DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 27, 2023

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

Re: Reinspection Results
Event ID: HG0812

Dear Administrator:

On January 18, 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 December 1, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2023

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

RE: CCN: 245052
Cycle Start Date: October 14, 2022

Dear Administrator:

On October 31, 2022, we notified you a remedy was imposed. On December 1, 2022 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 January 10, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 15, 2022 be discontinued as of January 10, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 31, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 14, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 16, 2022

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

RE: CCN: 245052
Cycle Start Date: October 14, 2022

Dear Administrator:

On October 31, 2022, we informed you of imposed enforcement remedies.

On December 1, 2022, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) , as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 15, 2022, will remain in effect.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 15, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 15, 2022.

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.

As we notified you in our letter of October 31, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 14, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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 April 14, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 16, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: HG0811

Dear Administrator:

The above facility was surveyed on November 28, 2022 through December 1, 2022 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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/28/22, to 12/1/22, 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. 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. 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 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		12/28/22

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

Electronically Signed | 12/26/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 12/01/2022

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

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E 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

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 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 2 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from	E 039		

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 12/01/2022

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

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E 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

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 12/01/2022

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

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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E 039	Continued From page 8 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 9 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to conduct a full-scale community based exercise yearly. In addition, the facility failed to analyze their response to the simulated table top based drill to test their emergency preparedness program yearly. This had the potential to affect all 39 residents currently residing in the facility. The findings include: The facility's "Emergency Preparedness" three ring binder included information regarding a simulated winter storm table top drill conducted on 10/25/22, however, lacked analysis of the facility's response to the drill. The binder lacked a full-scale community based exercise. During an interview on 12/01/22, at 10:45 a.m. the maintenance director (MD) confirmed the facility had completed a table top drill on 10/25/22, however, lacked analysis of the facility's response to the drill to determine if it had been effective. The MD verified the facility had not completed a full-scale community based drill due to not really knowing what to do. The MD indicated the facility was aware it was a requirement to complete a table top and full scale	E 039	1. It is the expectation of Moorhead Restorative Care Center that employees participate in community full scale exercise and tabletop exercise annually. It is the expectation that IDT reviews the findings of these exercises in a timely manner and educates staff if indicated. On 10/25/22 facility conducted a tabletop exercise but failed to analyze or educate based upon the findings. The IDT will conduct an after-action plan, by 12/28/23 with opportunities for improvement identified. A full-scale community exercise will be placed on the schedule for the annual exercise. 2. The deficient practice has the potential to impact all residents at the facility. Records were reviewed, and no residents were found to have negative outcomes related to any situations requiring use of the EP policy and procedure in the last year. Upon identification of this deficient practice, A full-scale community exercise will be placed on the schedule on an annual basis. 3. The policy entitled Emergency Preparedness Training Plan was reviewed	

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E 039	Continued From page 10 exercise on an annual basis. During an interview on 12/01/22, at 1:30 p.m. the administrator confirmed the facility had completed a simulated winter storm table top drill on 10/25/22, however, an analysis of the facility's response to the drill had not been completed. The administrator verified the facility had not completed a full-scale community based exercise and would have expected staff to complete the table top and full scale exercises every six months or annually. The administrator indicated he would expect staff to be educated on the results of the drills being completed. Review of facility policy titled, Emergency Preparedness Training Plan undated, indicated training would be completed on an annual basis with staff who were employed at Moorhead Rehab and Healthcare center. Each year a community based event would take place and tabletop exercise would be performed with the staff. These events would then have been evaluated afterwards to identify opportunities for improvement moving forward.	E 039	and remains appropriate. Education was completed with facility management on the policy with a focus on full scale and tabletop drills on 12/28/22. An all-staff training is scheduled for 12/28/22, and ongoing education with staff will be completed for new hires, and at a minimum annually based on drills, exercises, and findings from after action plans that were conducted. 4. Audits of EP drills and education will be completed weekly x 4 weeks, then monthly x 3 months. Audits will be brought to and monitored through the QAPI meetings or further recommendations and ongoing monitoring. 5. Maintenance Director or Designee responsible for compliance.	
F 000	INITIAL COMMENTS Moorhead Restorative Care Center is a Special Focus Facility (SFF). On 11/28/22, to 12/1/22, 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, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED:	F 000		

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F 000	Continued From page 11 H50525569C (MN00087666), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited. H50526291C (MN00088944), and H50525572C (MN00086477) with a deficiency cited at (F609). The following complaints were found to be UNSUBSTANTIATED: H50525570C (MN00086941), and H50525573C (MN00088083). 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. 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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		12/28/22

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F 561	Continued From page 12 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure preferences for shaving were honored and implemented for 1 of 2 residents (R2) reviewed for choices. Findings include: R2's quarterly Minimum Data Set (MDS) dated 9/2/22, identified R2 had intact cognition and had diagnosis which included dementia without behavioral disturbance and bipolar disorder. The MDS indicated R2 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, toileting and personal hygiene tasks which consisted of::combing hair, brushing teeth and shaving.	F 561	1. It is the expectation of Moorhead Restorative Care Center that all residents' preferences are honored and/or given reasonable accommodation to meet their needs including but not limited to maintaining appearance with facial hair/grooming. R2 was offered facial hair/grooming. R2's care plan was reviewed and updated to reflect preferences. 2. The deficient practice has the potential to impact all residents. All other residents were reviewed for preferences related to facial grooming/appearance. Care plans and tasks were reviewed and updated as needed. 3. The policy entitled Self Determination	

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F 561	Continued From page 13 R2's care plan dated 7/8/22, identified R2 required extensive assistance with personal hygiene and oral cares. The care plan indicated R2 had intact cognitive and had to request facial hair removal when desired. During an observation on 11/28/22, at 2:46 p.m. R2 was lying on his back in bed and was observed to have thick facial stubble noted on his chin and upper lip which extended to the jaw line. During an observation on 11/29/22, at 9:02 a.m. R2 was in the dining room eating breakfast and continued to have thick facial stubble on his chin and upper lip which extended to the jaw line. During an interview on 11/29/22, at 10:56 a.m. R2 indicated staff typically only shaved him once a week when he received his bath. R2 stated he wanted staff to shave him at least every other day without having to ask. R2 indicated he had informed the staff his shaving preferences several times however, they continued to only offer shaving weekly. During an interview on 12/1/22, at 10:22 a.m. nursing assistant(NA-D) indicated R2 required assistance from staff to shave. NA-D stated staff shaved R2 weekly during his bath. NA-D indicated male residents should have been offered to shave daily. During an interview on 12/1/22, at 10:27 a.m. trained medication aide (TMA-A) indicated she had assisted R2 with cares earlier that morning and confirmed she had not offered shaving to R2. TMA-A stated staff typically had only offered R2 assistance with shaving weekly with his bath unless the resident asked.	F 561	and Participation was reviewed and remains appropriate. All Nursing Staff will receive education on the policy with a focus on preferences and grooming on 12/28/22, 4. Audits for compliance will be completed on a random sample weekly x 4 weeks, and monthly x 3 months. Audits will be brought to and monitored through the QAPI meetings or further recommendations and ongoing monitoring. 5. Social Services or designee responsible for compliance	

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F 561	Continued From page 14 During an interview on 12/1/22, at 10:31 a.m. clinical manager (CM) confirmed R2 required extensive assistance with shaving and had only been offered shaving weekly with his bath. CM stated her expectation would be staff would have offered R2 to be shaved daily. During an interview on 12/1/22, at 10:47 a.m. director of nursing (DON) confirmed R2 required extensive assistance from staff to shave. DON stated her expectation was R2 should have been offered to be shaved daily without having to request it from staff. A facility policy titled Self Determination and Participation revised 2/21, identified each resident was allowed to choose activities, and schedule health care and healthcare providers, that were consistent with his or her interests, values, assessments and plans of care, including: daily routine such as sleeping walking,eating, exercise, and bathing schedules; personal care needs, such as bathing methods, grooming styles and dress.	F 561		
F 578 SS=D	. Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		12/28/22

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F 578	Continued From page 15 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578		

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F 578	Continued From page 16 Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident advanced directives were accurately documented in the resident's paper and electronic medical record (EMR) to reflect the residents current wishes for 1 of 1 resident (R23) reviewed for advanced directives. Findings include: R23's quarterly Minimum Data Set (MDS) dated 11/4/22, identified R23 had diagnoses which included diabetes, congestive heart failure, chronic obstructive pulmonary disease and end stage renal disease. The MDS identified R23 had intact cognition. Review of R23's Order Summary Report signed 11/1/22, revealed an order dated 8/15/22, which identified R23 was a DNR (do not resuscitate). Review of R23's care plan revised 11/18/22, identified he had a POLST (physician orders for life sustaining treatment) and had signed DNR orders. Review of R23's POLST form signed 8/17/22, identified R23 wanted CPR (cardiopulmonary resuscitation), however further on the form, it was revealed R23 requested comfort-focused treatment which was to allow for a natural death. During an interview on 11/29/22, at 3:50 p.m. R23 stated he did not want any life saving measures	F 578	1. It is the expectation of Moorhead Restorative Care Center to ensure that residents advanced directives will be honored. To ensure this; it is the expectation that the facility maintains accurate medical records both paper and EHR. On 12/1/22 it was identified that R23 advanced directive did not match the EHR. Upon identification of this, R 23 was reviewed, and records updated to reflect resident's wishes. 2. The deficient practice has potential to impact all residents. An audit was completed of resident's POLST against the EHR, any discrepancies were clarified and updated to EHR as needed. To prevent recurrence, upon admission, significant change and during each care conference the POLST form will be reviewed, and preferences honored; and then checked against the EHR for accuracy. 3. The policy entitled Advanced Directives was updated to reflect review of both the EHR and the signed POLST with each care conference including baseline care plan meeting. Social services and Licensed Nurses will be educated advanced directives with focus on accurate transcription from document to EHR. 4. Audits will be completed weekly x 4 weeks, then monthly x 3 months. Audits will be brought to and monitored through	

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F 578	Continued From page 17 to be implemented if needed. R23 stated he wanted to be a DNR and had signed the form identifying his desire when he was admitted to the facility several months ago. During an interview on 12/1/22, at 9:59 a.m. the director of social services indicated she was responsible for obtaining a resident's life sustaining wishes. She confirmed she had met with R23 upon his admission and he had requested to be DNR. The director confirmed R23's POLST form had an x marking the box to provide CPR. She indicated she had accidentally checked that box instead of the one below which identified DNR request. During an interview on 12/1/22, at 10:19 a.m. the director of nursing (DON) indicated it was part of the facility's social service directors' admission process to obtain a resident's POLST wishes. The DON stated she would have expected each resident's POLST to accurately reflect the resident's wishes and would also correlate with the doctor's orders. Review of a facility policy titled, Advanced Directives revised December 2016, identified advanced directives would have been respected in accordance with state law and facility policy. The policy revealed upon admission, residents would have been provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chose to do so.	F 578	the QAPI meetings or further recommendations and ongoing monitoring. 5. Social Services or designee responsible for compliance	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		12/28/22

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F 580	Continued From page 18 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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	245052	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 580	Continued From page 19 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician and power of attorney were notified of newly developed pressure ulcers for 1 of 1 resident (R33) reviewed for facility acquired pressure ulcers. R33's admission Minimum Data Set (MDS) dated 11/6/22, identified R33 had diagnoses which included debility (physical weakness), atrial fibrillation, and hypertension. Identified R33 had moderately impaired cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and bathing. Identified R33 was always incontinent of bowel and bladder and was not on a toileting plan. Identified R33 was at risk for pressure ulcers and had a pressure relieving device for his bed and chair and was not on a turning and repositioning program. R33's admission Care Area Assessment (CAA) dated 11/6/22, revealed R33 had moderate cognitive impairment which limited his abilities to recognize his needs. Identified R33 required extensive assistance with ADL's, and was not able to remember the need to change position. Revealed R33 preferred to be lying in his bed or	F 580	1. It is the expectation of Moorhead Restorative Care Center that all significant changes in condition will result in prompt notification to the Attending Physician and POA/Guardian when applicable. Notification has been provided to both parties regarding R33's pressure ulcer. 2. Failure to notify physician and responsible party with a resident's change in medical/mental condition and/or status has the potential to impact all residents. Resident charts were audited for like occurrences and parties notified as necessary. 3. The policy entitled Change in a Resident's Condition or Status was reviewed and remains appropriate. All nursing staff will be educated regarding proper identification of a residents change in condition and prompt notification requirements on 12/28/22. 4. Audits for compliance will be completed on a random sample weekly x 4 weeks, and monthly x 3 months. Audits will be brought to and monitored through the QAPI meetings or further recommendations and ongoing monitoring.	

