<br><br>The form listed Acquired Pressure ulcers, however the form lacked any analysis, trends or actions for implementation of pressure ulcer interventions for these repeated deficiencies.<br><br>The facility's QA program lacked a process for reporting, investigation, in depth analysis, improvement activities, and action plans to address deficient practices. The facility lacked a system for documentation demonstrating the development, implementation and evaluation of corrective actions or performance improvement activities for identified, and repeated quality of life and quality of care deficiencies.<br><br>The facility lacked any QAPI action items or PIP's related to repeated deficiencies which include; implementation of interventions for pressure ulcers prevention/healing, falls, assisting | 2 255 | | |

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| 2 255 | Continued From page 6<br><br>residents with activities of daily living, ensuring and maintaining sanitary kitchen services, infection control surveillance, and ensuring resident rights were maintained.<br><br>Review of facility policy titled, QAPI program revised February 2020, identified the purpose of the policy was the facility should develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of outcomes of care and quality of life for the residents of the facility. The policy revealed interpretation and implementation objectives which would;<br>- provide means to measure current, potential indicators for outcomes of care an quality of life,<br>- provide means to establish and implement performance improvement projects to correct identified or problematic indicators,<br>-reinforce, build upon effective systems and processes related to the delivery of quality of care and services,<br>- establish systems through which to monitor and evaluate corrective actions.<br>The policy identified QAPI plan implementation process would include the following key components:<br>-tracking and measuring performance<br>- establishing goals and thresholds for performance improvement<br>- identifying and prioritizing quality deficiencies<br>- systemically analyzing underlying causes of systemic quality deficiencies<br>- developing and implementing corrective action/performance improvement activities, and<br>- monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.<br><br>SUGGESTED METHOD OF CORRECTION: The | 2 255 | | |

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| 2 255 | Continued From page 7<br><br>quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these areas on a regular basis and make recommendations for any changes. The administrator will be responsible for implementation.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 255 | | |
| 2 685 | MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death<br><br>Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to complete a discharge summary with a recapitulation of stay, medication reconciliation, and discharge plan of care for 1 of 1 residents (R32) who was discharged home with services.<br><br>Findings include:<br><br>R32's admission Minimum Data Set (MDS) dated 2/8/23, indicated R32 had diagnoses which included hypertension, pneumonia, other inter-vertebral disc displacement of lumbo-sacral | 2 685 | corrected | 6/26/23 |

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| 2 685 | Continued From page 8<br><br>region and was cognitively intact. Identified R32 required supervision for activities of daily living (ADL's). Indicated a discharge plan for R32 was to return to the community and no referral was made to local contact agency.<br><br>Review of R32's Order Details dated 3/2/23, indicated R32 was to discharge home with home care for nursing, physical/occupational therapy to increase mobility and strength, follow up with primary care provider in two to three weeks and medication refill for 30 days with no refills.<br><br>Review of R32's Progress Notes from 2/2/23, to 3/9/23, revealed the following:<br>- on 2/7/23, R32 admitted from hospital, had been living independently in his apartment and the plans were to return to his apartment. R32 was cognitively intact, had no behaviors and had mild depression.<br><br>-on 2/26/23, R32 required staff assistance with transfers, bathing, used a wheel chair independently within facility and would inform staff when he needed assistance. R32 would be discharged home soon with assistance from his family.<br><br>-on 3/3/23, R32 would be discharged to his parents home where they can assist him, R32 was cognitively intact and had minimal symptoms of depression.<br><br>R32's medical record lacked documentation of a discharge summary, recapitulation of R32's stay, heath status, medication reconciliation of all pre/post discharge medications, and discharge plan of care had been completed at the time of discharge to ensure continuity of care. | 2 685 | | |

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| 2 685 | Continued From page 9<br><br>During a telephone interview on 5/10/23, at 1:01 p.m. the director of social services (DSS) indicated R32's discharge was planned and he had been discharged to his parent's place. The DSS stated the the nurse manager NM-A was responsible for obtaining the discharge orders from the provider and to ensure services were in place, and completed a recapitulation of the resident's stay in the medical record.<br><br>During an interview on 5/10/23, at 1:37 p.m. the NM-A confirmed the above findings and indicated the social worker would initiate the discharge process such as: discharge destination, medication refills needed and services/referrals needed. NM-A indicated nursing was responsible for completing the recapitulation of the resident's stay. confirmed the above findings and indicated the facility did not have a process in place for when residents were discharged. The NM-A stated she would expect staff to ensure the tasks were completed as needed for discharges.<br><br>During an interview on 5/10/23, at 2:17 p.m. the director of nursing (DON) confirmed the above findings and indicated nursing staff were responsible for completing a recapitulation/summary of the resident's stay at the nursing home. The DON indicated she would expect staff to follow through with the discharge process and to follow the facility policy.<br><br>Review of the facility policy titled, Transfer or Discharge Documentation undated, indicated when a resident was transferred or discharged, the reason for the transfer or discharge would be documented in the medical chart. The documentation must include: the reason, appropriate notice provided, date and time, location, mode of transportation, a summary of | 2 685 | | |

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| 2 685 | Continued From page 10<br>resident's overall medical, physical and mental condition, disposition of personal effects, disposition of medications and signature of person recording the data.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could review applicable policies and procedures to ensure the timely completion of a resident's discharge summary; then educate staff and audit to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 685 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to do a comprehensive assessment after a resident fell and received a major injury. Further, the facility failed to | 2 830 | corrected | 6/26/23 |

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| 2 830 | Continued From page 11<br><br>implement interventions to prevent further falls for 1 of 1 resident (R 25) who had a fall with a major injury.<br><br>Findings include:<br><br>R25 's admission Minimum Data Set (MDS), dated 3/15/23, identified R25 had diagnosis which included deep vein thrombus (blood clot in a deep vein), cerebral vascular accident (CVA) and chronic obstructive pulmonary disease (COPD). R25 had intact cognition and required extensive assistance with activities of daily living (ADL's) including bed mobility, transfers, and toileting. Indicated R25 had fallen in the past month.<br><br>R25's admission Care Area Assessment dated 3/23/23, identified R25 had changing cognitive status and had diagnosis which included Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA) (small strokes), and falls. Indicated R25 had impaired balance during transitions and was at an increased risk for falls.<br><br>Review of R25's most recent fall risk assessment dated 3/8/23, identified R25 was at moderate risk for falls related to prior falls and the need for assistive devices such as a cane or walker.<br><br>Review of R25's care plan revised 3/29/23, revealed R25 had limited mobility and required extensive assistance with transfers, and toileting. The care plan revealed R25 was at high risk for falls. R25's care plan listed interventions which included; bed in low position, encourage call light usage, and fall mat.<br><br>Review of R25's progress notes dated 3/22/23, at 10:10 a.m. revealed R25 was found lying on the floor near his bed in a left lateral recumbent | 2 830 | | |

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| 2 830 | Continued From page 12<br><br>position. R25 stated he had gotten up to go to the bathroom and his walker had gotten away from him. R25 complained of pain in his left clavicle and was sent to the emergency room (ER).<br><br>The progress note lacked documentation of a post-fall assessment and new interventions placed to prevent further falls.<br><br>Further review of R25's medical record lacked documentation a post-fall assessment had been completed to determine causative factors.<br><br>Review of R25's left shoulder X-ray dated 3/22/23, revealed R25 had a left clavicle fracture.<br><br>During an observation on 5/8/23, at 2:07 p.m. R25 was lying in bed and a fall mat was across the room placed up against the wall. R25's bed was not in a low position.<br><br>During an observation on 5/9/23, at 9:19 a.m. R25 was lying in bed and a fall mat continued to be across the room leaned up against the wall. R25's bed was not in low position.<br><br>During an interview on 5/9/23, at 9:20 p.m. R25 stated he had fallen a few months ago and fractured his shoulder. R25 stated a nurse came in a few days later and just threw a fall mat next to the bed and said it was for falls however no one discussed it with him. R25 indicated he asked a staff member to remove it the next day as his bedside table would not roll with the mat next to his bed. R25 stated no one had mentioned anything about his bed needing to be in a low position and stated "the staff are in complete control of the bed remote."<br><br>During an observation on 5/10/23, at 9:40 a.m. | 2 830 | | |

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| 2 830 | Continued From page 13<br><br>R25 was lying in bed and the fall mat continued to be across the room placed against the wall. R25's bed was not in a low position.<br><br>During an interview on 5/10/23, at 9:44 a.m. nursing assistant (NA)-A confirmed R25's fall mat was across the room against the wall and R25's bed was not in a low position. NA stated she was aware of R25's fall with a major injury and the interventions that were implemented after the fall which included the fall mat and the bed in low position. NA-A stated she thought the fall mat had been discontinued and was not sure why R25's bed was not in the low position.<br><br>During an interview on 5/10/23, at 10:37 a.m. licensed practical nurse (LPN)-C verified R25's fall mat was across the room and against the wall and R25's bed was not in low position. LPN-C stated she was unaware R25 had a fall with a major injury. LPN-C stated she was however, aware R25 was supposed to have a fall mat next to his bed but R25 did not like the fall mat. LPN-C stated she was unaware R25's bed was supposed to be in a low position.<br><br>During an interview on 5/11/23, at 11:01 a.m. director of nursing (DON) indicated she was aware of R25's fall with a major injury on 3/22/23. Don confirmed no comprehensive fall assessment had been completed after R25's fall with a major injury. DON stated her expectation would have been interventions would have been followed and a post fall assessment would have been completed after R25's fall with a major injury.<br><br>A facility policy titled Fall Prevention reviewed 5/18/22, identified a post fall assessment would have been completed after each fall and any | 2 830 | | |

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| 2 830 | Continued From page 14<br><br>interventions would have been noted on the form, on the residents care plan, care sheets, and the nurses notes.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) could Inservice staff to ensure that resident's have effective, individualized safety programs with appropriate assessed interventions and the programs are monitored for efficacy. Audits could be conducted to ensure that falls prevention programs are appropriately implemented, revised, and monitored. The results of the audits could be reported to quality assurance committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. | 2 900 | | 6/26/23 |

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| 2 900 | Continued From page 15<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure timely assistance with repositioning for 2 of 5 resident (R19, R14) with a history of pressure ulcers and at risk for further development of pressure ulcers. In addition, the facility failed to implement interventions for 1 of 5 residents (R14) who was at high risk for pressure ulcers.<br><br>Findings include:<br><br>R19's Significant Change In Status Assessment (SCSA) Minimum Data Set (MDS) dated 4/19/23, identified R19 had diagnoses which included heart failure, diabetes, renal insufficiency and was cognitively intact. Indicated R19 required extensive assistance of two staff for bed mobility and transfers. Identified R19 was at risk for the development of pressure ulcers and listed various treatments which included pressure ulcer treatment and application of ointments/medication.<br><br>R19's SCSA Care Area Assessment (CAA) dated 3/29/23, indicated R19 was at risk for developing pressure ulcers and required staff assistance with bed mobility. Identified R19 had maceration with moisture associated skin damage and was at risk for pressure ulcers related to incontinence, poor nutrition, chronic or end stage renal, liver, heart disease, diabetes, and immobility.<br><br>R19's Braden Scale for Predicting Pressure Sore Risk form, dated 5/2/23, identified R19 was at moderate risk for the development of pressure ulcers, skin was often very moist, was chair fast, had slightly limited mobility, probably inadequate nutrition and had a problem of friction and | 2 900 | corrected | |