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F 580	Continued From page 20 seated in a wheelchair and was to have a pressure relieving device on his bed and his wheelchair. Identified R33 was at risk for developing pressure ulcers and had no pressure ulcers at the time of the assessment. R33's admission skin assessment dated 10/31/22, revealed R33's skin was intact. R33's weekly skin review form dated 11/25/22, identified R33 had a small open area on his sacrum in which barrier cream was applied. During an interview on 11/30/22, at 9:05 a.m. with nurse manager (NM)-A, stated R33 had no pressure ulcers when he was admitted to the facility approximately one month prior. NM-A confirmed R33 currently had facility acquired pressure ulcers, one stage two on his sacrum and pressure ulcers to both heels which were unstagable due to deep tissue injury. NM-A stated she was not aware if R33's family had been notified of the pressure ulcers. During an interview on 11/30/22, at 9:16 a.m. Certified Nurse Practioner (NP)-A, stated she had met with R33 several times since his admission and was familiar with him. NP-A indicated she had been notified approximately a week ago R33 had redness on his buttocks, and felt it was due to R33's bowel and bladder incontinence. NP-A confirmed she had not been notified R33's sacrum was noted to have an open area on 11/25/22, and had not been notified of R33's bilateral heel deep tissue injury. R33's medical record lacked any documentation R33's practioner or family member/power of attorney had been notified of his pressure ulcers.	F 580	5. Director of Nursing or designee responsible for compliance	

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F 580	Continued From page 21 During an interview on 12/1/22, at 10:29 a.m. the director of nursing (DON) indicated she would have expected R33's practioner and family member to be notified of any changes in R33's condition, which included newly developed pressure ulcers. During a telephone interview on 12/1/22, at 10:44 a.m. R33's family member (FM)-A indicated she was not been notified R33 had any pressure ulcers. FM-A stated she would have wanted to have been notified of any changes in R33's condition. Review of a facility policy titled, Change in a Resident's Condition or Status reviewed 11/30/21, identified it was the purpose of the policy the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the residents's medical/mental condition and/or status.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		12/28/22

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F 609	Continued From page 22 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than 2 hours, an allegation of abuse to the State Agency (SA) for 3 of 3 residents (R4, R13, R26) reviewed for abuse. Findings include: R4 R4's quarterly Minimum Data Set (MDS) dated 11/2/22, identified R4 had diagnosis which included cerebral vascular accident (CVA), hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms. legs, and facial muscles) and seizure disorder. Indicated R4 had severe cognitive impairment and required limited assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R4's care plan revised 9/3/22, revealed R4 had a	F 609	1. It is the expectation of Moorhead Restorative Care Center that all alleged violations will be reported immediately, but no later than 2 hours to the state agency (SA). Notification for (R4, R13, R26) has been completed in regard to these incidents. 2. Failure to timely report allegations of abuse to the state agency has the potential to impact all residents who resident at Moorhead Restorative Care Center. All recent incidents and accidents were reviewed to identify any allegations that had not been reported. 3. The policy titled Abuse Prevention Program revised 6/22/22 was reviewed and remains appropriate. All staff education on the facility Abuse Prevention Program, specifically timely reporting, will be completed on 12/28/22 4. Audits for compliance will be completed on accidents, incidents,	

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F 609	Continued From page 23 mood problem related to feeling unsafe with another resident at the facility. The care plan directed staff to limit exposure to the resident R4 felt unsafe around. The facility SA report dated 9/2/22, at 7:08 p.m. indicated R4 stated there was unwanted kissing between R4 and R14. The report identified R4 and R14 were placed on frequent checks to ensure well-being. During an interview on 12/1/22, at 9:24 a.m. registered nurse (RN-D) stated on 9/2/22, while R4 was eating breakfast around 8:00 a.m. RN-D noticed three red marks on R4's neck. RN-D stated she asked R4 what happened to her neck and R4 stated "R14 had placed hickeys on her neck" and she did not like it. RN-D was unsure of what time the allegation of abuse was reported to the administartor. During an interview on 12/1/22, at 9:41 a.m. trained medication aide (TMA-B) indicated she noticed three red marks on R4's neck around 8:30 a.m. on 9/2/22. TMA-B indicated she had informed RN-D R4 identified the red marks were from R14 and R4 did not like having the red marks present on her neck. During an interview on 12/1/22, at 9:55 a.m. administrator stated he had been made aware of the allegation of abuse before 10 a.m. on 9/2/22. Administrator confirmed the allegation of abuse had not been reported to the SA within two hours. Administrator stated his expectation would have been the allegation of abuse would have been reported to the SA within two hours. R13	F 609	grievances, and allegations to ensure no other residents were impacted by failure to report timely. Audits will be done weekly x 4 weeks, then monthly x 3 months. Audits will be brought to and monitored through the QAPI meetings or further recommendations and ongoing monitoring. 5. LNHA/DON/SSC will be responsible for compliance.	

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F 609	Continued From page 24 R13's quarterly MDS dated 8/27/22, identified R13 was cognitively intact and had diagnoses which included: diabetes mellitus type two, hypertension and chronic kidney disease. Indicated R13 was independent with activities of daily living (ADLs). identified R13 had received insulin injections seven of past seven days and antidepressant medication seven of seven days. R13's Care Area Assessment (CAA) dated 5/27/22, identified R13 was cognitively intact and was able to make his needs known. Indicated R13 had some behavioral symptoms which included social inappropriateness. R13's care plan revised 6/13/22, identified R13 was independent with bed mobility, transfers, dressing and toilet use. R13's care plan indicated R13 had behavioral problem which included fixation on specific staff followed by repeated allegations of perceived retaliation of unknown origin that could not be substantiated. During an interview on 11/28/22, at 2:30 p.m. R13 stated he had made a report to a nurse, unidentified, who had filed a report with the facility regarding concerns with registered nurse Infection preventionist (RNIP)-A who had mistreated him and placed something in his water. During a follow up interview on 11/28/22, at 2:40 p.m. with an interpreter present, R13 identified he was afraid of RNIP-A. R13 stated he believed RNIP-A was trying to poison him as he had witnessed her place eye drops in his water the last Sunday morning of September. R13 indicated he had been refusing medications from RNIP-A.	F 609		

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F 609	Continued From page 25 R13 stated he just wanted to stay in his room because he was afraid and felt the facility had not done anything to resolve the issue. Review of the SA reports and grievance log provided by the facility lacked documentation of a report filed related to R13's allegation. On 11/28/22, at 7:28 p.m. surveyor reported to administrator R13 indicated he had been mistreated by a staff member and was afraid of her. Administrator confirmed no SA report had been filed regarding R13's allegation and stated he would interview R13. During an interview on 11/29/22, at 8:27 a.m. administrator indicated the director of social services (DSS)-A and himself interviewed R13 with an interpreter present on the evening of 11/28/22. A grievance form was completed after the interview and both the administrator and DSS-A interviewed RNIP-A. Administrator stated the plan going forward was to have another nurse administer R13's eye drops. Administrator confirmed R13 alleged during their interview RNIP-A placed eye drops in his water and was afraid of her. Administrator confirmed the facility had not completed a SA report of alleged abuse. During an interview on 11/29/22, at 8:41 a.m. DSS-A confirmed when interviewed, R13 had reported he believed RNIP-A had placed eye drops in his water and stated he was afraid of taking medications from her. DSS-A stated the facility was unsure if the allegation was accurate and indicated R13 was not always truthful. DSS-A stated RNIP-A stated she had not placed eye drops in R13's water and indicated R13 and	F 609		

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F 609	Continued From page 26 RNIP-A did not like one other. DSS-A confirmed she had been aware R13 had been refusing medications from RNIP-A prior to the surveyor reporting the allegation. DSS-A confirmed R13 requested a grievance form be filed. DSS-A confirmed the facility had not filed an abuse allegation report to the SA. Review of R13's Concern Or Problem Resolution Form dated 11/28/22, identified R13 had a concern RNIP-A placed eye drops in his water to poison him. R13 identified the date of occurrence on 9/27/22. R13 was now afraid to take medications from RNIP-A. The form identified a different staff member would now provide medications to R13. During an interview on 11/30/22, at 11:41 a.m. director of nursing (DON) indicated she was aware of R13's allegation of abuse and the facility had interviewed RNIP-A and R13. DON stated as a result of the allegation, the facility now had another nurse administering R13's medications. DON-A stated she had been aware R13 refused medication from RNIP-A and had been aware of his accusation regarding eye drops placed in his water for about a month. DON confirmed if R13 said he had been mistreated and felt afraid of RNIP-A, it would have been considered an allegation of abuse and it should have been reported to the SA. During a follow-up interview on 12/1/22, at 1:05 p.m. administrator confirmed the facility had not submitted a vulnerable adult report to the SA within the required time frames and stated they had submitted a vulnerable adult report today to the SA. Administrator indicated after further review of R13's grievance form, he felt it was	F 609		

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F 609	Continued From page 27 more of an allegation of abuse than they thought in the beginning since R13 had expressed he did not feel safe. R26 R26's significant change in status assessment (SCSA) Minimum Data Set (MDS) dated 10/25/22, identified R26 had diagnoses which included knee replacement, arthritis, anemia and hypertension. Indicated R26 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and dressing. R26 had other behaviors directed towards others four (4) to six (6) days but not daily, which interfered with her care and/or disrupted her living environment (these could include hitting, scratching self, rummaging, or verbal symptoms like screaming). R26's care plan revised 10/25/22, revealed R26's safety was at risk, was a potential for abuse due to current medical conditions, need for assistance with cares, mobility and her husband had had "escalated behaviors towards resident." The care plan revealed when R26's husband visited, frequent checks were to be completed. Review of facility state agency (SA) report dated 11/29/22, at 9:43 a.m. identified on 11/27/22, at 12:00 in R26's room, she had "received verbal abuse from her husband." The report identified a witness as nursing assistant (NA)-A. The report identified when staff heard verbal altercations in the residents room, they would intervene, and if necessary ask the husband to leave.	F 609		

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F 609	Continued From page 28 During an interview on 12/1/22, at 8:28 a.m. NA-A indicated R26's husband visited daily and she had heard R26's husband yell at her in the past once, when she did not remember something he had said. NA-A indicated on 11/27/22, she had passed by R26's room and noticed she had looked upset. NA-A indicated she had asked R26 if anything was wrong, and R26 told her to forget about it. NA-A indicated she felt R26 was upset by her husband at times and was concerned he was verbally abusing her. She indicated she had not observed R26 crying or any changes in her mood, however she indicated R26 appeared upset when her husband visited. NA-A indicated she had not reported her concern to anyone until morning report on 11/29/22, as R26 had declined to say anything. NA-A indicated she completed frequent checks on R26 when her husband was at the facility and encouraged her to keep her door open. During an interview on 12/1/22, at 9:49 a.m. the director of social services stated she was made aware of an allegation R26's husband had verbally abused R26 on 11/27/22. She indicated she had met with R26 regarding the allegation and R26 denied any abuse or concerns. She indicated R26 has had no observed changes in her mood or behavior within the last few weeks. The director indicated she had met with R26's husband on several occasions when he had become verbally aggressive towards her, and had hit a wall out of frustration during a conversation with her. She stated she had never seen R26's husband act aggressive towards her or yell at R26 in the past and had not observed R26 appear fearful when her husband was visiting. . The director of social services indicated she had met with R26 to assess her psychosocial needs,	F 609		

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F 609	Continued From page 29 the facility had implemented frequent checks for R26 while her husband was visiting, and immediately after he left. She indicated she was reaching out to see if R26 would talk with a mental health practioner in addition to working with the county regarding concerns with R26's husbands cognitive status and safety in the community. During an interview on 12/1/22, at 10:22 a.m. the director of nursing (DON) stated she was notified of the allegation of verbal abuse of R26 by her husband on 11/29/22, during morning report. The DON stated she would have expected to be notified immediately when facility staff observed the concern. The DON indicated R26's husband visited daily, and had not observed R26's husband acting abusive towards her. During an interview on 12/1/22, at 12:58 p.m. the facility administrator stated he had been made aware of the allegation during morning report on 11/29/22, and had submitted a report to the SA immediately. The administrator stated he expected to be notified of all allegations of abuse immediately and indicated a SA report should have been completed within two hours of the allegation. However, he indicated he had not been aware of the allegation until two days afterwards. A facility policy titled Abuse Prevention Program revised 6/22/22, indicated all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were to be reported immediately, but no later than 2 hours after the allegation is made, if the events that caused the allegation involved abuse or	F 609		