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| 2 900 | Continued From page 16<br><br>shearing. The form indicated R19 was at risk for skin breakdown and required moderate to maximum assistance from staff for activities of daily living (ADL's), repositioning and mobility.<br><br>R19 ' s current care plan revised on 5/10/23, identified R19 had potential for pressure ulcer development related to history of ulcers, immobility and was dependent on staff for all cares. The care plan directed staff to turn and reposition at least every two hours, or more often as needed.<br><br>Review of the Aide Kardex dated 5/10/23, indicated R19 required staff assistance to turn and reposition at least every two hours or more often as needed or requested. The Kardex instructed staff to follow the facility's policies/procedures for the prevention/treatment of skin breakdown.<br><br>During observations on 5/10/23, at 7:10 a.m. R19 was seated in her brown recliner in her room, with her feet up on the footrest and was working on a cross word puzzle book.<br>-At 7:11 a.m. trained medication aid (TMA)-A entered R19's room and began making the bed. TMA-A donned a pair of gloves, grabbed the basin of water setting on R19's bedside table and emptied it in the bathroom. TMA-A removed the gait belt from around R19's waist, collected the dirty linen in a bag, immediately left R19's room and sanitized her hands, while R19 remained in her recliner.<br><br>- at 7:19 a.m. R19 continued to be seated in her recliner.<br><br>- at 8:01 a.m. R19 continued to be seated in her recliner. | 2 900 | | |

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| 2 900 | Continued From page 17<br><br>- at 8:15 a.m. R19 continued to be seated in her recliner.<br><br>- at 8:40 a.m. R19 continued to be seated in her recliner with her eyes closed, she was leaning slightly to the right and while resting.<br><br>- at 8:48 a.m. R19 continued to be seated in her recliner resting.<br><br>- at 8:57 a.m. R19 continued to be seated in her recliner resting and occasionally opening her eyes.<br><br>- at 9:02 a.m. R19 continued to be seated in her recliner.<br><br>-at 9:07 a.m. R19 staff entered R19's room, deliver her breakfast tray and placed on her bedside table in front of her. R19 began eating her breakfast independently while nursing assistant (NA)-C walked by her room.<br><br>- at 9:16 a.m. R19 continued to eat her breakfast independently in her room.<br><br>- at 9:21 a.m. R19 remained the same.<br><br>- at 9:38 a.m. R19 continued to be seated in her brown recliner, when nurse practitioner (NP)-A and nurse manager (NM)-A entered her room and told R19 it was Wednesday, and they were going to check her skin. The NP-A closed the door, and NP-A and NM-A proceeded to donn gloves on their hands and lifted up R19's abdominal fold. The area had no open areas and was reddish/pink in color. NP-A and NM-A then checked the skin under R19's breasts, no open areas noted with skin reddish/pink in color. NM-A | 2 900 | | |

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| 2 900 | Continued From page 18<br><br>retrieved R19's walker and placed it in front of her. NM-A placed a gait belt around R19 waist while she sat in her recliner, NM-A gathered her supplies and she counted to three and assisted R19 to stand while holding her walker. NM-A took a picture of R19's buttocks area and R19 began to get tired of standing and NP-A and NM-A assisted R19 to sit back in her recliner.<br><br>- at 9:47 a.m. NP-A and NM-A assisted R19 to a standing position while using her walker. R19's buttocks had no open areas, with dry flaky patches of skin and was reddish/pink in color. NM-A applied a wound adhesive (Cavilon no sting barrier film) and assisted R19 to sit back down in her recliner. NP-A and NM-A removed their gloves, sanitized their hands and made sure R19 was comfortable. NP-A gave R19 her call light, placed her bed side table next to her and NP-A and NM-A immediately left the room. R19 verified this was the first time she had been up out of her recliner since this morning.<br><br>R19 had not offered to reposition every two hours as directed by her care plan and was unable to reposition herself independently. R19 had not been repositioned for a total of 2 hours and 27 minutes and was at risk for pressure ulcers.<br><br>During an interview on 5/10/23, at 11:53 a.m. TMA-A confirmed R19 required staff assistance with her ADL's and was compliant with cares. TMA-A indicated she did not know the last time R19 had been repositioned and thought maybe it was when she had therapy sometime that morning. TMA-A indicated R19 was at risk for developing pressure ulcers and verified staff were to reposition R19 every two hours.<br><br>During an interview on 5/10/23, at 11:56 a.m. R19 | 2 900 | | |

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| 2 900 | Continued From page 19<br><br>confirmed she has had pressure ulcers in the past and staff assisted her with cares. R19 indicated staff had not been in to turn and reposition her since she had gotten up this morning. R19 stated she had rested until she received her breakfast tray and the nurse came in to assess her bottom.<br><br>During an interview on 5/10/23, at 1:45 p.m. NM-A confirmed R19 required staff assistance with her ADL's and was cognitively intact. NM-A indicated R19 was at risk for pressure ulcers and she would expect staff to follow her care plan and to reposition R19 every two hours. NM-A stated she did not know the last time R19 had been repositioned and had only come into R19's room to do her treatment to her buttocks. NM-A indicated she would expect staff to follow the facility policy for repositioning.<br><br>During an interview on 5/10/23, at 2:05 p.m. the director of nursing (DON) confirmed R19 required staff assistance with ADL's and was incontinent of bowel and bladder. The DON verified R19's care plan, verified she was at risk for pressure ulcers, and she would expect staff to turn and reposition R19 as per her schedule and to follow her care plan. The DON indicated R19 should have been repositioned every two hours.<br><br>R14's quarterly Minimum Data Set (MDS) dated 4/29/23, identified R14 was cognitively intact with diagnoses of diabetes, heart failure, and atrial fibrillation (chronic irregular heart beat). Indicated R14 required extensive assistance with bed mobility, transfers, toilet use, hygiene and dressing. R14 had no behaviors and was at risk for pressure ulcers, but had no current unhealed pressure ulcers. R14's pressure risk interventions identified included application of | 2 900 | | |

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| 2 900 | Continued From page 20<br>ointment/medication other than to feet.<br><br>R14's admission Care Area Assessment (CAA) dated 4/29/23, identified R14 was at risk for pressure ulcer development due to requiring extensive assistance with bed mobility, frequent incontinence of bowel and had scored at risk for development on nursing admission assessment. R14's CAA identified R14 was immobile, bed bound and was incontinent. Instructed staff to offer toileting and repositioning periodically. Licensed staff to do complete skin check weekly with bath/shower.<br><br>R14's Braden Scale For Predication Pressure Sore Risk Assessment dated 12/22/22, identified R14 had a score of 14, which indicated high risk for pressure sores.<br><br>R14's care plan revised 5/9/23, identified R14 had ADL's self care needs due to disease process. R14's interventions included extensive assistance with toilet use and transfers, and limited assistance with hygiene and dressing. R14 was identified to be independent with repositioning and turning in bed. R14's care plan identified R14 was at risk for pressure ulcer development related to immobility and disease process. R14's interventions included to follow facility policies/protocols for prevention/treatment of skin breakdown. R14's interventions instructed staff to offer resident assistance with turning. In addition, R14's care plan identified R14 had skin impairment to bilateral lower extremities related to edema and blisters, and interventions included staff to reposition every two to three hours.<br><br>R14's Order Summary Report signed 4/26/23, included the following orders:<br>-Prevalon boots (pressure relieving boots) every | 2 900 | | |

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| 2 900 | Continued From page 21<br><br>shift when in bed , start date 12/12/22.<br>-wash and apply barrier cream to buttocks and perineal area to protect skin from breakdown two times a day and as needed, for skin break down prevention with a start date of 8/29/22.<br>-weekly skin review on day shift every Saturday start date 7/30/22.<br><br>On 5/8/23, at 2:05 p.m. R14 was lying on his back in his bed, with his head of bed slightly elevated, wearing a hospital gown. R14 indicated he thought he had a pressure sore on his bottom, which he stated the nurses assessed at times. R14 stated he was supposed to be wearing Prevalon boots, which were not on his heels and lying in his recliner.<br><br>On 5/10/23, at 7:13 a.m. to 9:00 a.m. during continuous observations:<br>-7:13 a.m. R14's door was closed, NA-F entered room 304 with a lift.<br>-7:14 a.m. NA-C left a room across the hall from R14, then re-entered the same room. NA-F left room 304, walked past R14's room and walked away.<br>-7:17 a.m. NA-F returned to hallway and entered room 304 again. R14's door remained closed.<br>-7:24 a.m. surveyor knocked, then entered R14's room. R14 was lying on his back in his bed, gown on, covered with sheet and blanket, with his head of bed slightly raised. R14's bed side table was over his bed, and he was working on a word search book. R14 had his Prevalon boots on. R14 stated he was wearing his blue Prevalon boots, then stated he was able to move around in his bed at times. R14 informed surveyor staff had been in to assist him with cares a few hours ago.<br>-7:42 a.m. two staff members walked by R14's room, NA-C entered a room across the hall from R14's room. | 2 900 | | |

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| 2 900 | Continued From page 22<br><br>-9:00 a.m. NA-F entered R14's room, with his breakfast tray, which she set up on his bedside table. R14 used the bed controls and raised the head of his bed up to nearly 90 degrees and R14 began to eat his breakfast and remained on his back.<br><br>On 5/10/23, at 9:36 a.m. R14 remained in bed on his back, head of bed slightly elevated, continuing to work on his word search book. R14 informed surveyor no one had assisted him with repositioning, and stated he could only move himself around in bed somewhat. R14 stated his bottom was a "little sore" and agreed to have a nurse come in and assess it.<br><br>On 5/10/23, at 9:52 a.m. nurse manager NM-A and surveyor entered R14's room. NA-C was in R14's room and confirmed she had not been in R14's room yet that morning, and indicated she was going to assist him with incontinence cares. NA-C instructed R14 to turn to his left side, placed her right hand on his right side then back, while she assisted him to turn, and he used the grab bar to remain in position on his left side. NA-C used a wipe to cleanse R14's buttocks and indicated R14 was dry at that time. NM-A assessed R14's buttocks. NM-A stated R14's skin had no open areas, was blanchable, with scar tissue present, pink in color, over coccyx area. NM-A applied a new brief, removed his Prevalon boots, inspected his heels, which were noted to be intact, blanchable, with no redness. NM-A confirmed staff should have assisted R14 with repositioning every two hours as R14 was high risk for developing pressure ulcers and had a history of pressure ulcers. NM-A confirmed she expected R14's Prevalon boots to be on when R14 was in bed. R14 was lying on his back, with his head of bed slightly elevated, and NM-A | 2 900 | | |

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| 2 900 | Continued From page 23<br>applied a pillow under his knees.<br><br>R14 had not been offered to reposition every two hours as directed by his care plan and was unable to fully reposition himself independently. R19 had not been repositioned for greater than 2 hours and 36 minutes.<br><br>During an interview on 5/10/23, at 1:47 p.m. NA-C indicated she provided limited assistance to R14 for repositioning, however indicated R14 could move himself. NA-C stated R14 was to have his Prevalon boots on while in bed and to be repositioned every two hours. NA-C indicated she was responsible for R14's cares, confirmed she had not repositioned him prior to cares at 9:52 a.m. and stated she should have assisted him sooner.<br><br>During an interview on 5/10/23, at 2:35 p.m. LPN-G confirmed she had not assisted R14 to reposition that morning, and indicated she did not usually assist with repositioning the residents.<br><br>During an interview on 5/10/23, at 2:05 p.m. the director of nursing (DON) confirmed R19 required staff assistance with ADL's and was incontinent of bowel and bladder. The DON verified R19's care plan, verified she was at risk for pressure ulcers, and she would expect staff to turn and reposition R19 as per her schedule and to follow her care plan. The DON indicated R19 should have been repositioned every two hours.<br><br>During an interview on 5/11/23, at 11:58 a.m. director of nursing (DON) indicated she would expect staff to follow care plan interventions, such as Prevalon boots and repositioning, to prevent skin breakdown for R14. | 2 900 | | |

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| 2 900 | Continued From page 24<br><br>Review of facility policy titled, repositioning undated, identified the facility was to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized call plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents.<br><br>The facility policy titled Pressure Ulcers-Skin Breakdown-Clinical Protocol dated 4/18, identified the nursing staff and practitioner would assess and document an individual's significant risk factors for development of pressure ulcers. The policy indicated the nurse would describe, document and report the following criteria which included; the residents mobility status, current treatments, including support surfaces and all active diagnoses. The physician would order pertinent would treatments, including pressure reduction surfaces, and help identify medical interventions.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents to determine if at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 2 900 | | |

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

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| 2 920 | Continued From page 25 | 2 920 | | |
| 2 920 | MN Rule 4658.0525 Subp. 6 B Rehab - ADLs<br><br>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide assistance with facial hair removal for 1 of 1 resident (R3) who was dependent on staff for activities of daily living (ADL's) and requested to be clean shaven.<br><br>Findings include<br><br>R3's quarterly Minimum Data Set (MDS) dated 4/13/23, identified R3 had diagnoses which included cancer, blindness, and difficulty walking. R3 was cognitively intact and required extensive assistance with ADL's, which included dressing, personal hygiene and bathing. R3 had no refusals of care during the assessment period.<br><br>R3's Significant Change of Status Assessment (SCSA) MDS dated 1/11/23, identified R3 had diagnoses which included cancer, blindness, and difficulty walking. R3 was cognitively intact and required extensive assistance with ADL's, which included dressing, personal hygiene and bathing. R3 had no refusals of care during the assessment period.<br><br>R3's SCSA Care Area Assessment (CAA) 1/11/23, identified R3 was cognitively intact, had | 2 920 | corrected | 6/26/23 |

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| 2 920 | Continued From page 26<br><br>severely impaired vision, and required assistance with ADL's of dressing, personal hygiene and bathing. R3 was able to verbalize his needs, required verbal cues due to visual impairment.<br><br>R3's care plan revised 4/12/23, identified R3 had impaired vision, required assistance of one staff with dressing, personal hygiene and bathing. R3's care plan revealed he preferred to be clean shaven, staff were to offer assistance with shaving three times weekly and as needed in the morning.<br><br>R3's nursing assistant (NA) care guide printed 5/11/23, revealed R3 required extensive assistance with dressing and preferred to be clean shaven.<br><br>During an observation on 5/8/23, at 4:52 p.m. R3 was seated at a table alone in the dining room in an armed chair, he wore a pair of bleach stained sweat pants, a gait belt was around his waist and his walker was positioned to his left side. R3's cheeks, chin, upper lip were covered with white, thick, course stubble approximately five (5) to six (6) millimeter (mm) long and his neck was covered with thick, white course hair approximate 10-12 mm long. At that time, nursing assistant (NA)-B approached R3, leaned towards him, and took his order for the evening meal.<br><br>-at 6:00 p.m. R3 had remained seated in the dining room, at that time, NA-I approached asked if he was ready to go back to his room, which he accepted, donned the gait belt around R3's waist and walked with him back to his room. R3 sat on the side of his bed as NA-I placed his call light within his reach and left his room. R3's cheeks, chin, upper lip were covered with white, thick, course stubble approximately 5-6 mm long, and | 2 920 | | |

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| 2 920 | Continued From page 27<br><br>his neck remained covered with thick, course, white facial hair approximately 10-12 mm long.<br><br>During an observation on 5/9/23, at 12:22 p.m. R3 was seated in a chair alone at a table in the dining room. R3's cheeks, chin, upper lip continued to be with covered with white, thick, course stubble approximately 5-6 mm long, and his neck remained covered with thick, course, white facial hair approximately 10-12 mm long.<br><br>-at 12:38 p.m. R3 remained seated in a wheelchair at a table in the dining room, had eaten a few bites of his food, at that time, nursing assistant (NA)-C approached R3, offered to walk him him back to his room, she donned a gait belt, assisted him to stand with a front wheeled walker and proceeded to assist R3 back to his room. NA-C assisted R3 onto a wheelchair, wheeled him next to his bed, provided his call light and left the room. R3 remained unshaved.<br><br>During an observation on 5/10/23, at 7:12 a.m. R3 was lying in bed, his mouth was opened, his eyes were closed, he was covered with a blanket from his feet to his upper chest. R3's cheeks, chin, upper lip continued to be with covered with white, thick, course stubble approximately 5-6 mm long, and his neck remained covered with thick, course, white facial hair approximately 10-12 mm long.<br><br>-at 7:21 a.m. R3 was seated in a wheelchair next to his bed, at that time NA-A obtained a wash basin, washed his face and proceeded to shave R3's face, neck and upper lip. NA-A stated she felt R3 had not been shaved since the weekend when she had shaved him last. NA-A was unable to remove all of R3's facial hair, indicated she would have to shave him again after he eats his | 2 920 | | |

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| 2 920 | Continued From page 28<br><br>breakfast. NA-A stated R3 preferred to be clean shaven and he did not refuse cares.<br><br>During an interview on 5/9/23, at 9:51 a.m. R3 stated he typically liked to be clean shaven, however he felt he had no control over what the facility staff did with him and did not complain as some of the staff were not always nice. R3 frowned, his forehead was furrowed, he placed his head in his hands, shook his head and indicated he no longer wished to talk about the facility.<br><br>R3 declined a subsequent attempt at a follow up interview.<br><br>During an interview on 5/10/23, at 11:14 a.m. NA-C stated R3 required extensive assistance with dressing, grooming and did not typically voice his needs or wishes. NA-C indicated she was not aware what R3's preferences for shaving were, however indicated she would look at his care plan.<br><br>During an follow up interview on 5/10/23, at 12:18 p.m. (NA)-A stated R3 required extensive assistance with dressing, bathing and personal hygiene. She indicated R3 was blind and was not able to see himself, but would feel his face with his hands to check to see if he was shaved. NA-A indicated she worried about R3 when she was not working as she felt he was overlooked by some of the staff. NA-A indicated she felt R3 would not say anything if something was bothering him, nor would he ask for help with shaving.<br><br>During an interview on 5/11/23, at 9:45 a.m. the director of nursing (DON) confirmed R3 was blind, did not typically voice his needs or wishes, and required assistance dressing, and grooming, | 2 920 | | |

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| 2 920 | Continued From page 29<br><br>which included shaving. She confirmed R3's care plan identified he preferred to be clean shaven. The DON stated she expected R3 to be clean shaven and staff to follow his care plan.<br><br>A facility policy titled, Activities of Daily Living reviewed 4/2/18, identified it was the purpose of the policy to preserve ADL function, promote independence and increase self esteem and dignity. The policy identified residents who required assistance with ADL's including grooming, would be assisted per their plan of care.<br><br>An undated facility policy titled, Shaving the Resident identified it was the purpose of the policy to promote cleanliness and to provide skin care. The policy revealed a step by step procedure for shaving a resident which included reviewing the residents care plan to identify his/her shaving needs/preferences.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to activities of daily living. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing assistance with activities of daily living.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 2 920 | | |
| 21015 | MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi<br><br>Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in | 21015 | | 6/26/23 |

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| 21015 | Continued From page 30<br>the operation of the dietary department at all times.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential for development of foodborne illness. In addition, the facility failed to ensure proper glove use and hand washing techniques were used during food preparation in the kitchen. Furthermore, the facility failed to ensure food stored in the refrigerators, freezers and dry storage were labeled, dated and discarded properly and the food was stored and served at safe food temperatures. These deficient practices had the potential to affect all 35 residents who were served food and beverages from the kitchen.<br><br>Findings include:<br><br>During an initial tour of the kitchen with the dietary manager (DM) on 5/8/23, at 11:56 a.m. the following opened items were observed in the walk in refrigerator:<br>-approximately 20 slices of turkey sandwich meat without notation of a date with a green fuzzy substance covering it.<br>-approximately 20 slices of turkey sandwich meat dated 4/29/23.<br>-large container of mayonnaise with a date of 1/18/23.<br>-large container of tomato soup prepared with milk dated 4/2/23.<br>-1 cup of french dressing dated 1/17/23.<br>-large container of thousand island dressing dated 2/17/23. | 21015 | corrected | |

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| 21015 | Continued From page 31<br><br>-two large containers of vanilla icing dated 1/17/23.<br>-one half container of pork base dated 2/10/23.<br>-one cup of chicken base dated 2/13/23.<br>-one half large tub of butter undated.<br>-one large container of pickles undated.<br>-half container of dill relish dated 1/17/23.<br>-one container of enchilada sauce dated 3/7/23.<br>There were several pickle and pickle juice noted on the floor of the walk in cooler.<br><br>The following was observed in the juice refrigerator in the kitchen:<br>-Approximately four quarts of orange juice mixed from concentrate dated 4/28/23, which contained a white fuzzy substance on top of the juice and on the side of the container.<br>-large container of lemon juice dated 2/7/23.<br>-one fourth bottle of prune juice dated 1/20/23.<br><br>The following was observed in the pantry:<br>-three- fourths of a medium sized jar of salsa dated 1/13/23.<br><br>The following was observed on a break rack on the floor:<br>-six packages of bread opened undated.<br>-one package of buns which contained a green fuzzy substance on three of the buns undated.<br><br>The following was observed in the chest freezer:<br>-chest freezer was not sealing properly<br>-four bags of potatoes wedges open undated.<br><br>During a follow up tour of the kitchen on 5/9/23, at 9:34 with DM the walk in cooler felt warm and had a strong, rancid rotten odor. The thermometer in the cooler identified the internal temperature of the cooler was 60 degrees Fahrenheit (F). DM denied smelling any odors coming from the walk | 21015 | | |

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| 21015 | Continued From page 32<br>in cooler.<br><br>On 5/9/23, at 9:44 a.m. director of maintenance (DOM), identified an internal temperature of 66.7 degrees F in the walk in cooler. DOM and director of nursing (DON) verified there was an odor coming from the walk in cooler.<br><br>During an interview on 5/9/23, at 11:04 a.m. DON stated all the food from the walk in cooler had been thrown out and the refrigeration company had been contacted to service the walk in cooler.<br><br>During an observation of the lunch meal service on 5/9/2023, the following observations were noted:<br><br>At 12:20 p.m. dietary cook (DC) did not perform hand hygiene, used her bare hands to remove a bun from a plastic bag and placed the bun on a tray.<br><br>At 12:22 p.m. DC did not perform hand hygiene, used her bare hands to remove a bun from a plastic bag and placed the bun on a tray.<br><br>At 12:27 p.m. DC did not perform hand hygiene, used her bare hands to remove a bun from a plastic bag and placed the bun on a tray.<br><br>At 12:29 p.m. the above trays were placed on a cart to be delivered to residents.<br><br>At 12:32 p.m. DC did not perform hand hygiene, entered the kitchen and proceeded to remove two slices of bread out of a bag with her bare hands and made a peanut butter and jelly sandwich. She placed the sandwich in a Ziploc bag and delivered the sandwich to a resident. | 21015 | | |