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F 609	Continued From page 30 resulted in serious bodily injury, or no later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the state agency.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a thorough investigation to assure residents were safe, following an allegation of abuse, for 1 of 3 residents (R13) investigated for abuse. In addition, the facility failed to prevent further potential abuse by allowing the alleged perpetrator (AP) to continue to have access to R13 and other vulnerable adults following the allegation of abuse.	F 610	1. It is the policy of this facility to investigate, prevent and correct alleged violations involving residents. After the surveyor identified the deficient practice, an investigation was completed regarding R13 and incident identified. 2. All residents have the potential to be affected by failure to complete thorough investigations and report findings timely to the state agency. Facility documentation of incidents and accidents were reviewed	1/3/23

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	245052	A. BUILDING _____ B. WING _____	C 12/01/2022

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

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F 610	Continued From page 31 Findings Include: R13's quarterly Minimum Data Set, dated 8/27/22, identified R13 was cognitively intact, with diagnoses which included: diabetes mellitus type two, hypertension and chronic kidney disease. R13 was independent with activities of daily living (ADLs). R13 had received insulin injections seven of past seven days and antidepressant medication seven of seven days. R13's Care Area Assessment (CAA) dated 5/27/22, identified R13 was cognitively intact and and was able to make his needs known. R13 had some behavioral symptoms which included social inappropriateness. R13's care plan revised 6/13/22, identified R13 was independent with bed mobility, transfers, dressing and toilet use. R13's care plan identified R13 had a behavioral problem which included fixation on specific staff followed by repeated allegations of perceived retaliation of unknown origin that could not be substantiated. On 11/29/22, at 8:27 a.m. RNIP-A was observed passing medications on R13's hallway, and was standing in front of the medication cart, two doors down from R13's room. During an interview on 11/28/22, at 2:30 p.m. R13 stated he had made a report to a nurse, unidentified, who had filed a report with the facility regarding concerns with registered nurse Infection preventionist (RNIP)-A who had mistreated him and placed something in his water. During a follow up interview on 11/28/22, at 2:40	F 610	to ensure no other investigations were needed. 3. On 12/28/22 all staff will receive in-service training on requirements for investigating, preventing and corrective actions taken when receiving reports of abuse allegations. Documentation of investigations, interviews, record review will be included. 4. All incident reports will be reviewed daily during the week. Audits will be completed by the DON/SSC/Designee weekly x 4 weeks, then monthly x 3 months. All deficiencies will be corrected upon identification and findings brought to monthly QAPI committee for further review and recommendations. 5. LNHA/DON/SSC will be responsible for this POC.	

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F 610	Continued From page 32 p.m. with an interpreter present, R13 identified he was afraid of RNIP-A. R13 stated he believed RNIP-A was trying to poison him as he had witnessed her place eye drops in his water the last Sunday morning of September. R13 indicated he had been refusing medications from RNIP-A. R13 stated he just wanted to stay in his room because he was afraid and felt the facility had not done anything to resolve the issue. Review of the SA reports and grievance log provided by the facility lacked documentation of a report filed related to R13's allegation. On 11/28/22, at 7:28 p.m. surveyor reported to administrator R13 indicated he had been mistreated by a staff member and was afraid of her. Administrator confirmed no SA report had been filed regarding R13's allegation and stated he would interview R13. During an interview on 11/29/22, at 8:27 a.m. administrator indicated the director of social services (DSS)-A and himself interviewed R13 with an interpreter present on the evening of 11/28/22. A grievance form was completed after the interview and both the administrator and DSS-A interviewed RNIP-A. Administrator stated the plan going forward was to have another nurse administer R13's eye drops. Administrator confirmed R13 alleged during their interview RNIP-A placed eye drops in his water and was afraid of her. During an interview on 11/29/22, at 8:41 a.m. DSS-A confirmed when interviewed, R13 had reported he believed RNIP-A had placed eye drops in his water and stated he was afraid of taking medications from her. DSS-A stated the	F 610		

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F 610	Continued From page 33 facility was unsure if the allegation was accurate and indicated R13 was not always truthful. DSS-A stated RNIP-A stated she had not placed eye drops in R13's water and indicated R13 and RNIP-A did not like one other. DSS-A confirmed she had been aware R13 had been refusing medications from RNIP-A prior to the surveyor reporting the allegation. DSS-A confirmed R13 requested a grievance form be filed. DSS-A indicated no other staff or residents had been interviewed. Review of R13's Concern Or Problem Resolution Form dated 11/28/22, identified R13 had a concern RNIP-A placed eye drops in his water to poison him. R13 identified the date of occurrence on 9/27/22. R13 was now afraid to take medications from RNIP-A. The form identified a different staff member would now provide medications to R13. During an interview on 11/30/22, at 11:00 a.m. RNIP-A confirmed she had remained working in the facility after R13's allegation of abuse however she had been instructed to not administer R13's medications. RNIP-A confirmed she continued to have contact with R13 and other residents in the facility and was never removed from the facility's schedule while the investigation ensued. During an interview on 11/30/22, at 11:41 a.m. DON stated R13 and RNIP-A were interviewed after the allegation of abuse was received and confirmed no other residents or staff had been interviewed. DON indicated RNIP-A continued to work in the facility and was never removed from the facility's schedule. DON indicated her usual practice was to suspend a staff member during	F 610		

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F 610	Continued From page 34 an investigation. DON stated she would normally choose three other residents at random to interview to determine if they felt safe or had concerns. During an interview on 12/1/22, at 1:03 p.m. administrator confirmed the facility had not originally completed a thorough investigation however now the facility were beginning to further investigate the allegation. The facility policy titled Grievances/Complaints, Filing reviewed 6/22, identified the social service director of designee was the grievance officer. The policy identified the grievance officer would coordinate actions with appropriate state and federal agencies, dependent upon the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property would have been reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. The policy indicated the grievance officer, administrator and staff would have taken immediate action to prevent further potential violations of resident rights while the alleged violation was being investigated.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		1/10/23

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F 656	Continued From page 35 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 3 residents (R24) reviewed for activities.	F 656	1. It is the expectation of Moorhead Restorative Care Center that all patients have a comprehensive care plan developed upon admission and reviewed regularly by the IDT to include but not	

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F 656	Continued From page 36 Finding include: R24's admission Minimum Data Set (MDS) dated 5/11/22, indicated R24's had diagnoses which included depression, anxiety disorder, bipolar disorder and was cognitively intact. R24 required extensive assistance of one or two staff for all activities of daily living (ADL's). R24's activities that were very important to her were listening to music and being around animals. R24's activities that were somewhat important to her were going outside for fresh air, doing her favorite activities, and keeping up with the news. R24's least favorite activities were reading books, news papers, magazines, doing group activities, and religious activities. Review of R24's care area assessment (CAA) dated 5/11/22, indicated R24 preferred group activities and being active in activities. The CAA indicated R24's activity functional status would be addressed in her care plan with overall objectives to maintain her current level of functioning. Review of R24's Activity Data Collection (Admission) dated 5/9/22, indicated R24's leisure activities were reading, watching TV drama shows, listening to 80's music, visiting with family, going to church and enjoyed being with dogs. Review of R24's careplan revised on 11/10/22, lacked any documentation of what R24's activity preferences, approaches, or goals were for activities. During an interview on 11/29/22, at 2:30 p.m. with director of activities (DA) she confirmed the above findings and indicated the activity/preference assessments were to be	F 656	limited to preferred activities. Activities care plan was added for R24. 2. The deficient practice has potential to impact all residents. Resident care plans were reviewed and updated as needed. The policy entitled Activity Evaluation was reviewed, no updates required to remain compliant with CMS and MDH requirements. 3. Education will be provided to activity and MDS staff regarding the above policy with a focus on timeliness of development of a comprehensive care plan as well as routine review of said care plan per CMS requirements. 4. Audits of the comprehensive care plan will be completed weekly x 4 weeks then monthly x 3 months. All deficiencies will be corrected upon identification and findings brought to monthly QAPI committee for further review and recommendations. 5. MDS or Designee responsible for compliance	

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F 656	Continued From page 37 completed within seven days of a residents admission. The DA indicated the information from the the assessment was shared with only activity staff and indicated most of the residents were able to tell staff what they wanted to do for activities. The DA verified R24 currently did not have a activity careplan developed due to not having the training when she was hired. The DA indicated she did not know how to complete a care plan and was currently not doing them. The DA indicated most residents were only in the facility for a few weeks and did not require a care plan. During an interview on 11/29/22, at 2:55 p.m. the activity aid (AA)-A indicated she documented all activity participation under the progress notes in the medical record. AA-A confirmed she had no written direction or activity careplan to follow and indicated she just knew what each resident enjoyed for activities. During an interview on 12/01/22, at 2:07 p.m. with director of nursing (DON) confirmed R24's care plan lacked any documentation of R24's activity focus, goals, or interventions. DON indicated she would expect staff to do a base line care plan within 48 hours of admission and a comprehensive care plan done within fourteen days after the assessment had been completed. She stated she would expect staff to complete care plans and to include activities focus, goals and interventions. Review of facility policy titled, Activity Evaluation undated, indicated staff would have evaluated residents within 14 days of admission and would develop an individual activities care plan (separate or as part of the comprehensive care	F 656		

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F 656	Continued From page 38 plan). The policy identified each resident's activity care plan would have been related to his/her comprehensive assessment and would reflect his/her individual needs and the care plan would have identified if the resident was capable of pursuing activities without intervention from facility. The policy indicated the activity evaluation would have been part of the resident's medical record and should have been updated as necessary, but at least annually.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 1 of 3 residents (R24) who was dependent on staff for activities. Findings include: R24's admission Minimum Data Set (MDS) dated 5/11/22, indicated R24's had diagnoses which included depression, anxiety disorder, bipolar disorder and was cognitively intact. R24 required extensive assistance of one or two staff for all	F 679	1. It is the expectation of Moorhead Restorative Care Center that all residents are routinely provided with meaningful activities concurrent with their level of ability. R24's preferences were reviewed, care plan updated for staff reference and a schedule of 1:1 activity for this resident was developed. 2. The deficient practice has the potential to impact all residents. Resident charts were reviewed to ensure activity care planning and documentation were	1/10/23

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F 679	Continued From page 39 activities of daily living (ADL's). R24's activity preferences that were very important were listening to music and being around animals. R24's preferences that were somewhat important were going outside for fresh air, doing favorite activities, and keeping up with the news. R24's least favorite activities were reading books, news papers and magazines, group activities, and religious activities. Review of R24's care area assessment (CAA) dated 5/11/22, indicated R24 preferred group activities and being active in activities. The CAA indicated R24's activity functional status would be addressed in her care plan with overall objectives to maintain her current level of functioning. Review of R24's Activity Data Collection (Admission) dated 5/9/22, indicated R24's leisure activities were reading, watching TV drama shows, listening to 80's music, visiting with family, going to church and enjoyed being with dogs. Review of R24's Activity Participation Review dated 10/26/22, indicated R24 preferred one on one activities and enjoyed live music events. The review identified R24's activities remained appropriate, goals were met and to continue until next quarter. Review of R24's careplan revised on 11/10/22, lacked any documentation of what R24's activity preferences, approaches, or goals were for activities. Review of R24's Progress Notes from 9/1/22, to 12/1/22, revealed the following: - 10/19/22, activity aid visited with R24 about the	F 679	present. The policy entitled Activity Assessment was reviewed and remains appropriate 3. Education will be provided to activity staff regarding policy and procedure related to assessing, care planning and implementing resident preferences in activities to ensure person centered care. Activity staff will develop and maintain a schedule for activities which will be reviewed during routine business days at morning stand up. The activities staff will also notify the IDT if a resident is refusing participation to determine if action can be taken or CP updates warranted. 4. Audits will be completed of activity documentation with a focus on participation and activities related to resident preference. Audits will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. Activities Director or Designee responsible for compliance	