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| 21015 | Continued From page 33<br><br>On 5/9/23 at 12:36 p.m. dietary cook DC was observed serving potato salad which was positioned next to the steam table. The potato salad was in a plastic container which was in a cardboard box with no ice. The temperature of the potato salad was noted to be 60 degrees (F). DC continued to dish up potato salad and placed a total of five more bowls of potato salad on a cart of room trays to be served to residents. Additionally, there were already 10 trays on the cart.<br><br>At 12:42 p.m. approximately 15 residents had been served the potato salad.<br><br>At 12:55 p.m. The cart which contained the dinner rolls and the potato salad was brought into the hallway and had already been served to four residents when state agency(SA) requested the remaining 10 trays be removed from the cart.<br><br>On 5/9/23, at 1:36 p.m. a follow up visit to the kitchen revealed the walk in cooler was still not functioning and the food was still present. The following food temperatures were checked:<br>- An unopened container of potato salsa was 65 degrees F.<br>- open container of past sauce was 65 degrees F.<br>-turkey sandwich meat was 60 degrees F.<br>-container of tomato soup with a green substance on it was 60 degrees F.<br><br>During an interview on 5/9/23, at 1:11 p.m. refrigerator repairman (RR) confirmed there was a rancid odor in the walk in cooler and verified the cooler was not functioning properly. The RR stated based on his experience, he believed the walk in cooler had not been working properly for at least 24 hours and it was highly unlikely the cooler had just stopped working that morning. | 21015 | | |

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| 21015 | Continued From page 34<br><br>During an interview on 5/9/23, at 1:50 p.m. DC stated she had removed the potato salad from the juice refrigerator at approximately 11:55 a.m. five minutes prior to the meal service. DC indicated she had not checked the temperature of the potato salad prior to meal service and she was unaware she needed to check the temperature or place the potato salad on ice while serving. DC confirmed she not sanitized hands and had not worn gloves while placing the buns on the tray when serving lunch. DC stated someone had told her it was not necessary to complete hand hygiene prior to dishing up food or wear gloves while touching residents' food.<br><br>During an interview on 5/10/23 at 11:58 a.m. DM confirmed the above findings. DM stated he was not certain when items should have been discarded and believed it was about five days. DM stated several of the items in the walk in cooler including the moldy sandwich meat should have been discarded. DM was unable to verify the last time any of the expired or moldy food items had been served to a resident. DM stated all food items should have been temped prior to serving to the residents and toward the end of meal service. DM indicated he expected staff to temp the food prior to service and to remove outdated and moldy food items from the coolers and refrigerators per the facility policy. DM stated he expected staff to perform hand hygiene and wear gloves when handling resident food.<br><br>During an interview on 5/11/23, at 9:43 a.m. registered dietician (RD) indicated it was the responsibility of the DM to oversee the storage of food and food prep. DM stated it had been a few weeks since she was in the walk in cooler, juice refrigerator, or pantry. DM indicated she had not | 21015 | | |

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| 21015 | Continued From page 35<br><br>been aware of the outdated or moldy food in the walk in cooler, juice refrigerator, or panty. DM stated she expected staff to follow the facility policy regarding the storage of food and food prep.<br><br>During an interview on 5/11/23, at 11:01 a.m. director of nursing (DON) confirmed the walk in cooler had an odor on 5/9/23, and the temperature of 60 degrees F. DON stated she expected staff to promptly dispose of outdated and moldy food. DON indicated she expected staff to discarded immediately when the walk in cooler was determined to not be functioning. DON stated she expected staff to temp food prior to meal service and cold items to be placed on ice. DON stated she expected all staff serving food to perform hand hygiene and wear gloves when handling resident food.<br><br>A facility policy titled Food Temps and Storage Policy reviewed 6/28/22, indicated all refrigerated food would have been stored at 41 degrees F in such a manner as to avoid spoilage and contamination. The policy indicated all food stored in the refrigerator would have been tabled, dated, and monitored daily for expiration dates or "use by"dates and outdated items discarded immediately. The policy identified all cold food would have been held at a continuous temperature of 41 degrees F. or below and cold foods needed to be placed on ice while being served.<br><br>SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs. | 21015 | | |

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| 21015 | Continued From page 36<br><br>The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21015 | | |
| 21025 | MN Rule 4658.0615 Food Temperatures<br><br>Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 2 of 3 residents (R13 and R25) reviewed for dining services.<br><br>Findings include:<br><br>R13's MDS indicated R13 had intact cognition and was able to feed himself after staff set up his tray.<br><br>R25's MDS indicated R25 required limited assistance to eat. | 21025 | corrected | 6/26/23 |

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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) COMPLETE DATE |
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| 21025 | Continued From page 37<br><br>During an interview on 5/8/23, at 4:17 p.m. R13 stated he enjoyed eating some of his meals in his room and indicated most of the time the hot food was not hot and the cold food was not cold by the time he received his tray.<br><br>During an interview on 5/8/23, at 1:58 p.m. R25 stated he was able to feed himself and he preferred to eat most of his meals in his room. R25 indicated most of the time hot foods were not served hot and cold foods were not served cold.<br><br>On 5/9/23 at 12:36 p.m. dietary cook DC was observed serving potato salad which was positioned next to the steam table. The potato salad was in a plastic container which was in a cardboard box with no ice. The temperature of the potato salad was 60 degrees (F). DC continued to dish up potato salad and placed a total of five more bowls of potato salad on a cart of room trays to be served to residents. Additionally, there were already 10 trays on the cart.<br><br>On 5/9/23, at 12:42 P.M. 15 residents had been served the potato salad.<br><br>At 12:55 p.m. The cart which contained the potato salad was brought into the hallway and had already been served to four residents when state agency(SA) requested the remaining 10 trays be removed from the cart.<br><br>During an interview on 5/9/23, at 1:09 p.m. R25 stated I only ate 25% of my potato salad today as it wasn't very cold.<br><br>During an interview on 5/9/23, at 1:50 p.m. DC stated she had removed the potato salad from | 21025 | | |

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| 21025 | Continued From page 38<br><br>the juice refrigerator at approximately 11:55 a.m. five minutes prior to the meal service. DC indicated she had not checked the temperature of the potato salad prior to meal service and was unaware she needed to check the temperature or place the potato salad on ice while serving.<br><br>During an interview on 5/10/23, at 11:58 a.m. dietary manager (DM) stated he was unaware the temperature of the potato salad had not been checked prior to being served. DM indicated his expectation would have been all food items would be temped prior to being served and at the end of meal service.<br><br>During an interview on 5/11/23, at 9:43 a.m. registered dietician (RD) indicated her expectation would have been staff to follow the facility regarding the preparation and storage of food while being served.<br><br>During an interview on 5/11/23, at 11:01 a.m. director of nursing (DON) stated she expected staff would have checked the temperature of food prior to meal service and cold items would have been placed on ice while being served.<br><br>A facility policy titled Food Temps and Storage Policy reviewed 6/28/22, indicated all cold food would have been held at a continuous temperature of 41 degrees F. or below and cold food needed to be placed on ice while being served.<br><br>SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could inservice staff regarding proper holding procedures of foods for resident consumption, and audit for compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 21025 | | |

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| 21025 | Continued From page 39<br>(21) days. | 21025 | | |
| 21100 | MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food<br><br>Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential for development of foodborne illness. In addition, the facility failed to ensure proper glove use and hand washing techniques were used during food preparation in the kitchen. Furthermore, the facility failed to ensure food stored in the refrigerators, freezers and dry storage were labeled, dated and discarded properly and the food was stored and served at safe food temperatures. These deficient practices had the potential to affect all 35 residents who were served food and beverages from the kitchen.<br><br>Findings include:<br><br>During an initial tour of the kitchen with the dietary manager (DM) on 5/8/23, at 11:56 a.m. the following opened items were observed in the walk in refrigerator:<br>-approximately 20 slices of turkey sandwich meat without notation of a date with a green fuzzy substance covering it.<br>-approximately 20 slices of turkey sandwich meat | 21100 | corrected | 6/26/23 |

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| 21100 | Continued From page 40<br><br>dated 4/29/23.<br>-large container of mayonnaise with a date of 1/18/23.<br>-large container of tomato soup prepared with milk dated 4/2/23.<br>-1 cup of french dressing dated 1/17/23.<br>-large container of thousand island dressing dated 2/17/23.<br>-two large containers of vanilla icing dated 1/17/23.<br>-one half container of pork base dated 2/10/23.<br>-one cup of chicken base dated 2/13/23.<br>-one half large tub of butter undated.<br>-one large container of pickles undated.<br>-half container of dill relish dated 1/17/23.<br>-one container of enchilada sauce dated 3/7/23.<br>There were several pickle and pickle juice noted on the floor of the walk in cooler.<br><br>The following was observed in the juice refrigerator in the kitchen:<br>-Approximately four quarts of orange juice mixed from concentrate dated 4/28/23, which contained a white fuzzy substance on top of the juice and on the side of the container.<br>-large container of lemon juice dated 2/7/23.<br>-one fourth bottle of prune juice dated 1/20/23.<br><br>The following was observed in the pantry:<br>-three- fourths of a medium sized jar of salsa dated 1/13/23.<br><br>The following was observed on a break rack on the floor:<br>-six packages of bread opened undated.<br>-one package of buns which contained a green fuzzy substance on three of the buns undated.<br><br>The following was observed in the chest freezer:<br>-chest freezer was not sealing properly | 21100 | | |

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| 21100 | Continued From page 41<br>-four bags of potatoes wedges open undated.<br><br>During a follow up tour of the kitchen on 5/9/23, at 9:34 with DM the walk in cooler felt warm and had a strong, rancid rotten odor. The thermometer in the cooler identified the internal temperature of the cooler was 60 degrees Fahrenheit (F). DM denied smelling any odors coming from the walk in cooler.<br><br>On 5/9/23, at 9:44 a.m. director of maintenance (DOM), identified an internal temperature of 66.7 degrees F in the walk in cooler. DOM and director of nursing (DON) verified there was an odor coming from the walk in cooler.<br><br>During an interview on 5/9/23, at 11:04 a.m. DON stated all the food from the walk in cooler had been thrown out and the refrigeration company had been contacted to service the walk in cooler.<br><br>During an observation of the lunch meal service on 5/9/2023, the following observations were noted:<br><br>At 12:20 p.m. dietary cook (DC) did not perform hand hygiene, used her bare hands to remove a bun from a plastic bag and placed the bun on a tray.<br><br>At 12:22 p.m. DC did not perform hand hygiene, used her bare hands to remove a bun from a plastic bag and placed the bun on a tray.<br><br>At 12:27 p.m. DC did not perform hand hygiene, used her bare hands to remove a bun from a plastic bag and placed the bun on a tray.<br><br>At 12:29 p.m. the above trays were placed on a cart to be delivered to residents. | 21100 | | |

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| 21100 | Continued From page 42<br><br>At 12:32 p.m. DC did not perform hand hygiene, entered the kitchen and proceeded to remove two slices of bread out of a bag with her bare hands and made a peanut butter and jelly sandwich. She placed the sandwich in a Ziploc bag and delivered the sandwich to a resident.<br><br>On 5/9/23 at 12:36 p.m. dietary cook DC was observed serving potato salad which was positioned next to the steam table. The potato salad was in a plastic container which was in a cardboard box with no ice. The temperature of the potato salad was noted to be 60 degrees (F). DC continued to dish up potato salad and placed a total of five more bowls of potato salad on a cart of room trays to be served to residents. Additionally, there were already 10 trays on the cart.<br><br>At 12:42 p.m. approximately 15 residents had been served the potato salad.<br><br>At 12:55 p.m. The cart which contained the dinner rolls and the potato salad was brought into the hallway and had already been served to four residents when state agency(SA) requested the remaining 10 trays be removed from the cart.<br><br>On 5/9/23, at 1:36 p.m. a follow up visit to the kitchen revealed the walk in cooler was still not functioning and the food was still present. The following food temperatures were checked:<br>- An unopened container of potato salsa was 65 degrees F.<br>- open container of past sauce was 65 degrees F.<br>-turkey sandwich meat was 60 degrees F.<br>-container of tomato soup with a green substance on it was 60 degrees F. | 21100 | | |

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| 21100 | Continued From page 43<br><br>During an interview on 5/9/23, at 1:11 p.m. refrigerator repairman (RR) confirmed there was a rancid odor in the walk in cooler and verified the cooler was not functioning properly. The RR stated based on his experience, he believed the walk in cooler had not been working properly for at least 24 hours and it was highly unlikely the cooler had just stopped working that morning.<br><br>During an interview on 5/9/23, at 1:50 p.m. DC stated she had removed the potato salad from the juice refrigerator at approximately 11:55 a.m. five minutes prior to the meal service. DC indicated she had not checked the temperature of the potato salad prior to meal service and she was unaware she needed to check the temperature or place the potato salad on ice while serving. DC confirmed she not sanitized hands and had not worn gloves while placing the buns on the tray when serving lunch. DC stated someone had told her it was not necessary to complete hand hygiene prior to dishing up food or wear gloves while touching residents' food.<br><br>During an interview on 5/10/23 at 11:58 a.m. DM confirmed the above findings. DM stated he was not certain when items should have been discarded and believed it was about five days. DM stated several of the items in the walk in cooler including the moldy sandwich meat should have been discarded. DM was unable to verify the last time any of the expired or moldy food items had been served to a resident. DM stated all food items should have been temped prior to serving to the residents and toward the end of meal service. DM indicated he expected staff to temp the food prior to service and to remove outdated and moldy food items from the coolers and refrigerators per the facility policy. DM stated he expected staff to perform hand hygiene and | 21100 | | |

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| 21100 | Continued From page 44<br>wear gloves when handling resident food.<br><br>During an interview on 5/11/23, at 9:43 a.m. registered dietician (RD) indicated it was the responsibility of the DM to oversee the storage of food and food prep. DM stated it had been a few weeks since she was in the walk in cooler, juice refrigerator, or pantry. DM indicated she had not been aware of the outdated or moldy food in the walk in cooler, juice refrigerator, or panty. DM stated she expected staff to follow the facility policy regarding the storage of food and food prep.<br><br>During an interview on 5/11/23, at 11:01 a.m. director of nursing (DON) confirmed the walk in cooler had an odor on 5/9/23, and the temperature of 60 degrees F. DON stated she expected staff to promptly dispose of outdated and moldy food. DON indicated she expected staff to discarded immediately when the walk in cooler was determined to not be functioning. DON stated she expected staff to temp food prior to meal service and cold items to be placed on ice. DON stated she expected all staff serving food to perform hand hygiene and wear gloves when handling resident food.<br><br>A facility policy titled Food Temps and Storage Policy reviewed 6/28/22, indicated all refrigerated food would have been stored at 41 degrees F in such a manner as to avoid spoilage and contamination. The policy indicated all food stored in the refrigerator would have been tabled, dated, and monitored daily for expiration dates or "use by"dates and outdated items discarded immediately. The policy identified all cold food would have been held at a continuous temperature of 41 degrees F. or below and cold foods needed to be placed on ice while being | 21100 | | |

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| 21100 | Continued From page 45<br>served.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of dietary services or designee could development and implement policies and procedures to ensure food storage refrigerators were in proper working condition to prevent perishable foods from rotting. The director of dietary services or designee could educate staff on those policies, and then monitor the appropriate staff for adherence to the policies and procedures.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 21100 | | |
| 21375 | MN Rule 4658.0800 Subp. 1 Infection Control; Program<br><br>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to maintain an on-going infection control program, which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility, to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 35 residents who resided in the facility.<br><br>Findings include: | 21375 | corrected | 6/26/23 |

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| 21375 | Continued From page 46<br><br>Review of the facility Infection Surveillance Monthly Report, dated February 2023, revealed the following:<br>-An overall Summary By Infection Category was listed at the beginning of the report which identified the type of infections and totals for each type.<br>-The log of each infection followed and identified the following headings: Residents listed in alphabetical order including their name, unit/room, infection onset, infection, signs & symptoms, status, pharmacy order-order name, order date, prescriber, and comments.<br>-For the month of January 2023; there were four infections identified; two were identified as unknown, one was cellulitis and one was candidiasis (a fungal infection caused by a yeast (a type of fungus) called Candida). One of the infections had no signs or symptoms listed. Three of the infections were treated with antibiotics and all infections were marked as closed/resolved.<br>-For the month of February 2023; there were 14 infections identified, two were urinary tract infections (UTI's), one was cellulitis and one was candidiasis. 10 of the infections were identified as unknown and no signs and symptoms were listed. 13 of the infections were treated with antibiotics and one was treated with an anti-fungal medication. 11 were marked as closed/resolved, two were marked as closed/discharged and one was marked as closed/deceased.<br>-For the month of March 2023; there were 12 infections identified, one was clostridium difficile ( a bacterium that causes an infection in the large intestine), four were cellulitis and one was a wound infection. Six of the infections were identified as unknown and one of those had no signs or symptoms listed. All of the infections were treated with antibiotics, nine were marked as closed/ resolved and three were marked as | 21375 | | |

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| 21375 | Continued From page 47<br><br>closed/discharged.<br>-For the month of April 2023, there were 14 infections identified, four UTI's, one was periodontitis ( a serious gum infection that damages the soft tissue around teeth), one was otitis media (ear infection), two were bronchitis, four were cellulitis, one was a wound infection and one was candidiasis. Four of the infections had no signs or symptoms identified. 12 of the infections were treated with antibiotics and two were treated with anti-fungal medications. All of them were marked as closed/resolved.<br><br>The facility's current surveillance log lacked necessary data which included; identification of all illnesses, identification of signs and symptoms for each infection, diagnostics performed, test dates, type of tests, specimen source, results of tests, antibiotic resistant organisms and time outs, (timeframe used after an antibiotic was initiated to assure appropriate use and effectiveness).<br><br>During this time frame, there were 17 of 44 resident entries which did not include signs and symptoms, however the entries included the onset dates and identified the infections had been resolved. In addition, there were 18 of 44 entries which indicated infections were identified as unknown. These entries did not include symptoms, however several identified treatment with antibiotics and resolved under the status area.<br><br>During an interview on 5/10/23, at 12:00 p.m. registered nurse infection preventionist (IP)-A stated she was responsible for overseeing the facility's infection control program and maintaining the facility's infection control surveillance log. IP-A confirmed the facility's current surveillance log lacked necessary data | 21375 | | |

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| 21375 | Continued From page 48<br><br>which included; identification of all illnesses, diagnostics performed, test dates, type of tests, specimen source, results of tests, antibiotic resistant organisms and time outs, (timeframe used after an antibiotic was initiated to assure appropriate use and effectiveness). In addition, IP-A confirmed the log had blank areas for some residents' infection types and residents' signs and symptoms. IP-A indicated some entries were made prior to her starting at the facility and confirmed she had made similar entries after she started her position when she was not certain what the infection or signs or symptoms were. IP-A stated she had not received training on the facility online program used for infection control surveillance and as a result was unable to complete all the necessary areas. IP-A indicated she had recently completed her IP training in March 2023, and stated she did not feel competent yet in overseeing the infection control surveillance program for the facility. If she was not aware of the symptoms she had entered unknown, or did not include any symptoms if she was unaware. In addition, the logs lacked documentation of what national criteria was used or followed prior to antibiotic use, to assure appropriate use of antibiotics. No outbreaks were noted.<br><br>During an interview on 5/11/23, at 11:48 a.m. DON stated the facility used the computer medical records program for the facility surveillance log. DON indicated IP-A was responsible for maintaining the surveillance log. DON stated she had not been aware the surveillance log lacked all the necessary components. DON indicated it was important to assure all necessary data was included to prevent infectious outbreaks in the facility. | 21375 | | |

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| 21375 | Continued From page 49<br><br>The facility policy titled Surveillance For Infections, revised 9/17, identified the IP would conduct ongoing surveillance for healthcare-associated infections and other epidemiologically significant infections that had substantial impact on potential resident outcome and they may require transmission based precautions (TBP) and other preventative interventions. The policy further identified for residents with infections that met the criteria for surveillance, to collect the following data as appropriate: identifying information, diagnoses, infection site, pathogens, invasive procedures, and pertinent remarks.<br><br>SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all illnesses in the facility as well as an antibiotic stewardship program and that a facility assessment and plan are written. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed.<br><br>TIME PERIOD OF CORRECTION: Twenty-one (21) days. | 21375 | | |
| 21475 | MN Rule 4658.1005 Subp. 1 Social Services: General Requirements<br><br>Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, | 21475 | | 6/26/23 |

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| 21475 | Continued From page 50<br>substance abuse, or financial services.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to comprehensively assess, monitor and implement appropriate medically related social service interventions for 1 of 1 residents (R186) who made comments of suicidal ideation.<br><br>Findings Include:<br><br>R186's Admission Record identified R186 was admitted to the facility on 5/1/23, and had diagnoses which included unspecified dementia, nicotine dependence, bipolar disorder, major depressive disorder, claustrophobia.<br><br>R186's care plan dated 5/8/23, identified R186 had potential for ineffective coping related to reported history of traumatic events, with interventions which included encourage resident to resume normal activities and begin new ones, and provide a safe therapeutic environment where R186 could regain control as needed. R186's care plan identified R186 had a mood problem related to admission and interventions included: monitor/document/report as needed, any risk for harm to self, suicidal plan, past attempt at suicide, risky actions or intentionally harmed or tried to harm self.<br><br>R186's care plan did not identify he had thoughts he would be better off dead or further appropriate interventions.<br><br>R186's Social Service Admission assessment dated 5/5/23, identified R186 had bipolar disorder, personality disorders claustrophobia, | 21475 | corrected | |

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| 21475 | Continued From page 51<br><br>attention and concentration deficit, dementia and other behavioral disturbance, depression and insomnia. R186's assessment indicated R186 was cognitively intact and the assessment for trauma and post traumatic stress disorder (PTSD) was positive. R186's PHQ-09 (mood assessment) indicated a score of 21, severe depressive disorder. R186's assessment summary identified R186 had thoughts he would be better off dead and no plan.<br><br>R186's PHQ-09 dated 5/5/23, identified R186 had a score of 21, severe depressive disorder. The assessment indicated R186 had thoughts he would be better off dead, or of hurting himself in some way, symptoms present, with no frequency identified.<br><br>R186's Social Service-Trauma Informed Care History assessment completed 5/5/23, identified R186 had been through life threatening or trauma as described as being homeless in Minneapolis. R186's assessment indicated nothing helped him get through those difficult times, and the question what are some things you do now to help you manage consequences of having gone through tough times was left blank. R186's assessment indicated R186 did not know of any particular triggers, that made it worse for him.<br><br>Review of R186's progress notes dated 5/1/23, to 5/11/23, identified the following:<br>-5/5/23, at 1:14 p.m. -social service admission note-R186's assessment for trauma and PTSD were positive. R186's PHQ-09 score was 21, which indicated severe depression symptoms with thoughts he would be better off dead but no plan.<br><br>R186's progress notes lacked further | 21475 | | |