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F 679	Continued From page 40 show she was watching while nursing assistant (NA) did her nails. - 10/25/22, activity aid stopped in and asked R24 if she would like to attend bingo and R24 declined. - 11/3/22, activity director (AD) indicated R24 was confused and required one to one supervision while in activity today. The progress notes lacked documentation R24 offered or attended activities on a routine basis. During observation on 11/28/22, from 1:52 p.m. to 7:15 p.m. - at 1:52 p.m. R24 was laying in bed on her back covered with a blanket, bed in low position, mat on floor next to bed, call light in reach and the TV was on. - at 5:41 p.m. R24 remained the same. Review of the facility November 2022, activity calendar, indicated staff were to have a beach ball activity at 2:00 p.m. and one on one visits at 3:30 p.m. R24 was not observed attending any activities through out the evening. During observation on 11/29/22, from 8:17 a.m. to 3:56 p.m. - at 8:17 a.m. R24 was seated in her wheelchair in the dining room and was eating her breakfast independently. - at 10:05 a.m. R24 was laying in bed covered with a blanket, bed in low position and call light within reach. - at 2:09 p.m. R24 was laying in bed covered with blanket, had her cell phone in her hand, bed in low position, head of bed elevated, mat on floor	F 679		

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F 679	Continued From page 41 and was independently eating chips. - at 2:17 p.m. R24 remained the same and continued to eat her chips. - at 2:46 p.m. R24 remained the same while a housekeeper cleaned her room and R24 told the housekeeper she was hungry. - at 3:02 p.m. R24 remained in her room while lying in bed, bed in low position, mat on floor, call light within reach and was talking to herself repeatedly. - at 3:28 p.m. R24 remained lying in bed, when licensed practical nurse (LPN)-A entered her room and gave R24 a snack and immediately left the room. - at 3:47 p.m. R24 was yelling out loudly, when registered nurse (RN)-C entered R24's room and began talking with R24 about taking her blood pressure. RN-C proceeded by taking R24 blood pressure and immediately left the room. - at 3:56 p.m. R24 was yelling out loudly, when RN-C entered her room asking R24 if she would like to get up, go to the dining room, or if she wanted a cup coffee and R24 declined. Review of the facility November activity calendar, indicated staff were to have this day in history/daily devotions at 9:30 a.m., board/card games at 10:00 a.m., bingo at 2:00 p.m., and one on one activities at 3:30 p.m. R24 was not observed attending any activities through out the day or having one on one activities with staff. During observations on 11/30/22 from 7:20 a.m. to 1:30 p.m. -at 7:20 a.m. R24 was laying in bed, bed was in low position, call light within reach and R24 was talking to herself repeatedly. - at 8:23 a.m. R24 remained the same and was yelling out loudly while talking to herself	F 679		

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F 679	Continued From page 42 repeatedly. - at 8:31 a.m. R24 remained the same, when the director of social services (DSS) entered R24's room and asked R24 if she would like to eat breakfast in her room or the dining room. R24 indicated she would like to eat in her room and the DSS immediately left R24's room. - at 8:34 a.m. R24 was seated on the edge of her bed, when the dietary manager (DM) entered R24's room with a room tray, set the tray on the bedside table, assisted R24 as needed and immediately left the room. - at 8:37 a.m. R24 remained the same, when the director of rehab (DR) entered R24's room and asked R24 if she would like to get up. R24 yelled at the DR to get out of her room and DR immediately left her room. While DR was walking down the hallway, R24 then yelled at her to shut the door. The DR turned around and proceeded to shut R24's door. - at 8:50 a.m. R24 door remained closed and and she continued to talk to herself. - at 10:54 a.m. R24 was laying in bed on her back, bed in low position, mat on floor and appeared to be resting. - at 11:05 a.m. R24 remained the same. - at 1:30 p.m. R24 remained the same. Review of the facility November activity calendar for 11/30/22, indicated staff were to have shopping lists at 9:30 a.m., shopping for residents at 10:00 a.m., bowling at 2:00 p.m., and one on one visits at 3:30 p.m. R24 was not observed attending any activities through out the day or having one on one activities with staff. During an interview on 11/30/22, at 2:15 p.m. nursing assistant (NA)-D indicated R24 enjoyed visiting, having her hair and make up done. NA-D	F 679		

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	245052	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 679	Continued From page 43 indicated R24 had recently had an increase in behaviors with yelling out and staff would offer her a snack, to watch videos on her phone or call her son. NA-D indicated R24 did not like to go to the activity room and usually stayed in bed. During an interview on 11/30/22, at 2:30 p.m. with director of activities (DA) confirmed the above findings and indicated R24 preferred one on one activities. The DA indicated facility staff completed one to one activities daily, although the DA could not identify which activities R24 preferred. The DA stated resident activity/preference assessments were to be completed within seven days of admission and were shared verbally with activity staff only. The DA indicated most of the residents could inform staff what they wanted to do for activities and confirmed staff documented activity participation in the resident's progress notes. The DA stated activity staff did not have a schedule for doing one on ones activities for residents and her expectation were for staff to offer residents activities daily and residents should have been receiving one on one activities on a daily basis. During an interview on 11/30/22, at 2:55 p.m. the activity aid (AA)-A indicated R24 liked to visit about her son, write letters and enjoyed being out and about within the facility. AA-A stated R24 was receptive to activities however would occasionally refuse. The AA-A indicated all activity participation was documented under progress notes in the medical record. AA-A confirmed she had no written direction or activity careplan to follow and indicated she just knew what each resident liked for activities. During an interview on 12/01/22, at 2:07 p.m. with	F 679		

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F 679	Continued From page 44 director of nursing (DON) confirmed the above findings and indicated she would expect staff to offer the residents activities and to follow the careplan. Review of facility policy titled, Activity Evaluation undated, indicated staff would have evaluated residents within 14 days of admission and would have developed an individual activities care plan (separate or as part of the comprehensive care plan). The policy identified each residents activities care plan would have been related to his/her comprehensive assessment and would have reflected his/her individual needs. The policy indicated the care plan would have identified if the resident was capable of pursuing activities without intervention from facility. The policy indicated the activity evaluation would have been part of there resident's medical record and should have been updated as necessary, but at least annually.	F 679		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with 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.	F 686		1/3/23

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F 686	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement interventions to promote healing and prevent worsening of pressure ulcers for 1 of 1 resident (R33) reviewed with a current stage two pressure ulcer on the sacrum (tailbone area) and two deep tissue injury pressure ulcers on both heels. R33 sustained actual harm when the facility failed to assess and monitor his skin which resulted in the development of two deep tissue injuries to his bilateral heels. Stage two pressure ulcer: partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister. Deep Tissue Injury (DTI) : is an injury to a patients underlying tissue below the skin's surface that results from prolonged pressure in an area of the body. Similar to a pressure sore, a deep tissue injury restricts blood flow in the tissue causing the tissue to die. Findings include: R33's admission Minimum Data Set (MDS) dated 11/6/22, identified R33 had diagnoses which included debility (physical weakness), atrial fibrillation, and hypertension. Identified R33 had moderately impaired cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and bathing. Identified R33 was always incontinent of bowel and bladder and was not on a toileting plan. Identified R33 was at risk for pressure	F 686	1. It is the expectation of Moorhead Restorative Care Center that all patients skin is assessed upon admission and weekly thereafter. It is the expectation that upon identification of a new skin concern or risk for skin concerns notifications are made and interventions are implemented. It is the expectation that all wounds are measured and documented at least every 7 days to monitor progress. R33's plan of care has been reviewed and updated to reflect appropriate interventions. Notifications have been made to POA and medical provider. 2. This deficient practice has the potential to impact all residents. Resident charts were reviewed and care plans updated as needed. Policy entitled Prevention of Pressure Ulcers, and the policy entitled Pressure Ulcer/Skin Breakdown Protocol were reviewed and remain appropriate. 3. All licensed staff will be educated on weekly skin checks and notification of change in skin condition to the DON, provider and POA. All nursing staff will be educated on preventative measures for skin breakdown. Nursing management or designee will be educated on use of the skin and wound companion app for PCC to allow for ease of tracking and availability for consult from remote providers/consultants as needed. 6. Audits will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and	

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F 686	Continued From page 46 ulcers and had a pressure relieving device for his bed and chair and revealed R33 was not on a turning and repositioning program. Identified R33 was at risk for pressure ulcers and had a pressure relieving device for his bed and chair however was not on a turning and repositioning schedule and incorrectly identified R33 had a current pressure ulcer at the time of admission. R33's admission Care Area Assessment (CAA) dated 11/6/22, revealed R33 had moderate cognitive impairment which limited his abilities to recognize his needs. Identified R33 required extensive assistance with ADL's, and was not able to remember the need to change position. Revealed R33 preferred to be lying in his bed or seated in a wheelchair and was to have a pressure relieving device on his bed and his wheelchair. Identified R33 was at risk for developing pressure ulcers and had no pressure ulcers present at the time of the assessment. Review of R33's care plan revised 11/22/22, revealed R33 had a potential/actual impairment to his skin and identified the following interventions: barrier cream, pressure reducing devices for his chair, bed and heel protectors to protect his skin. R33's admission skin assessment dated 10/31/22, identified R33's skin was intact. Review of R33's Braden scale (an assessment tool for predicting the risk of pressure ulcers, based on the total scores given in the categories of sensory perception, moisture, activity, mobility, nutrition, and friction and shear) dated 10/31/22, identified R33 was at low risk for developing pressure ulcers.	F 686	recommendations. 4. DON or designee responsible for compliance	

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F 686	Continued From page 47 R33's weekly skin review form dated 11/25/22, identified R33 had a small open area on his sacrum in which barrier cream was applied. The form lacked identification, staging, measurements, tissue characteristics or causative factors of R33's open area. R33's medical record lacked any further skin assessments or identification of any other open areas. During an observation on 11/28/22, at 2:44 p.m. R33 was lying in bed on his back, his face was pale gray in color, his eyes were closed and he was covered with a yellow blanket. During an observation on 11/28/22, at 5:36 p.m. R33 was observed lying in bed on his back, his face was pale gray in color, his eyes were closed. He was covered with a yellow blanket from his feet to his mid chest. -at 5:56 p.m. R33 was observed lying in the same position, his face was pale gray in color, his eyes were closed and he was covered with a yellow, fuzzy blanket. At that time, nursing assistant (NA)-B and NA-F entered his room, indicated to R33 it was time for him to eat. NA-B and NA-F removed the yellow blanket, which revealed R33's bilateral heels had been resting directly on the standard mattress with no off-loading (heels hovered over the bed by a pillow or use of pressure relieving heel protectors) devices in place. R33 was boosted up in bed by NA-B and NA-F, covered with a yellow blanket and the head of bed was elevated to a sitting position. R33's meal tray was placed on an over the bed table, which was then moved in front of R33.	F 686		

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F 686	Continued From page 48 On 11/29/22, at 2:56 p.m. R33 was observed lying in bed on his back, his eyes were closed and he was covered from his feet to his mid-chest with a fuzzy yellow blanket. -at 3:22 p.m. R33 remained lying in the same position, his eyes were closed and he was covered from his feet to his mid-chest with a fuzzy yellow blanket. During an observation on 11/30/22, at 7:00 a.m. R33 was lying in bed on his back, his eyes were closed, and he was covered with a yellow blanket from his feet to his mid-chest. - at 7:30 a.m. R33 was observed to lying in the same position, his eyes were closed and he was covered with a yellow blanket from his feet to his mid-chest. R33 was not observed to make any independent changes in position. -at 7:56 a.m. R33 was observed to remain lying in the same position, his eyes were closed and he was covered with a yellow blanket. At that time, NA-B and NA-K entered his room, indicated they were going to assist him with morning cares. At 8:00 a.m. registered nurse manager (NM)-A entered R33's room and indicated she was there to assist with morning cares. NA-B removed the yellow blanket, which revealed R33 wore a hospital gown, gripper socks and both of his heels rested directly on the standard mattress. At that time, NM-A confirmed R33 had a standard mattress with no pressure relieving devices. R33 was assisted to turn to his right side by NM-A who held onto R33's body, while NA-B removed R33's urine soaked soiled incontinent brief. R33 had an open area on his sacrum and redness which completely surrounded the open area. At that	F 686		

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F 686	Continued From page 49 time, NM-A stated she was unaware R33 had a pressure ulcer. - At 8:17 a.m. the NM-A assessed and measured R33's sacral pressure ulcer which revealed R33 had a stage two (2) pressure ulcer which measured a surface area of 3.1 centimeters (cm). NM-A stated the redness surrounding R33's stage 2 pressure ulcer was non-blanchable (reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device), on the lower right side of the wound, extending several cm's from the open area. She confirmed R33's non-blanchable skin was indicative of further skin breakdown. NM-A proceeded to cleanse the wound, applied Cavalon Barrier Cream (cream used to help protect and repair the skin of anyone suffering from incontinence), to R33's open area and applied a Cavilon wand (transparent film designed to protect intact or damaged skin from urine, feces, other body fluids, adhesive trauma and friction), to the surrounding redness. -At 8:33 a.m. NM-A picked up R33's right foot, palpated the entire area of his heel (approximately the size of golf ball) and confirmed R33's entire right heel, was completely and significantly boggy (refers to abnormal texture of tissues characterized by sponginess, indicative of a deep tissue injury/unstagable pressure ulcer). NM-A then picked up R33's left heel, which revealed a forming blister with hardened edges, that measured approximately 2.0 cm in length and 3.5 cm in width. NM-A palpated the inside the blister which revealed bogginess. NM-A confirmed R33 had bilateral unstagable (suspected deep tissue injury) pressure ulcers on his heels. NM-A then proceeded to check the rest	F 686		

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F 686	Continued From page 50 of R33's skin for any further pressure ulcers and none were found. On 11/30/22, at 9:05 a.m. during an interview with NM-A, confirmed R33 had no pressure ulcers when he was admitted to the facility approximately one month prior. She indicated R33 had been declining in the past few weeks and had required increased assistance. NM-A stated she was not aware R33 had any skin breakdown on his sacrum or heels. NM-A indicated R33 should have been assisted to reposition every two hours, his heels should have been off-loaded and his skin should have been checked weekly for signs of breakdown. On 11/30/22, at 9:16 a.m. during an interview, R33's Certified Nurse Practioner (NP)-A, stated she had met with R33 several times since his admission and was familiar with him. She indicated R23 had experienced a decline in the last few weeks with dizziness, low blood pressures and has had some bloody stools which the facility had been monitoring. NP-A indicated R33 had been in bed more often than when he was first admitted and seemed to prefer to be in his room. NP-A stated she had not been aware R33 had a pressure ulcer on his sacrum, and she was not aware R33 had DTI to his bilateral heels. NP-A indicated she had been notified approximately a week ago R33 had redness on his buttocks, and felt it was due to R33's bowel and bladder incontinence. She indicated barrier cream should have been applied routinely to prevent further breakdown. NP-A stated she had not assessed R33's sacrum at that time. NP-A stated she expected R33's skin to be assessed weekly, and she expected R33 to have pressure relieving interventions in place such as routine	F 686		

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F 686	Continued From page 51 repositioning, the use of heel protectors or Prevalon boots to his heels. NP-A confirmed R33's boggy heels were indicative of deep tissue injuries, as they were not able to stage the pressure ulcers since they had not opened yet. On 11/30/22, at 8:10 a.m. during an interview, NA-B indicated R33 required extensive assistance with bed mobility, and used a full mechanical lift for transfers. NA-B stated R33 was always incontinent of bowel, bladder and did not typically use his call light for assistance. She indicated R33 was supposed to be repositioned every two hours and confirmed that morning he had last been checked and changed at approximately 5:00 a.m., a total of 2 hours and 56 minutes from when she entered his room that morning. NA-B stated she was not aware R33 had a pressure ulcer on his buttocks and was not aware of the DTI to his heels. On 12/1/22, at 8:40 a.m. during an interview, NA-A indicated R33 had required assistance with bed mobility, transfers, and dressing since his admission. She stated R33 was assisted with repositioning and was to be checked and changed every two hours as he was totally incontinent of bowel and bladder. NA-A stated she felt R33 refused assistance with cares frequently and indicated he needed a lot of encouragement to allow staff to assist him. NA-A indicated she was not aware R33 had any pressure ulcers and was not aware of any pressure relieving interventions for his heels. Review of R33's progress notes from 10/31/22, to 12/1/22, revealed the following: - 10/31/22, revealed R33 was seen by NP-A for	F 686		

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F 686	Continued From page 52 an initial visit for his admission following a 30 day inpatient hospital stay. The note indicated R33 had been hospitalized with a recent heart attack which required surgical intervention. The note revealed R33 complained of dizziness, had weakness and would have therapy work with him to improve his mobility and ADL function. The note indicated NP-A completed a comprehensive review R33 and identified his skin was intact and free of ulcers. -10/31/22, an admission summary note revealed R33 had declined to have his skin checked and had agreed to have the nurse complete a skin assessment the following day. - 11/11/22, a nursing note revealed R33 had refused a shower, skin check and was sleeping. -11/12/22, a nursing note revealed R33 was in bed all day, required extensive assistance with turning and repositioning, toileting and personal hygiene. Review of R33's medical record lacked any documentation of R33's bilateral heel DTI's. On 12/1/22, at 10:29 a.m. during an interview, the director of nursing (DON) indicated she expected a skin assessment to have been completed when R33's stage two pressure ulcer was first observed on 11/25/22, per the skin note. The DON confirmed R33's Braden scale which was completed upon admission revealed R33 was at minimal risk for skin breakdown. She indicated R33 had declined in the past few weeks related to his medical condition, which the facility had been monitoring. The DON indicated R33 had been in his bed more often than when he was first	F 686		

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F 686	Continued From page 53 admitted. The DON confirmed R33's admission MDS incorrectly identified he had a pressure ulcer upon admission, medical record lacked routine skin monitoring and indicated she would expect his skin to be checked weekly. She indicated R33 should have had pressure relieving interventions in place for his heels, to include Prevalon boots and to off-load his heels from the bed as needed. The DON confirmed she was not aware R33 had any pressure ulcers and indicated NM-A had recently returned to the facility and would be implementing weekly wound/skin rounds. On 12/1/22, at 10:44 a.m. during a telephone interview, R33's family member (FM)-A indicated she was not aware R33 had any pressure ulcers and had recently been notified R33 was transferred to the hospital. FM-A stated she would have wanted to be notified of any changes in R33's condition. Review of a facility policy titled, Prevention of Pressure Ulcer Injuries reviewed 9/29/21, revealed it was the purpose of the procedure to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The policy revealed resident's skin was to be comprehensively assessed upon admission, and should be inspected daily with cares. The policy identified the following prevention strategies; prevention, nutrition, mobility/repositioning, support surfaces and pressure redistribution, device related pressure injuries and monitoring. Review of a facility policy titled, Pressure Ulcer/Skin Breakdown - Clinical Protocol, revised 7/12/22, identified nursing staff and practioner	F 686		

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F 686	Continued From page 54 would assess and document an individuals significant risk factors for developing pressure ulcers. In addition, the nurse should complete a full assessment of newly admitted residents, identify cause of any skin breakdown, implement treatment/management measures and monitoring the effectiveness and healing.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 3 (R8) residents identified at risk for falls to prevent further falls. Findings include: R8's quarterly Minimum Data Set (MDS) dated 11/3/22, identified R1 had moderate impaired cognition and had diagnoses which included diabetes mellitus, borderline personality disorder (a mental illness characterized by a distorted self-image, impulsiveness, unstable and intense relationships, and extreme emotions) and depression. Indicated R1 required limited assistance for transfers and extensive assistance for toileting.	F 689	1. It is the expectation of Moorhead Restorative Care Center that with each fall the care plan is reviewed and interventions are implemented as appropriate to meet the individual safety needs. R8's care plan has been reviewed and all identified interventions are in place. 2. The deficient practice has the potential to impact all residents. Resident charts reviewed to ensure interventions in place as necessary. 3. All nursing staff will be educated on facility policy for Fall and Managing Fall risk with focus on the evaluation of a fall and implementation of ongoing interventions to prevent future falls. 4. Audits of fall interventions will be	1/3/23

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	245052	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 689	Continued From page 55 R8's fall assessment dated 10/28/22, identified R1 was at high risk for falls due to impaired cognition, medications, and previous falls. R8's fall assessment indicated R8 was incontinent of bladder and required staff assistance with transfers. Review of R8's care plan revised 10/20/22, revealed R8 was at high risk for falls related to immobility and weakness. The care plan revealed fall interventions which included call light in reach, bed in low position at night and a fall mat next to the bed. Review of 8's adverse event reports from 10/13/22, to 11/29/22, revealed the following: -10/13/22, R8 had an unwitnessed fall at 10:30 p.m. The event report identified staff found R8 on the floor The report revealed another resident informed staff R8 had self transferred from her bed and fell onto the floor. The report identified R8 had been sent to the emergency room (ER) to be evaluated related to R8 having an unwitnessed fall. The report further reveled R8 had not received any injuries from the fall. The report lacked immediate interventions to prevent future falls. -10/17/22, R8 had a witnessed fall at 9:30 p.m. event report revealed R8 had call light on and when staff entered the room R8 was standing by her bed and was starting to sit down so staff lowered R8 to the floor. The report lacked immediate interventions to prevent future falls. -10/18/22, R8 had an unwitnessed fall at 4:20 a.m. The report revealed R8 was found on the	F 689	completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. DON or designee responsible for compliance	

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F 689	Continued From page 56 floor next to her bed. The report revealed R8 stated "I don't like this bed it is possessed I'm not going back. The report revealed an immediate intervention to place a fall mat on the floor next to the bed. During an observation on 11/28/22, at 7:00 p.m. R8 was lying in bed. No fall mat next to the bed. During an observation on 11/29/22, at 3:12 p.m. R8 was lying on her stomach in bed and slid to the floor to her knees next to the bed. No fall mat next to R8's bed. Surveyor alerted licensed practical nurse (LPN-A) that R8 was on the floor. When LPN-A arrived R8 had gotten to a standing position and was attempting to get back into bed so LPN-A assisted R8 into bed. R8 was assessed by nurse practioner (NP) and was sent to the ER for bilateral knee pain. X-ray report dated 11/29/22, revealed R8 had a contusion to her right knee. During an interview on 11/29/22, at 3:22 p.m. LPN-A indicated R8 was suppose to have a fall mat on the floor next to her bed due to R8 frequently puts herself on the floor and has had falls out of bed. LPN-A confirmed R8 did not have a fall mat next to the bed prior to her fall. During an interview on 11/30/22, at 1:01 p.m. nursing assistant (NA-D) indicated R8 has placed herself on the floor and has had some falls. NA-D further indicated she had not been aware R8 was supposed to have a fall mat on the floor next to the bed and stated she had never seen a mat on the floor next to R8's bed. During an interview on 11/30/22, at 1:13 p.m. clinical manager (CM) stated R8 has placed	F 689		

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F 689	Continued From page 57 herself on the floor and has had falls out of bed. CM confirmed R8 was to have a fall mat on the floor next to her bed. CM confirmed there was no fall mat next to R8's bed at the time of the fall. During an interview on 11/30/22, at 1:29 p.m. director of nursing (DON) stated R8 had placed herself on the floor and has had falls. DON verified R8 was to have a fall mat next to her bed. DON confirmed R8 had not had a fall mat next to her bed during her fall on 11/29/22. DON stated her expectation was R8's fall interventions including the fall mat would have been implemented. A facility policy titled Falls and Fall Risk, Managing reviewed 10/22, indicated according to the MDS, a fall was defined as: unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. The policy indicated in conjunction with the attending physician , staff would identify and implement relevant interventions, to try to minimize serious consequences of falling.	F 689		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 712		1/3/23

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F 712	Continued From page 58 §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure newly admitted residents received 30 day physician visits for the first 90 days for 1 of 1 residents (R22) reviewed for physician visits. In addition, the facility failed to ensure long term residents received routine physician visits (every 60 days) for 1 of 3 residents R2 reviewed for routine physician care. Findings include: R22 Review of R22's face sheet indicated R22 was admitted on 10/6/22, with a diagnosis of unspecified severe protein calorie malnutrition. R22's medical record indicated R22 was seen by a nurse practioner (NP) on 10/6/22, 10/14/22, and 11/17/22. The record lacked documentation R22 had been seen by a physician during her stay at the facility. R2 Review of R2's face sheet indicated R2 was admitted on 5/28/21, with a diagnosis of acute bronchitis. R2's medical record indicated R2 was	F 712	1. It is the expectation of Moorhead Restorative Care Center that all patients are seen by a Physician every 30 days from admission for the first 90 days, then every 60 days thereafter. Per regulation the facility expectation is that the physician may elect to alternate visits between Physician and Midlevel provider (NP, PA) every other visit after the initial. R2 and R22 were reviewed and scheduled for the next routine rounds if needed. 2. The deficient practice has the potential to impact all residents at the facility. Patient charts were reviewed for rounding frequency and rounds schedule and updated appropriately to ensure compliance. 3. Education on the policy/procedure for physician rounds will be provided to HUC and all licensed nurses with a focus on frequency and ensuring initial and alternating visits include the Physician. 4. Audits of physician visits will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further	