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| 21475 | Continued From page 52<br><br>documentation R186's thoughts of better off dead had been addressed, interventions implemented or R186's provider had been contacted.<br><br>During an interview on 5/10/23, at 12:58 p.m. R186 confirmed he had attempted suicide in the past. R186 stated he had received help in the past regarding suicidal ideation. R186 informed surveyor he did not feel suicidal at that time, and felt he still had hope.<br><br>During a telephone interview on 5/10/23, at 2:33 p.m. social service designee (SSD)-A confirmed R186 had talked about suicide with her, however indicated he had no plan at that time. SSD-A indicated she had not asked him about a history of suicide attempts or thoughts, as that was not her department, however indicated she had referred him to nurse practitioner (NP)-A who would then refer him to the psychiatric NP. SSD-A stated she was not sure when she made the referral, as she had not documented it. SSD-A confirmed she had not initiated monitoring for R186 and stated her process was only to make the referral. SSD-A indicated she was not aware if NP-A had seen R186 since then.<br><br>During an interview on 5/10/23, at 3:08 p.m. NP-A confirmed she had been informed by SSD-A on 5/5/23, R186 had made comments about suicide and had thoughts about hurting himself. NP-A indicated R186 needed to be seen by the facility's psychiatric NP. NP-A stated she planned for R186 to be seen by herself and the psychiatric NP on 5/5/23, however he was at dialysis and she had left before he returned to the facility. NP-A confirmed she had not assessed R186 the day he made those comments, and if she would have, she would have sent him to the ER. NP-A stated she was not aware R186 had a history of suicidal | 21475 | | |

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| 21475 | Continued From page 53<br><br>attempts. NP-A stated her usual process if staff informed her a resident had suicidal ideation included to send them to the emergency room (ER) and for staff to complete 15 minute checks on them.<br><br>During an interview on 5/10/23, at 2:57 p.m. licensed practical nurse (LPN)-B indicated she had not been aware R186 had made any comments about suicide and had not seen him cry or sad. LPN-B indicated if she had been aware, she would ask if R186 had a plan and would report to the nurse and provider.<br><br>During an interview on 5/10/23, at 3:09 p.m. LPN-G stated she had not witnessed R186 exhibit any signs of crying, sadness or concerns of harming self. LPN-G indicated she had not been informed of R186 making suicidal comments, and was not aware of the process at the facility if someone had made such comments.<br><br>During an interview on 5/11/23, at 9:46 a.m. NA-H stated R186 had never made comments to him about harming himself. NA-H indicated he had never been informed R186 had made these comments, and would expect it to be discussed during report and the staff to be given instructions on what to do.<br><br>During an interview on 5/11/23, at 10:22 a.m. quality nurse-educator (QN)-A indicated she was aware the usual facility process if someone made comments of suicide or harming self, was to notify NP-A to assess the resident and then send the resident to the ER for evaluation. QN-A stated she had not been aware R186 had made any comments of suicide or harming self, and would expect R186 would have been evaluated by the psychiatric nurse or at the ER, and to | 21475 | | |

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| 21475 | Continued From page 54<br>follow their plan after the evaluation.<br><br>During a follow up interview on 5/11/23, at 10:49 a.m. SSD-A stated she had completed R186's assessments on 5/5/23, after he returned from dialysis. SSD-A indicated R186 had informed her he had thought about suicide in the past, had fleeting thoughts now and then, however did not have a current plan. SSD-A stated she thought she had informed NP-A in her office after her assessment of R186, however confirmed NP-A gave her no instructions. SSD-A indicated she did not report his thoughts of suicide to anyone else and stated the nurses and nursing assistants were able to read her progress note. SSD-A indicated if she felt suicide was imminent she would have informed director of nursing (DON). SSD-A confirmed no other social service interventions had been developed or implemented other than her referral to NP-A.<br><br>During interview on 5/11/23, at 11:55 a.m. DON confirmed she had not been informed of R186's suicidal comments by SSD-A on 5/5/23. DON stated she did not become aware of the comments until 5/10/23, after R186 had been seen by NP-A. DON stated she would have expected the concern to be addressed immediately per facility policy.<br><br>The facility policy titled Suicide Threats, dated 12/07, identified staff shall report any resident threats of suicide immediately to the nurse supervisor/charge nurse. The supervisor/charge nurse would immediately assess the situation and would notify the charge nurse/supervisor and or director of nursing services of such threats. A staff member would remain with the resident until the nurse supervisor/charge nurse arrived to evaluate the resident. After assessing the | 21475 | | |

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| 21475 | Continued From page 55<br><br>resident in more detail the nurse supervisor/charge nurse would notify the resident's attending physician and responsible party and would seek further direction from the physician. The policy further identified all nursing personnel and other staff involved in caring for the resident would be informed of the suicide threat and instructed to report changes in there resident's behavior immediately. As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. If the resident remained in the facility, staff would monitor the resident's mood and behavior and update care plans accordingly, unit a physician had determined that a risk of suicide did not appear to be present. Staff would document the details of the situation objectively in the resident's record.<br><br>The facility policy titled Social Services dated 3/28/18, identified each facility would have a representative responsible or the provision of social services. The policy indicated residents and their families had mental and psychosocial needs and social services staff must be able to identify the needs and implement effective interventions. The policy identified social services role to include monitoring of behavioral monitoring and interventions and to be part of review on high risk residents.<br><br>SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review and/or revise facility policies and procedures related to medically related social services. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward supporting the social service needs of the individual(s) identified in the deficiency, with supporting documentation maintained. Other | 21475 | | |

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| 21475 | Continued From page 56<br><br>residents could be evaluated for social service needs. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 21475 | | |
| 21545 | MN Rule 4658.1320 A.B.C Medication Errors<br><br>A nursing home must ensure that:<br>A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:<br>(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or<br>(2) the administration of expired medications.<br>B. It is free of any significant medication error. A significant medication error is:<br>(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or<br>(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or | 21545 | | 6/26/23 |

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| 21545 | Continued From page 57<br><br>resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br>C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility had an 8% percent medication error rate for 1 of 5 residents( R23) observed during morning medication administration.<br><br>Findings Include:<br><br>R23's quarterly Minimum Data Set (MDS) dated 4/26/23, identified R23 was cognitively intact and had diagnoses which included: hypertension, fibromyalgia (musculoskeletal pain disorder), depression, and anxiety.<br><br>R23's Order Summary Report signed 5/15/23, identified the following:<br>-calcium-Vitamin D tablet 600-400 milligram (mg)-unit. Give one tablet by mouth one time a day for supplement, start date 1/6/23<br>-fluticasone (steroid) -umeclidinium (anticholinergic-used to block involuntary muscle movement ) -vilanterol (bronchodialtor-relaxes | 21545 | corrected | |

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| 21545 | Continued From page 58<br><br>muscles around airways) aerosol powder breath activated 100-62.5-25 microgram one puff inhale orally one time a day related to chronic obstructive pulmonary disease, start date 2/21/23.<br><br>On 5/10/23, at 8:03 a.m. licensed practical nurse (LPN)-G stood in R23's doorway while she set up R23's medications on the medication cart, which included oral pills, a nasal spray and an inhaler. At 8:12 a.m. LPN-G entered R23's room, informed her of the medications, handed R23 the paper cup of pills and set the nasal spray and inhaler on the bedside table. R23 took her oral medications with water, and R23 administered her nasal spray and inhaler. LPN-G reminded R23 to swish and spit after her inhaler, which R23 completed. LPN-G sanitized her hands and placed the inhaler and nasal spray back in the medication cart.<br><br>LPN-G administered R23 12 medications during the observation, which included:<br>- calcium 500 mg plus vitamin D3 600 international unit (IU), one tablet.<br>-Trelegy (inhaled medication to prevent inflammation)-fluticasone 200 microgram (mcg) / umeclidinium 62.5 mcg/vilanterol 25 mcg, one puff.<br><br>During an interview on 5/10/23, at 9:09 a.m. LPN-G indicated she was aware the calcium plus Vitamin D 3 medication dosage was different then R23's order and stated it was a stock medication. LPN-G stated nurse practitioner (NP)-A should have been informed, however confirmed she had not informed NP-A. LPN-G indicated she was not aware the Trelegy had a different dosage than ordered. LPN-G stated she was not aware of the facility process in place if a medication error | 21545 | | |

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| 21545 | Continued From page 59<br><br>occurred and would leave notes for director of nursing (DON) when she discovered discrepancies.<br><br>During an interview on 5/11/23, at 12:03 p.m. director of nursing (DON) indicated she expected if a dosage of a medication did not match the order, the nursing staff were expected to clarify the order, and/or obtain a new label from pharmacy. DON stated she would expect this process to be followed to assure the resident received the correct dosage of medication.<br><br>During a phone interview on 5/11/23, at 12:52 p.m. pharmacy consultant (PC)-A confirmed her usual process included reviewing residents' orders with pharmacy records to determine if medications administrated matched current orders. PC-A indicated she was not aware R23's medications did not match the orders. PC-A stated her usual process included notifying the DON of any discrepancies were found and discussed findings at the facility Quality Assurance meeting. PC-A indicated she expected nursing staff to assure medications were administered correctly using the rights of medication administration.<br><br>The facility policy titled Administering Medications dated 4/19, identified medications were administered in a safe and timely manner as prescribed. The policy identified if the dosage was believed to be inappropriate, the person preparing or administering the medication would contact the prescriber, the resident's attending physician or the medical director to discuss the concerns.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could | 21545 | | |

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| 21545 | Continued From page 60<br><br>review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 21545 | | |
| 21695 | MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance<br><br>Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure housekeeping services and a clean environment were provided for 2 of 2 residents (R13) who had soiled wheelchair cushions without a cover and (R 29) whose bathroom toilet seat was visibly soiled.<br><br>Findings include:<br><br>R13's quarterly Minimum Data Set (MDS) dated 4/25/23, identified R13 was cognitively intact and had diagnosis which included: hypertension (elevated blood pressure) (HTN), anxiety disorder and depression. Identified R13 required supervision with activities of daily living (ADL's) | 21695 | corrected | 6/26/23 |

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| 21695 | Continued From page 61<br><br>which included bed mobility, transfers, and toileting.<br><br>R13's care plan revised 9/29/22, identified R13 had ADL deficits and required extensive assistance with cares and transfers. R13's interventions identified staff assistance in all areas of ADL's with set up assistance for eating.<br><br>R29's admission MDS dated 4/25/23, identified R29 had moderate cognitive impairment and had diagnosis which included: cancer, HTN, and hyperlipidemia (elevated cholesterol). R29 required supervision with ADL's which included bed mobility, transfers, and toileting.<br><br>R29's care plan revised 4/20/23, identified R29 had ADL deficits and required limited assistance in all areas of ADL's with the exception of R29 being independent with eating.<br><br>On 5/8/23, at 4:11 p.m. R13 was lying in bed and his wheelchair was positioned next to his bed and had two cushions which were both visibly soiled with large white and brown stains and neither cushion had a cover on it. R13 stated he would prefer the cushions had covers on them so they were easier to wash.<br><br>On 5/8/23, at 1:42 R29's toilet seat in her bathroom was noted to have a thick, brown substance on the back and right side of the seat.<br><br>During an interview on 5/8/23, at 8:41 p.m. family member (FM)-A stated R29 would not have appreciated sitting on a dirty toilet seat.<br><br>On 5/9/23, at 9:29 a.m. R29's toilet seat continued to have a thick, brown substance on the back and right side of the seat. | 21695 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MOORHEAD RESTORATIVE CARE CENTER | 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 |