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F 712	Continued From page 59 seen by a physician for routine rounds on 6/2/22, and 11/21/22. The medical record lacked documentation of an alternating physician visit between the NP visits which should have occurred in 10/2022. The visit was longer than a month overdue. During an interview on 12/1/22, at 11:00 a.m. clinical manager (CM) stated new admissions were required to be seen by a physician every 30 days for the first 90 days and then at least every 60 days thereafter. CM indicated a nurse practioner (NP) can alternate visits under the direction of a physician. CM stated it was the registered nurses (RN's) and the health unit coordinator (HUC) who were responsible for setting up physician rounds and confirmed R2 and R22 had missed being seen by a physician within the required time frames. During an interview on 12/1/22, at 11:10 a.m. director of nursing (DON) confirmed the requirement was for residents be be seen by a physician at least every 30 days for the first 90 days after admission and alternating every 60 days with a NP thereafter. DON stated her expectation was the regulation would have been followed accordingly. A facility policy titled Physician visit policy reviewed 12/21, indicated the medical care of each resident was supervised by a physician. The policy further identified the residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter per regulations.	F 712	follow up and recommendations. 5. DON or designee responsible for compliance	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		1/3/23

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F 757	Continued From page 60 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident blood pressure medication was held as ordered by the physician for 1 of 1 resident (R23) reviewed for unnecessary medications and who had parameters to to hold blood pressure medication based on his blood pressure results. Findings include: R23's quarterly Minimum Data Set (MDS) dated 11/4/22, identified R23 had diagnoses which included hypertension, congestive heart failure (CHF), hyperkalemia (high potassium) and	F 757	1. It is the expectation of Moorhead Restorative Care Center that medications will be administered in accordance with the physician's order including but not limited to obtaining vital signs prior to administration and any parameters to hold medication. R 23 was seen by NP to ensure well being. 2. The deficient practice has the potential to impact all patients with medications. Physician orders reviewed and current ordered parameters are in place and visible within the MAR. The facility policy title Medication	

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F 757	Continued From page 61 anemia. Identified R23 had intact cognition and was independent with his activities of daily living (ADL's). R23's Order Summary Reports signed 11/1/22, identified an order for Lisinopril (medication used to lower blood pressure) tablet five (5) milligrams (mg) by mouth one time a day for hypertension, hold for SBP (systolic blood pressure (top number)) less than 90 or DBP (diastolic blood pressure (bottom number)) less than 60. Review of R23's Medication Administration Record (MAR) from August 2022, through November 2022, revealed the following: - August 2022, MAR revealed on 8/19/22, R23's DBP was below 60, however his Lisinopril was not held. - September 2022, MAR revealed on 9/10/22, and 9/14/22, R23's DBP was below 60, however his Lisinopril was not held. - October 2022, MAR revealed on 10/13/22, and 10/22/22, R23's DBP was below 60, however his Lisinopril was not held. - November 2022, MAR revealed on 11/13/22, 11/16/22, and 11/25/22, R23's DBP was below 60, however his Lisinopril was not held. During an interview on 11/30/22, at 1:11 p.m. licensed practical nurse (LPN)-A stated R23 had an order to hold his Lisinopril based upon what his blood pressure was. She indicated she checked R23's blood pressure prior to administering his Lisinopril and if his DBP was below 60 she would have held the medication.	F 757	Administration was reviewed and remains appropriate. 3. Education will be provided to all Licensed nurses and TMAs on Medication Administration with a focus on following physician order including but not limited to parameters if present. 4. Audits of medications with parameters will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. DON or designee responsible for compliance.	

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F 757	Continued From page 62 LPN-A indicated she had not had to hold R23's Lisinopril due to a low blood pressure. During an interview on 12/1/22, at 11:18 a.m. registered nurse (RN)-A indicated he would have checked R23's blood pressure prior to giving him his blood pressure medication, and would hold the medication based on the parameters identified in the order. During an interview on 12/1/22, at 1:41 p.m. the director of nursing (DON) confirmed R23's physician orders directed nursing staff to check R23's blood pressure prior to being administered his Lisinopril. The DON confirmed R23's physician orders had parameters to hold R23's Lisinopril when his blood pressure was low. The DON stated she would have expected the medication to be held as ordered. During a telephone interview on 12/1/22, at 1:38 p.m. the facility's consulting pharmacist (CP) stated she had recently reviewed R23's electronic medical record (EMR), and on 11/28/22, she had identified his Lisinopril had not been held as ordered on several occasions. The CP indicated she had reviewed R23's EMR since his admission in August 2022, and had not identified any concern with his Lisinopril being given when his blood pressure was outside of the parameters prior to her November review. The CP stated she would expect R23's Lisinopril to have been held when his DBP was below 60. She indicated R23's blood pressure could go too low if he received the medication when his BP was below the recommended parameters. Review of a facility policy titled, Medication Administration reviewed 5/2022, revealed	F 757		

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F 757	Continued From page 63 medication should have been administered in a safe and timely manner and as prescribed. The policy identified medications must be administered in accordance with the orders. The policy identified vital signs (which would include blood pressure) must have been checked prior to administering medication when ordered.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		1/3/23

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F 758	Continued From page 64 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete timely tardive dyskinesia (TD) screenings (assessment for involuntary movements) for 1 of 3 residents (R17) reviewed for unnecessary medications, who received a routine dose of an antipsychotic medication. Findings Include: R17's significant change Minimum Data Set (MDS) dated 10/22/22, identified R17 had moderate cognitive impairment with disorganized thinking that fluctuated and had diagnoses which included: dementia, depression and diabetes mellitus. Identified R17 required extensive assistance with transfers, dressing, personal hygiene and toilet use. Indicated R17 had verbal behavioral symptoms daily, and rejected cares four to six days. Identified R17 received	F 758	1. It is the expectation of Moorhead Restorative Care Center that all patients are routinely assessed for side effects/efficacy/need for use of psychotropic medications. It is the expectation that an AIMs or equivalent assessments are completed for residents taking antipsychotics upon admission, every 6 months and with medication changes related to the antipsychotic medication. An assessment has been completed on R17. 2. All patients have the potential to be affected by the deficient practice. Residents with antipsychotics were reviewed and AIMs were updated as needed. The policy entitled Antipsychotic Medications was updated to reflect AIMs assessments upon admit, q 6 months and	

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F 758	Continued From page 65 antipsychotic medication six of the last seven days routinely. Review of R17's Care Area Assessment (CAA) dated 10/26/2, identified R17 received antipsychotic medication. Identified an actual psychotropic drug use problem/need. R17's CAA identified R17 took the medications for depression and dementia with behavioral disturbances and a referral to psych was warranted. R17's care plan revised 7/26/22, identified R17's activities of daily living (ADL) self-care needs were related to confusion and limited mobility and R17 required extensive assistance with bed mobility, bathing, dressing and personal hygiene. R17's care plan identified R17 had impaired cognitive function/dementia or impaired thought processes, and to administer medications as ordered and monitor/document for side effects and effectiveness. R17's care plan indicated R17 used anti-anxiety medications and antidepressant medication however lacked identification of R17's antipsychotic medication use. Review of R17's Order Summary Report signed 10/18/22, identified the following: -Seroquel 25 milligram (mg) give 0.5 tablet by mouth at bedtime related to major depressive disorder, order date 10/17/22. -Seroquel 25 mg give 0.5 tablet by mouth every six hours as needed for agitation, order date 10/17/2. Review of R17's medication administration record (MAR) dated 11/1/22, to 11/29/22, identified the following: -Seroquel 50 mg, give 50 mg by mouth two times	F 758	as needed with antipsychotic use. 3. All licensed nurses will receive education on psychotropic medication use with emphasis on routine monitoring and assessments. 4. Audits of appropriate assessment/monitoring for psychotropic will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. DON or designee responsible for compliance	

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F 758	Continued From page 66 a day, related to major depressive disorder, single episode unspecified, encephalopathy unspecified, start date 10/24/22, end date 11/2/22. -Seroquel 50 mg, give 75 mg by mouth two times a day for depression, start date 11/3/22. Review of R17's medical record identified the record lacked a tardive dyskinesia assessment had been completed prior to start of antipsychotic medication use. During a telephone interview on 12/1/22, at 1:32 p.m. pharmacist consultant (PC)-A confirmed she was aware R17 did not have an tardive dyskinesia assessment completed and indicated her usual process was to allow the facility about a month to complete the assessment. PC-A stated she would expect tardive dyskinesia assessments to be completed on admission, every six months and with a medication change. PC-A indicated she had made a recommendation for the facility to complete a tardive dyskinesia assessment on 11/28/22. During an interview on 11/30/22, 3:05 p.m. director of nursing (DON) confirmed R17 did not have an Abnormal Involuntary Movement Scale (AIMS) (an assessment used to assess tardive dyskinesia) completed. During a follow up interview on 12/1/22, at 1:49 p.m. DON indicated her expectation was for staff to complete an AIMS assessment upon admission and with any medication changes. DON confirmed R17 should have had one completed when his Seroquel was started, to get a baseline tardive dyskinesia assessment.	F 758		

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	245052	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 758	Continued From page 67 The facility policy titled Antipsychotic Medication Use, undated, identified nursing staff should monitor and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician which included: tardive dyskinesia. The policy failed to identify what assessment would be used and frequency to monitor for tardive dyskinesia.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a clean and sanitary condition of the kitchen floor, ceiling ventilation system, walk in cooler and freezers to promote sanitation in the kitchen. In addition, the	F 812	1. It is the policy of the facility to ensure proper food safety requirements, including maintaining a clean and sanitary condition of the kitchen floor, ceiling, ventilation system, walk in cooler and freezers to	1/3/23

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F 812	Continued From page 68 facility failed to maintain the water and ice machine to prevent potential contamination for all 39 of 39 residents who currently resided in the facility. Findings include: On 11/28/22, at 1:05 p.m. during an initial tour of the facility kitchen area with dietary manager (DM) the following concerns were identified: Floor: - the entire kitchen floor coverings and directly underneath the freezers, coolers, cabinets, stove area, and counter top food preparation areas were noted to be sticky and dirty. In addition, the floor coverings had several dust particles, dirt particles and dried food particles present on the entire surface of the kitchen floor. Walk in cooler: - upon entering the walk in cooler, the ceiling had visible droplets of water hanging and was dripping onto the floor. The floor had a large puddle of water on the walk way from the ceiling which was observed to be continuously dripping water. Chest freezer: - the chest freezer had a heavy build up of frost around the upper part of the freezer which extended all the way around the back and the sides of the freezer. The bottom of the freezer had large amounts of debris and food particles on the bottom of the freezer and was unclean. Inside the chest freezer was a half of a box of carmel rolls, which was uncovered, exposed to the elements and had freezer burn present on some of the carmel rolls.	F 812	promote sanitation in the kitchen. In addition, to maintain the water and ice machine to prevent potential contamination for residents who currently resided in the facility. The equipment has been serviced to ensure compliance. 2. All residents who resident in the facility have the potential to be affected by contamination on equipment that is not maintained properly. Dietary equipment has been inspected and serviced to ensure compliance. Facility policy's were reviewed and remain appropriate. 3. The Director of Maintenance was re-educated on potential for increased visual observation of ice machine and the potential for increased cleanings based on mineral content, and in addition to ensure equipment is maintained to ensure compliance. Dietary Manager was also re-educated on maintaining a clean and sanitary condition in the kitchen and dining areas. 4. Audits will be completed weekly x 4 weeks and monthly x 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification and brought to, reviewed by and ongoing recommendations provided through to the monthly quality assurance committee team for further expected review and monitoring. 5. Dietary Service Manager/Maintenance Director	

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F 812	Continued From page 69	F 812		

Meat freezer:
- The bottom of the freezer had large amounts of debris and food particles present and was unclean.

Ceiling vent:
- the large ceiling vent located in the middle of the kitchen by the clean dishes had moderate buildup of gray/brown dust and dirt particles on the grates of the vent.

Ice/water machine:
- the water and ice machine located in the main dining room of the facility had encrusted black substance around the water dispenser.

On 11/30/22, at 9:11 a.m. during the kitchen tour of the facility kitchen area with DM the following concerns were identified:

Floor:
- the entire kitchen floor coverings and directly underneath the freezers, coolers, cabinets, stove area, and counter top food preparation areas were noted to be sticky and dirty. The floor coverings had several dust particles, dirt particles and dried food particles present on the entire surface of the kitchen floor.

Walk in cooler:
- upon entering the walk in cooler, the ceiling had visible droplets of water hanging and was dripping onto the floor. The floor had a large puddle of water on the walk way from the ceiling which was observed to be continuously dripping water.

Chest freezer:
- the chest freezer had a heavy build up of frost

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	245052	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 812	Continued From page 70 around the upper part of the freezer which extended all the way around the back and the sides of the freezer. The bottom of the freezer had large amounts of debris and food particles present and was unclean. Inside the chest freezer was a half of a box of carmel rolls, which were uncovered, exposed to the elements and had freezer burn present on some of the carmel rolls. Meat freezer: - The bottom of the freezer had large amounts of debris and food particles on the bottom of the freezer and was unclean. Ceiling vent: - the large ceiling vent located in the middle of the kitchen by the clean dishes had moderate buildup of gray/brown dust and dirt particles on the grates of the vent. Ice/water machine: - the water and ice machine located in the main dining room of the facility had encrusted black substance around the water dispenser. Review of daily cleaning schedule undated, indicated staff were to sweep/mop the kitchen floor and the walk-in cooler. Review of monthly cleaning schedule dated 2022, indicated staff were to clean behind and under major appliances, wash vents and wipe down walk in cooler. DM confirmed the above findings during the kitchen tour and indicated the above areas should be cleaned daily. During an interview on 11/30/22, at 9:32 a.m. the	F 812		

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F 812	Continued From page 71 DM confirmed the above findings and indicated dietary staff had daily cleaning assignments, although the assignments had not been completed on a routine basis. The DM confirmed the walk in cooler had been leaking water since last March 2022. DM verified he had notified the maintenance director and administrator of the leaking cooler at that time and was directed to deal with it. The DM indicated he had not been trained on how/when to defrost the freezers and verifed it had been about seven months since the chest freezer had been defrosted and cleaned. The DM indicated he would expect staff to complete their daily check lists for cleaning, sweeping/mopping the floors and maintaining and cleaning the freezers. The DM stated he would expect the walk in cooler to be fixed and maintained. During an interview on 11/30/22, 10:30 a.m. the maintenance director (MD) confirmed he had been notified of the leak in the walk in cooler about six months ago or longer. The MD indicated he had notified the owner of the leaking walk in cooler and was told he would seek contractors to repair the leak in the cooler. The MD stated he was not certain who was responsible for maintaining and cleaning the kitchen equipment and ice/water machine. Review of facility policy titled, Cleaning and Sanitation of Dining and Food Service Areas undated, indicated the nutrition and food service staff would maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. On 11/30/22, a policy for cleaning ice/water	F 812		

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F 812	Continued From page 72 dispenser was requested however was not provided.	F 812		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. 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. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: 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 quality deficiencies identified during the survey that the facility was aware of or should have been aware of that had the potential to adversely affect all 39 residents which resided in the facility. Findings include: The facility's QA program lacked a process for	F 865	1. It is the expectation of Moorhead Restorative Care Center that QAPI meetings are held monthly and as needed to identify, quantify, track, trend and correct any identified areas of improvement for the facility. It is the expectation that a routine procedure is utilized to ensure consistency and that accurate minutes are recorded and maintained. 2. This deficient practice has the potential to affect all residents. A QA template has been provided and	1/3/23

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F 865	Continued From page 73 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. During an interview on 12/1/22, at 3:05 p.m. the director of nursing (DON) stated the facility's QA committee and processes were currently undergoing some changes which included adding a QAPI director who oversees the committee and projects in the future. The DON indicated at the current time, she felt the facility lacked a formal QA process and the facility was reactive vs pro-active in identifying and addressing quality concerns. The DON indicated the facility was currently working on a couple QA projects which included call light response time, falls, staff general orientation and reporting to the state agency. She indicated the current mechanism to obtain information for current projects was from information shared during morning report which was held Monday through Friday by facility leadership. The DON indicated there was no formal method of monitoring, data collection, or analysis of the aforementioned QA projects in place to ensure resident needs were consistently met. The DON was not able to provide evidence of actions plans with measurable goals and monitoring/auditing and evaluation of the identified projects. The facility provided an undated, 17 page document titled, QAPI Meeting Agenda, MRRC, which was identified as the facility's most recent QA meeting minutes. The QA meeting minutes identified the facility's most recent recertification	F 865	implemented within the facility as a guided tool for QA meetings going forward. All current deficiencies have been added to the template for this facility as well as routinely monitored areas of concern. The policy entitled QAPI was reviewed and remains appropriate. 3. All team members expected to participate in QAPI will be educated on expectations of QAPI meetings, responsibility for data collection has been assigned. 4. Audits for compliance will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. Administrator or Designee is responsible for compliance.	

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F 865	Continued From page 74 survey was conducted on 8/17/21, however, the facility's most recent recertification surveys had been conducted on 6/16/22, and 12/22/21. The form listed data and information regarding infection however, the form listed staff responsible for infection control was not identified as an employee of the facility. Further, the form revealed resident council meeting had been held on June 27, 2022, listed an activity director who was not listed as an employee of the facility. The document revealed several sections for outstanding and current items which included topics of falls, OHFC (Office of Health Facility Complaints) and staff competency-training. However, the form lacked accurate, thorough data, method or means to track the data, comprehensive analysis, trends or actions. Review of facility policy titled, QAPI reviewed 12/5/19, identified the purpose of the policy was the facility was to maintain a Quality Assurance and Performance Improvement (QAPI) Committee for continuous quality improvement of overall performance. The policy identified the committee was to monitor, sustain operational performance in clinical and non-clinical systems through self-identification and improvement areas where opportunities for improvement have been identified. The policy identified the critical functions of the QAPI committee included; review of operations, identify opportunities for improvement, prioritize opportunities for improvement, determine root cause, implement performance improvement projects. The policy identified the committee would conduct performance improvement projects, identify action items, collect and analyze data and implement corrective action.	F 865		

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F 868	Continued From page 75	F 868		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assurance (QA) committee met on a quarterly basis throughout the past calendar year to work on improving patient care and correcting any identified areas of concern. This had potential to affect all 39 residents residing in the facility. Findings include: Review of an undated QAPI (Quality Assurance Performance Improvement) Meeting Agenda Moorhead RHCC identified several members of the committee had been present at the meeting, however lacked documentation the infection preventionist had been present. The agenda did not identify when the facility's committee had last	F 868	1. It is the expectation of Moorhead Restorative Care Center that the QAPI committee consisting of Administrator or designee, DON, medical director, or designee and at least 2 other staff members will meet a minimum of Quarterly. 2. The deficient practice has the potential to affect all residents. A QAPI tool has been provided and implemented for accurate ongoing tracking of meeting data, attendance and findings. The facility as scheduled their ongoing QAPI meetings for the third week of each month. Members of the QA committee were notified. In the event QAPI must be rescheduled the Administrator or	1/3/23

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F 868	Continued From page 76 met. During an interview on 12/1/22, at 3:05 p.m. the director of nursing (DON) indicated the facility's QA committee had met in July or August of 2022, though was unsure of the date. The DON indicated she was unsure of when the facility's QA committee had met prior and stated they planned to be meeting quarterly going forward. The DON stated the facility recently hired a QA director who would be overseeing the facility's QAPI program and ensure the committee met quarterly. Review of facility policy titled, QAPI reviewed 12/5/19, identified the purpose of the policy was the facility to maintain a Quality Assurance and Performance Improvement (QAPI) Committee for continuous quality improvement of overall performance. The policy identified the committee was to meet monthly.	F 868	Designee will notify all members of the QA. The policy titled QAPI was reviewed and continues to remain appropriate. 3. All members of the QA committee will be educated on expectations for QA with an emphasis on timely meetings and routine review of existing or new concerns. 4. Audits for compliance will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. If it is identified that there is ongoing deficiency in QA the administrator or designee will initiate an Ad hoc QAPI with the QA committee and/or external consulting entities as needed. 5. Administrator or designee responsible for compliance	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 77 §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 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 78 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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, including identification of any patterns in residents, locations or pathogens in real time to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 39 residents who resided in the facility. Findings include: Review of the facility's infection control surveillance program was conducted on 11/30/22, at 1:04 p.m. with registered nurse infection preventionist (RNIP)-A. The infection logs included the following columns: resident name, room number, admit date, type of infection, surveillance definition met, symptoms, onset date, antibiotic name, class, dose, route, frequency provider, antibiotic start date, antibiotic end date, transmission on based precautions required, and date symptoms resolved.	F 880	1. It is the expectation of Moorhead Restorative Care Center that an infection prevention program including surveillance, documentation, monthly QA review for trends is maintained by the IPC and overseen/audited by the DON/designee. It is the expectation that all suspected or confirmed illnesses of staff and residents are tracked and sufficient data is documented to follow federal requirements and allow for comprehensive review. 2. The deficient practice has potential to affect all residents. An ADHOC QAPI with facility DON, consulting RN, consulting clinical manager, and facility DOR was conducted and reviewed by the governing body. It was identified that ongoing education would be required to ensure compliance. Facility infection prevention program policies, procedures and tracking/surveillance tools were gathered and reviewed, DON expressed an understanding of provided education/information for ongoing implementation and enforcement. The	

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F 880	Continued From page 79 The infection logs lacked necessary documentation for adequate surveillance of illnesses in the facility which should include: identification of all illnesses tracked, diagnostics preformed, test dates, type of tests, specimen source, results, if antibiotic resistant organism, time outs preformed, and dates resolved were not identified. A staff surveillance log was requested to determine possible communicable diseases in the facility including COVID-19, however was not provided. During an interview on 11/30/22, at 1:04 p.m. review of the facility's infection control plan and surveillance log was completed with RNIP-A. RNIP-A confirmed no surveillance, tracking or trending had been completed since October 2022, and indicated she was not provided the time required to maintain the infection control program. RNIP-A confirmed no diagnostic testing was tracked on her surveillance logs, or time outs, or infection results. RNIP-A confirmed the surveillance log was not kept up to date and stated no other staff member was responsible for tracking infections in the facility. RNIP-A verified she had not been tracking viral or other illnesses not treated with anti-infective agents. RNIP-A confirmed the facility residents had viral or other illnesses not treated with anti-infective agents occasionally. Additionally, RNIP-A confirmed she had not tracked any of the staff illnesses, however indicated the facility had no COVID-19 positive residents or staff in the past four weeks. During an interview on 12/1/22, at 11:10 a.m. DON confirmed RNIP-A was responsible for tracking all infections in the facility. DON	F 880	facility will transition all resident illness tracking to the integrated Infection Control tab in point click care which meets or exceeds criteria for data tracking and provides real time trending reports including but not limited to trends in infection type, trends by location etc. It additionally allows for the attachment of supporting diagnostics, assessments, ABT timeouts and creates a stop sign alert on the EHR for each resident with an open suspected or confirmed case to alert staff to active infections. DON/Admin will utilize consulting entities ongoing as needed or as determined by the governing body for education and oversight to ensure compliance. 3. Education will be provided to all licensed staff and members of QA committee on expectations of illness tracking and infection prevention. Education will include but is not limited to appropriate use of the infection control within PCC for reporting/following up on/trending active infections, oversight of floor staff documentation to identify and report infections as appropriate, and monthly QA oversight of IPC programming and standard infection prevention practices. Education will be completed on 12/28/22. A posttest will be completed to ensure staff understanding of education provided. Any failed tests will be followed up with immediate reeducation. 4. Audits will be conducted every regular business day as routine part of Clinical Standup. All audits will be brought to QAPI for review. 5. Infection Preventionist or designee	

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F 880	Continued From page 80 indicated she was not aware of how the facility should conduct their surveillance of infections in the facility however stated she was aware the facility was expected to track all illnesses. DON confirmed not all necessary components were being tracked with the infection control surveillance program. The facility policy titled Infection Control Policy, undated, identified a system of surveillance was designed to identify possible communicable diseases or infections before they could spread to other persons in the facility. The facility policy titled Surveillance For Infections, reviewed 1/18/22, identified the infection preventionist would conduct ongoing surveillance for health care associated infections and other epidemiological significant infections that had substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The policy identified the infections would include routine surveillance which would include evidence of transmissibility in a healthcare environment, processes and procedures that prevent or reduce the spread of infection, and pathogens associated with serious outbreaks. The policy indicated the surveillance should include any or all of the following information to help identify possibly indicators of infections which included; laboratory records, including culture result, and multi-drug-resistant reports that required immediate attention. The policy identified for residents with infections, to collect the following data which included: identifying information, diagnoses, date of onset, infection site, pathogens, invasive procedures, and treatment measures. The policy identified	F 880	responsible for compliance	

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F 880	Continued From page 81 targeted surveillance should use facility-created tools for a daily recording on individual infection report, monthly collection from individual reports and monthly summarization of data by unit and pathogen.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		1/3/23

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F 883	Continued From page 82 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R24, R5, R19) were offered or received pneumococcal and/or influenza vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the current CDC recommendations, Recommended Adult Immunization Schedule for ages 19 Years or older, United States, 2022, located at https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#table-age, identified the following:	F 883	1. It is the expectation of Moorhead Restorative Care Center that all residents are offered pneumococcal and influenza vaccinations upon admission and routinely thereafter in accordance with CDC recommendations for immunization. It is the expectation that refusals are documented, and education provided if indicated. R24, R19, and R5 were provided education on vaccinations available within the facility and were assisted in filling out a consent/declination form. 2. All residents have the potential to be affected by the deficient practice.	