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| 21695 | Continued From page 62<br><br>On 5/10/23, at 7:16 a.m. R29's toilet seat continued to have a thick, brown substance on the back and the right side of the seat.<br><br>On 5/10/23, at 8:01 housekeeper (H)-A confirmed there was a brown, thick substance on R29's toilet seat. H-A indicated all bathrooms were supposed to be cleaned on a daily basis and when visibly soiled. H-A verified it had been a few days since R29's bathroom had been cleaned.<br><br>During an interview on 5/10/23, therapy director (TD) stated she was responsible for resident's wheelchair cushions. TD verified R13's cushions in his wheelchair were visibly soiled and did not have a cover on them. TD stated she was unsure why R13's cushions in his wheelchair were not covered. TD stated her expectation would have been all wheelchair cushions would have been covered so they were able to be cleaned.<br><br>During an interview on 5/11/23, at 11:01 a.m. director of nursing (DON) stated her expectation would have been all toilet seats were cleaned when visibly soiled and all wheelchair cushions would have had covers on them so they were easy to clean.<br><br>A facility policy titled Cleaning and Disinfection of Environmental Surfaces revised 10/17, identified environmental surfaces would have been cleaned on a regular basis e.g., daily, three times per week, or when visibly soiled.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to report timely environmental, personal equipment concerns so they can be addressed timely to provide a safe and sanitary environment | 21695 | | |

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| 21695 | Continued From page 63<br>for the residents, staff and visitors.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 21695 | | |
| 21800 | MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. | 21800 | | 6/26/23 |

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| 21800 | Continued From page 64<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the resident bill of rights (BOR) were provided verbally for residents of the facility. This deficient practice had the potential to affect all 35 residents residing in the facility.<br><br>Findings include;<br><br>On 5/9/23, at 1:57 p.m. four residents were present at a resident council meeting held by surveyors. When questioned if the residents' (BOR) had been reviewed, all four residents present stated they were not aware of their BOR, and were not aware of where to find them in the facility.<br><br>During an interview on 5/11/23, at 10:03 a.m. the activity director confirmed the residents' BOR had not been reviewed with the residents during resident council meetings. She indicated a copy of the residents' BOR were provided to them upon admission with their admission packet, however she was unaware if they had been verbally reviewed with the residents or their representative. The activity director indicated the BOR were posted in the activity room however were hidden behind several items.<br><br>Review of monthly resident council meeting minutes from January 2023, to April 2023, lacked any evidence the residents' BOR had been reviewed with residents.<br><br>Review of an undated facility policy titled, Resident Rights, identified federal and state laws guaranteed certain basic rights to all residents of the facility, and included the right to be informed | 21800 | corrected | |

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| 21800 | Continued From page 65<br>about what rights and responsibilities she/he had.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could educate staff on the process of providing resident's rights to newly admitted residents, and during the residents stay in and provided in a manner to which the residents can understand, i.e. The administrator or designee could then audit to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21800 | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to promote dignity while providing cares for 1 of 1 resident (R136) who required catheterization. Further, the facility failed to promote dignity while utilizing a gait belt for an extended period of time, for 1 of 1 resident (R3) reviewed for extended use of a gait belt. In addition, the facility failed to ensure a resident was treated in a dignified manner for 1 of 4 residents (R3) reviewed for dignified dining. Further, the facility failed to promote dignity by initiating unnecessary transmission based precautions (TBP) for 1 of 1 residents (R186) | 21805 | corrected | 6/26/23 |

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| 21805 | Continued From page 66<br><br>who was restricted from leaving his room and using the facility common areas.<br><br>Findings include:<br><br>R136's Admission Record dated 5/10/23, identified R136 had diagnoses which included: age related physical disability, acute respiratory failure with hypoxia, and neuromuscular dysfunction of the bladder unspecified.<br><br>R136's care plan revised on 5/9/23, indicated R136 was cognitively intact and required limited staff assistance with activities of daily living (ADL's) and staff were to meet his needs. Identified R136 would use a disposable catheter for straight cath himself independently while laying on the floor.<br><br>R136's Nursing Aid Kardex dated 5/10/23, indicated R136 required limited staff assistance with ADL's and staff were to meet his needs. Identified R136 would use a disposable catheter for straight cath himself independently while laying on the floor.<br><br>R136's Bowel and Bladder Program Screener dated 5/3/23, indicated R136 was alert/orientated, not aware of the need to toilet, never voided appropriately without incontinence and required staff assistance to bathroom/transfer to toilet/commode/urinal and adjust clothing and wipe.<br><br>R136's Order Summary Report dated 5/10/23, indicated R136 had an order to straight cath himself every four hours as needed for diagnosis of neurogenic bladder and nursing was to assist.<br><br>During observations on 5/10/23, at 7:24 a.m. | 21805 | | |

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| 21805 | Continued From page 67<br>R136's call light was on, office staff knocked on the door and R136 indicated he was ready to get up and get dressed. Office staff left the call light on and informed nursing assistant (NA)-C R136 wanted to get up.<br>- at 7:25 a.m. NA-A entered R136's room and he was seated on the edge of his bed. NA-C indicated she had to get something and immediately left the room. R136 indicated he had been at the facility for about five or six days and indicated he was not able to cath himself anywhere. R136 indicated he could not do it in the bathroom because it was too small and was not able to cath himself on his bed. R136 indicated he was pretty independent with most of his cares and had been able to empty his bladder.<br>- at 7:30 a.m. R136 continued to be seated on the edge of his bed already dressed, when NA-A re-entered his room. NA-A proceeded to wash her hands, donned gloves and assisted R136 to pick out his clothes for the day. NA-A asked R136 if he had washed up and R136 replied he had. NA-A assisted R136 to removed his shirt and to put on a clean one. NA-A asked R136 if he could lay down due to his shorts not being all the way up and he laid back on the bed and rolled side to side so she could pull his shorts up and applied suspenders to his shorts. During his time she had called for a nurse on her walkie to apply a new dressing to the back of his right leg.<br>- at 7:35 a.m. licensed practical nurse (LPN)-C entered R136 room, donned a pair of gloves, applied a dressing to the back of his right leg and immediately left the room. NA-A applied R136 braces to his legs and assisted R136 into his wheel chair and placed his feet on his foot peddles. NA-A told R136 she was going to have to change his shorts due to them being wet/soiled with urine. During this time, R136 asked NA-A if | 21805 | | |

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| 21805 | Continued From page 68<br><br>she could assist him with his cathing, NA-A told R136 she could not do that and called for LPN-C to assist R136 with cathing. R136 indicated he could not cath himself while he was in the bed and he got back into his bed and sat on the edge of the bed.<br>- at 7:44 a.m. NA-A called LPN-C again for assistance while she got a brief out of the drawer.<br>- at 7:45 LPN-C entered R136's room and indicated she had never catheterized R136 before and would have to ask another nurse to assist her. LPN-C left the room, while NA-A raised the bed to working level, asked R136 if he could lay down and he did. The entire front of R136's gray shorts were wet and soiled. NA-A removed R136's wet shorts, his wet underwear and removed his incontinent brief which was saturated with urine. NA-A placed a clean incontinent brief on R136 while he rolled side to side and indicated he did not know the last time he had catheterized himself. R136 indicated staff had come in early this morning and changed his brief when he was sleeping. NA-A assisted R136 to put clean underwear on and a pair of pants. NA-A asked R136 if his bladder felt full and he indicated he did not know. NA-A called for LPN-C again on the walkie talkie, lowered his bed and assisted R136 to put his shoes back on.<br>- at 7:53 a.m. NA-C entered R136's room asking NA-A if she needed help with a transfer and told NA-C R136 was waiting to get catheterized. NA-C and NA-A collected the garbage and the linen and NA-C left the room. R136 indicated he just wanted to get up.<br>- at 7:56 a.m. NA-A raised the head of the bed for R136, clipped his call light to his shirt and left the room to get LPN-C.<br>- at 7:57 a.m. R136 remained in bed and indicated he was to get catheterized every 3 to 4 hours. The quality nurse (QN) dropped off cathing | 21805 | | |

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| 21805 | Continued From page 69<br>supplies on the bed side table next to the door while she walked by. R136 had a very stern voice and stated he was very frustrated while he waited for staff to come and assist him.<br>- at 7:59 a.m. NA-A re-entered R136's room and informed him she was still looking for LPN-C. R136 stated he was upset as they were not coming to assist him.<br>- at 8:04 p.m. R136 continued to wait for the nurse to assist him with cathing, while the director of nursing (DON) walked by his room several times looking in his door.<br>- at 8:06 a.m. R136 continued to wait for staff assistance, when NA-A entered his room and informed R136 the DON said he catheterized himself. R136 stated back to NA-A "normally yes, but here I cannot in bed", and said, " lets get the show on the road."<br>- at 8:08 a.m. LPN-C entered R136's room, had him roll over to his belly and she applied a new dressing to the back of his right leg due to the other dressing falling off. R136 stated to the LPN-C in a very angry and frustrated voice "forget about the cathing" and LPN-C said, "they haven't come to do that yet." LPN-C stated "normally he catheterized himself and they brought the stuff for him (meaning cath supplies) on the table" and she immediately left the room. NA-A assisted R136 to his wheel chair and he asked for another shirt. NA-A assist R136 with putting on another shirt and he said in a frustrated voice, " forget it", while NA-A collected the linen.<br>- at 8:13 a.m. R136 wheeled himself out of his room via wheel chair propelling with his hands and into the dining room for breakfast.<br>- at 8:38 a.m. R136 was seated in his wheel chair in his room and indicated staff still had not come in to cath him and the cathing supplies remained on the bed side table by the door.<br>- at 8:53 a.m. R136 remained the same. | 21805 | | |

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| 21805 | Continued From page 70<br><br>- at 9:02 a.m. R136 remained the same.<br>- at 9:08 a.m. R136 waited in the hallway in his wheelchair waiting for LPN-C to give him his medications. His catheter supplies remained on the bedside table by the door.<br>-at 9:12 a.m. LPN-C administered R136 his medications and he took them independently with water. LPN-C did not offer to assist R136 to cath as he continued to wait.<br>- at 9:21 a.m. R136 wheeled himself independently around the nursing home using his hands and his cath supplies remained on the table next to the door in his room.<br>- at 9:30 a.m. R136 was seated in his wheel chair in his room looking around. At 9:31 a.m. R136 indicated staff still had not assisted him with cathing and stated in a stern voice, "I don't know what happened to the supplies." R136 had a slight odor of urine noted.<br>- at 10:00 a.m. R136 remained the same and still had not been assisted with cathing.<br><br>During an interview on 5/10/23, at 9:25 a.m. NA-A confirmed staff assisted R136 with his ADL's and indicated R136 was incontinent of bowel and bladder. NA-A stated she had not seen R136 cath himself before and he had asked for assistance with it today. NA-A indicated R136 would refuse incontinent cares once in while, however staff were able to redirect him and he usually was compliant with the cares after that. NA-A stated nursing staff still had not assisted R136 with being catheterized.<br><br>During an interview on 5/10/23, at 12:02 p.m. LPN-C confirmed staff assisted R136 with ADL's and indicated he would normally cath himself. LPN-C indicated she was confused that morning since she had never assisted R136 with cathing and was not comfortable competing the task as | 21805 | | |

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| 21805 | Continued From page 71<br><br>she had never cathed R136 before. LPN-C said she had asked the QN to assist R136 and went back to passing her morning medications. LPN-C verified she had not assisted R136 that morning with cathing and neither did the QN. LPN-C indicated R136 had "kicked the DON out of his room" when she entered his room as he was upset he had asked for assistance and did not receive the help he requested. LPN-C stated it was not dignified for R136 to become incontinent in his brief while he waited for assistance from staff. LPN-C indicated the residents should be treated with dignity and verified R136 had not been assisted as he requested.<br><br>During an interview on 5/10/23, at 12:17 p.m. the QN confirmed the above findings and indicated R136 required staff assistance with some of his ADL's. The QN confirmed she had not assisted R136 to cath as she was not aware he required assistance. The QN indicated she had entered R136's room when he was in the dining room and she left the catheter supplies on his bedside table. The QN stated her expectation was for staff to assist R136 when he asked for assistance. The QN indicated staff disregarded R136 and it was not respectful or dignified for staff not so assist him as he had requested.<br><br>During an interview on 5/11/23, at 9:10 a.m. R136 indicated yesterday when he asked for help with cathing he was becoming angry and upset. R136 indicated he becomes very impatient when he has to wait a long time for assistance and verified a nurse finally came in, talked with him and assisted him however was not sure what time that was.<br><br>The Centers for Disease Control and Prevention (CDC) Interim Infection Control And Prevention | 21805 | | |

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| 21805 | Continued From page 72<br><br>Recommendations For Healthcare Personal During The Coronavirus Disease 2019 (COVID-19) Pandemic dated 9/23/22, identified empiric use of (TBP) was generally not implemented for admissions or for residents who left the facility for less than 24 hours, and did not meet the criteria for empiric TBP.<br><br>R186's medical record identified R186 was admitted to the facility on 5/1/23, and had diagnoses which included unspecified dementia, nicotine dependence, bipolar disorder, major depressive disorder, and claustrophobia.<br><br>R186's care plan dated 5/8/23, identified R186 had potential for ineffective coping related to reported history of traumatic events, with interventions that included encourage resident to resume normal activities and begin new ones, and provide a safe therapeutic environment where R186 could regain control as needed. Indicated R186 required extensive assistance of one staff for dressing, toilet use and transfers. Identified R186 had potential for ineffective coping related to history of traumatic events with interventions to encourage R186 to resume normal activities and begin new ones and provide a safe therapeutic environment where he could regain control as needed. Instructed staff to ask to attend activities of his choice.<br><br>R186's Order Summary Report dated 5/15/23, identified the following order:<br><br>-COVID Isolation times 10 days due to unvaccinated status, every shift for 10 Days. Start date 5/1/23, end date 5/11/23.<br><br>On 5/8/23, at 12:26 p.m. R186's door was closed, with two signs on his door; one identified | 21805 | | |

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| | 00938 | A. BUILDING: _____ B. WING _____ | C 05/11/2023 |

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

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| 21805 | Continued From page 73<br><br>droplet precautions, and the other instructed to report to the nurse before entering the room. There was a plastic two drawer bin next to his door labeled isolation, with personal protective equipment (PPE) inside the drawers.<br><br>On 5/9/23, at 9:20 a.m. R186's door was closed, and the signage and plastic drawer bin with PPE remained outside his door.<br><br>During an interview on 5/10/23, at 12:44 p.m. registered nurse infection preventionist (IP)-A stated TBP were initiated on residents newly admitted to the facility based on their vaccination status. IP-A indicated she was not aware of the current CDC guidelines for new admissions to the facility or what the facility policy instructed. IP-A and surveyor reviewed the facility policy titled Coronavirus Disease (COVID-19)-Testing residents, revised 9/22. IP-A verified the policy identified empiric use of TBP was generally not implemented for admissions or for residents who left the facility for less than 24 hours, and did not meet criteria for empiric TBP. IP-A stated the facility currently had three residents on TBP only due to their vaccination status and newly admitted.<br><br>On 5/10/23, at 12:58 p.m. IP-A entered R186's room and informed him he could be out of isolation now. R186 stated "thank God!" After IP-A left the room, R186 stated he had felt like he ,"was in prison", and stated he had a history of being in prison and jail and it brought back old feelings to him. R186 indicated he had post traumatic stress disorder. R186 stated when he was on TBP it made him feel like he could not breath, depressed, sad, and he felt like he had to fight to get out of there. R186 indicated he liked to socialize, so he would feel better now when he | 21805 | | |

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| 21805 | Continued From page 74<br>was able to leave his room.<br><br>During an interview on 5/10/23, at 12:32 p.m. the DON confirmed the above findings and indicated R136 was able to complete several tasks himself however still required some assistance from staff. The DON indicated she thought R136 was able to lay on the floor and self cath himself. The DON stated she was not impressed by what happened that morning and indicated her expectations would be for staff to assist F136 with cares as requested. The DON stated R136 had not been treated with respect or dignity that morning and would expect staff to follow the facility policy.<br><br>During an interview on 5/11/23, at 9:45 a.m. the DON confirmed R3 was blind, did not typically voice his needs or wishes, required assistance with ambulation, and locomotion in/out of the dining room. She indicated she would have expected staff to remove his gait belt once he was seated in the dining room. The DON indicated she expected staff to listen to R3 when he was speaking, and to inform R3 when the staff member walked away due to his inability to see. She indicated she would have expected staff to offer to bring R3 back to his room when he was done eating, or if they were unable due to helping other residents, she would have expected staff to let R3 know they would help him back to his room when they were able.<br><br>During an interview on 5/11/23, at 11:48 a.m. DON confirmed she was not aware of the CDC recommendations or the facility policy related to new admissions during COVID-19. After review, DON confirmed the facility did not follow CDC recommendations or the facility policy. DON stated it was important to not place a resident in TBP when it was not required, as the isolation | 21805 | | |

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| 21805 | Continued From page 75<br>could cause depression.<br><br>Review of facility policy titled, Quality of Life-Dignity undated, indicated each resident would have been cared for in a manner that promoted and enhanced quality of life, dignity, respect and individuality.<br><br>Review of a facility policy titled, Dignity of the Resident, reviewed 4/12/18, identified all residents would be treated in a manner and in an environment that maintained and enhanced residents dignity and respect in full recognition of his or her own individuality. The purpose of the policy identified treating residents with dignity and respect maintained and enhanced each residents self-worth and improved his/her psychosocial well-being and quality of life. Assuring resident is comfortable in the facility and treated like a person. The policy identified the following types of staff interactions with residents which maintained their dignity; promoting independence and dignity in dining, assisting residents with daily cares in a dignified manner, and focusing on a resident when they are speaking.<br><br>The facility policy titled Coronavirus Disease (COVID-19)-Testing Residents, dated 9/22, identified empiric use of transmission-based precautions was generally not implemented for admissions or for residents who left the facility for less than 24 hours and did not meet criteria for empiric TBP.<br><br>The facility policy titled Infection Control Policy and Procedure Manual dated 10/21/22, identified TBP should have the least restrictive possible for the resident based on his/her clinical assessment and used for the least amount of time, and once the resident was no longer at risk for transmitting | 21805 | | |

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| 21805 | Continued From page 76<br><br>the pathogen, removing TBP was required to avoid unnecessary involuntary seclusion. The policy identified boredom, anger, withdrawal and depression were just some of the mood changes that could occur.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement systems to ensure resident dignity is maintained. The facility could educate all staff on these systems. Random audits for dignity could be done to ensure ongoing compliance. The administrator or designee could take that audit results to the quality assurance group for review and further recommendations.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21805 | | |
| 21870 | MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to act promptly and respond timely on concerns brought up in the resident council for 4 of 4 residents (R13, R23, R17 and R12) who had attended resident council meetings in the facility.<br><br>Findings include: | 21870 | corrected | 6/26/23 |

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| 21870 | Continued From page 77<br><br>On 5/9/23, at 1:57 p.m. a resident council meeting was held with surveyors and four residents which included R13 who regularly attended meetings, R23 who had attended a few meetings, R17 who regularly attended , and R12 who was the resident council president. During the resident council meeting, residents expressed concerns with the facility when an item was brought to the staff's attention, there was not always a response provided as to why something could not be fixed, or changes made. Residents verbalized concerns with several areas of food service. The residents provided examples of food being cold when served, not being offered choices when they ate in their rooms, food not covered, staff touching their food/beverage tops, a lot of processed foods and poor taste. The residents indicated the facility had hired a new dietary manager and had hoped there would be changes noted in the future. R23, R13 and R17 indicated they ate in their rooms due to medical conditions and felt they should have been served the same food at the same temperature as the residents who ate in the dining room.<br><br>Review of resident council meeting minutes from January 2023, to April 2023, revealed the following;<br><br>- January 17, 2023, the form revealed eight residents attended the meeting, which included R12. The form identified the following food issues; food was always cold, residents asked for further variety such as pasta, ethnic foods such as Spanish beans/rice, soft shell tacos, waffles and eggs prepared in ways other than scrambled.<br><br>- March 1, 2023, the form revealed eight residents attended the meeting, with the activity director, dietary manager and activity aid present. | 21870 | | |

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| 21870 | Continued From page 78<br><br>The form revealed the DM reported changes in food service would be coming in the future and the residents voiced their suggestions on food items such as fresh fruit, ice cream, polish sausage and brats. The form did not review any specific concerns that were brought up in the prior meeting.<br><br>- March 21, 2023, the form revealed nine residents attended the meeting, with the activity director and the director of nursing present. The form revealed the following dietary concerns; not enough variety, getting the same foods repeatedly, specifically scrambled eggs, requests for ice cream, lighter lunches of soup, sandwiches and requested more butter be served with meals. The form revealed the DON had indicated the facility was working on menu rotation and having two options for meals. The form did not review any specific concerns that were brought up in the prior meeting.<br><br>- April 18, 2023, the form revealed 14 residents attended the meeting, with the activity director, quality nurse, occupational therapist and the dietary manager present. The form revealed the following dietary concerns; staff did not know how to cook, too much processed foods, residents requested more choices, snacks to be offered between meals, and food not being hot when it was delivered to resident rooms. The form revealed the dietary manager had indicated he would be making changes in the future and suggested residents come to the dining room "if they wanted a hot meal." The form did not review any specific concerns that were brought up in the prior meeting.<br><br>During an interview with the social service designee (SSD) she indicated she had no | 21870 | | |

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| 21870 | Continued From page 79<br><br>involvement with resident council and would follow up on resident concerns that were directed to her.<br><br>During an interview with the activity director on 5/11/23, at 10:03 a.m. she identified she arranged the facility's resident council meetings monthly and would attend with the residents. She indicated the residents had several concerns regarding dietary/food services at the facility and the concerns had been presented to the dietary manager. The director stated she would often bring in a representative of various disciplines to discuss concerns voiced by the residents. She indicated she had the DON, quality nurse and dietary manager attend the meeting to discuss resident concerns directly with the residents. She indicated any follow up would have been the responsibility of the discipline, such as food concerns would be addressed and any concerns followed up on by the dietary manager. She indicated at that time, the residents continued to have concerns with several areas of food services such as food being served cold (out of temperature) no variety, choices not offered, no fresh fruits and no seasonal foods.<br><br>Review of a facility policy titled Resident Council, revised February 2021, identified a resident council response form would be used for any concerns brought up in resident council, and would be addressed by the department responsible for the concern. The policy identified resident council concerns would be addressed with the facility quality assurance, performance improvement committee.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to | 21870 | | |

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| 21870 | Continued From page 80<br><br>ensure residents complaints and grievances are being addressed promptly. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) complaints and grievances are addressed on a timely basis. The results of these audits will be reviewed by the quality assessment committee to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days | 21870 | | |