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F 883	Continued From page 83 -Adults age 19 of age or older should receive the influenza vaccination annually. -Adults 65 years of age or older should receive 1 dose PCV15 followed by PPSV23 or 1 dose PCV20. R24, age 74, was admitted to the facility on 5/5/22. R24's medical record lacked documentation a pneumococcal or influenza vaccination was offered or received. R5 age 86, was admitted to the facility on 7/1/22. R5's medical record lacked documentation a pneumococcal or influenza vaccination was offered or received. R19 age 72, was admitted to the facility on 7/21/22. R19's medical record lacked documentation a pneumococcal or influenza vaccination was offered or received. During an interview on 12/1/22, at 3:34 p.m. director of nursing (DON) confirmed her expectation was for all residents on admission to be offered the influenza and pneumococcal vaccinations if eligible. DON confirmed she would expect the facility would follow their policies of vaccinations offered and to document results. DON confirmed she was aware R19 had refused all immunizations however was not certain if R19 had been provided education or offered the vaccinations. The facility policy titled Vaccination Of Residents reviewed 1/18/22, identified all residents would be offered vaccines that aid in preventing infectious diseases unless the vaccine was medically contraindicated or the resident had already been vaccinated. The policy identified certain	F 883	Resident charts were reviewed for current documentation of consent/declination and education provided if needed. Updates made as needed. The facility policy titled Vaccination of Residents was reviewed and remains appropriate. 3. Education will be provided for all licensed nurses on the vaccination of residents with emphasis on consent/declination/education on vaccination upon admission and ongoing per state and local guidance. 4. Audits of immunizations will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. Infection Preventionist or designee is responsible for compliance	

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F 883	Continued From page 84 vaccines, example influenza and pneumococcal vaccines, may have been administered per the physician-approved facility protocol (standing orders) after the resident had been assessed by the physician for medical contraindications for each vaccine. The policy identified the resident's attending physician must provide a separate written order for any other vaccination, and such orders would be recorded in the resident's medical record. The facility policy titled Pneumococcal Vaccine, undated, identified all residents would be offered pneumococcal vaccines to aid in prevention of pneumococcal infections. The policy identified prior to admission, residents would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated would be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident had already been vaccinated. The policy indicated before receiving the vaccine, the resident or legal representative would receive information and education regarding the benefits and potential side effects of the vaccine. The policy identified residents had the right to refuse vaccination, and if refused, appropriate entrees would be documented in each residents' medical record indicating the date of the refusal. The facility policy titled Influenza, Prevention, And Control of Seasonal, undated, identified the infection preventionist would promote and administer seasonal influenza vaccine and unless contraindicated, all residents would be offered the vaccine.	F 883		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6)	F 886		1/3/23

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F 886	Continued From page 85 §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing	F 886		

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F 886	Continued From page 86 was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide Centers for Disease Control And Protection (CDC) recommended COVID-19 testing of 2 of 2 residents (R238, R89) newly admitted to the facility during time when community transmission rates were high. This practice had the potential to affect all 39 residents and staff who resided at the facility. Findings Include: The CDC COVID-19 Integrated County View community transmission rate as of 11/16/22, was high.	F 886	1. It is the expectation of Moorhead Restorative Care Center that testing for Covid-19 will be conducted on residents and staff in accordance with state and local regulations. Upon review neither resident developed Covid-19 within 7 days of admit. 2. All residents have the potential to be affected by the deficient practice. On 12/7/2022 an ADHOC QAPI was conducted by facility DON, consulting RN, consulting clinical manager and facility DOR and later reviewed by governing body. The QA included but was not limited to full review of current Covid-19 guidance	

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F 886	Continued From page 87 The Centers For Medicare And Medicaid Services (CMS) QSO-20-38-NH revised 9/23/22, identified to enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities were required to test residents and staff based on parameters and frequency set forth by the health and human services (HHS) secretary. The memo indicated testing information of residents who were newly admitted or readmitted to the facility and those who left the facility for 24 hours or longer. The memo referred to the managing admissions and residents who left the facility section of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic webpage. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, revised 9/23/22, included managing admissions and residents who left the facility section which identified: Testing was recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. In general, admissions in counties where Community Transmission levels were high should have been tested upon admission. R238 Review of R238's medical record identified R238 was admitted 11/16/22. Review of R238's hospital COVID Screening and Lab Report identified R238 had a SARS-CoV-2 completed 11/15/22, with results not detected.	F 886	as provided through MDH routine Covid-19 calls, CMS QSO memos and MDH adaptation/adoption of said recommendations. Review of policies and procedures surrounding Covid-19 including but not limited to current testing guidance. The facility policies for Covid-19 were reviewed and found to be in line with current guidance. 3. Education will be provided to all licensed staff regarding testing requirements for staff and residents. The IPC will be responsible for updating staff to changes in this guidance. In the absence of the IPC the DON will designate a responsible entity. 4. Audits of covid testing for residents and staff will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. DON or designee will be responsible for compliance	

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F 886	Continued From page 88 R238's medical record lacked further testing as recommended by CDC for residents newly admitted to the facility in an area of high community transmission rate. R89 Review of R89's medical record identified R89 was admitted 11/18/22. Review of R89's hospital COVID Screening and Lab Report identified R89 had a SARS-CoV-2 completed 11/18/22, with results not detected. R89's medical record lacked further testing as recommended by CDC for new residents newly admitted to the facility in a an area of high community transmission rate. During an interview on 12/1/22, at 3:34 p.m. director of nursing (DON) indicated most residents were tested prior to entering the facility. DON confirmed R238 and R89 had not completed all necessary COVID-19 testing. DON stated she would expect newly admitted residents would be tested on day one, three and five to prevent COVID-19 to be spread in the facility. The facility policy titled COVID-19 Facility Guidelines, revised 11/2/22, identified residents would be tested per state and local guidance and updated on their results in a timely manner. The facility policy titled F886, revised 4/27/22, identified to enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities were required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary.	F 886		

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F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum,	F 887		1/5/23

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F 887	Continued From page 90 the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure COVID-19 vaccinations were offered and received for 1 of 5 resident (R19) reviewed for COVID-19 vaccination status. Findings Include: R19 age 72, was admitted to the facility on 7/21/22. R19's medical record lacked documentation a COVID-19 vaccination was offered or received. On 12/1/22, at 3:34 p.m. director of nursing (DON) indicated she would expect COVID-19 vaccination would be offered when residents were	F 887	1. It is the expectation of Moorhead Restorative Care Center that all residents are offered Covid-19 vaccination upon admission and given the opportunity to consent and receive or decline with appropriate education. The expectation is that staff allow residents the opportunity to update their consent status if they so choose. R19 has been offered consent/declination for Covid-19. 2. All residents have the potential to be affected by the deficient practice. Resident charts were reviewed for current consent/declinations for Covid-19 vaccination and updated as needed. The	

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	245052	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 887	Continued From page 91 admitted. DON confirmed R19's medical record lacked documentation a COVID-19 vaccination had been offered. DON indicated she had been aware R19 had refused all vaccinations, however would expect nursing staff to follow the facility's policy regarding vaccinations. The facility policy titled Vaccination Of Residents reviewed 1/18/22, identified all residents would be offered vaccines that aid in preventing infectious diseases unless the vaccine was medically contraindicated or the resident had already been vaccinated. The policy further identified certain vaccines, may be administered per the physician-approved facility protocol (standing orders) after the resident had been assessed by the physician for medical contraindications for each vaccine. The policy identified the resident's attending physician must provide a separate written order for any other vaccination, and such orders would be recorded in the resident's medical record.	F 887	policy titled Resident Vaccination was reviewed and remains appropriate 3. All licensed staff will be educated on the policy for Covid-19 vaccination with an emphasis on offering and documenting consent/declination upon admission and as needed. 4. Audits of consents will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. DON or designee responsible for compliance	
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 943		1/10/23

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F 943	Continued From page 92 §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure abuse and/or vulnerable adult (VA) training was completed upon hire as directed by facility policy for 1 of 1 employees (registered nurse infection preventionist (RNIP)-A) identified as an alleged perpetrator (AP) in an allegation of potential verbal abuse. Findings Include: During an interview on 11/28/22, at 2:30 p.m. R13 stated he had made a report to a nurse, unidentified, who had filed a report with the facility regarding concerns with registered nurse Infection preventionist (RNIP)-A who had mistreated him and placed something in his water. Review of the SA reports and grievance log provided by the facility lacked documentation of a report filed related to R13's allegation. On 11/28/22, at 7:28 p.m. surveyor reported to administrator R13 indicated he had been mistreated by a staff member and was afraid of her. Administrator confirmed no SA report had been filed regarding R13's allegation and stated he would interview R13. During an interview on 11/30/22, at 7:45 a.m. business office manager (BOM)-A confirmed RNIP-A started employment at the facility on 2/8/22. BOM-A indicated RNIP-A had been transferred to the facility from a sister company	F 943	1. It is the policy of the facility to ensure training on abuse, neglect and exploitation requirements are completed upon hire and annually. Training and education has been provided to RNIP. 2. All residents have the potential to be affected by this deficient practice based on failure to ensure completion of abuse, neglect and exploitation training upon staff hire. Staff were re-educated on the facility policies and procedures on abuse reporting and investigations. An in-service will be held for further training and education on 12/28/22. 3. On 12/28/22 all staff will receive in-service training regarding requirements for reporting, investigating, preventing and correctly handling allegations of abuse. Management will ensure new hires complete abuse and neglect training prior to floor orientation at the facility, as well as ongoing at a minimum annually to ensure continued education and training compliance is sustained. 4. Audits of abuse neglect and exploitation training for all staff including new hires will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. Business Office Manager or designee responsible for compliance	

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F 943	Continued From page 93 facility where she began work on 7/6/20. Review of RNIP-A's personnel file lacked documentation abuse and/or vulnerable adult (VA) training had been completed since RNIP-A began work in the facility on 2/8/22. During an interview on 11/30/22, at 11:00 a.m. RNIP-A indicated she had completed abuse prevention and vulnerable adult training at the previous facility, however could not remember how long ago. During an interview on 11/30/22, at 3:45 p.m. director of nursing (DON) confirmed RNIP-A had not completed abuse prevention training at the facility. DON indicated she believed since RNIP-A transferred from a sister facility, the training was not required. The facility policy titled Abuse Prevention Program revised 1/22/22, identified comprehensive policies and procedures had been developed to aid their facility in preventing abuse, neglect or mistreatment of their residents. The policy indicated the facility program mandated a staff training/orientation program that included such topics as abuse prevention, identification and reporting of abuse, stress management, dealing with violent behavior or catastrophic reactions, etc. (and so on).	F 943		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 11/28/22, to 12/1/22, a standard licensing survey was conducted completed 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: (TAG).	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H50525569C (MN00087666), however NO licensing orders were issued due to actions implemented by the facility prior to survey The following complaints were found to be UNSUBSTANTIATED: H50526291C (MN00088944), and H50525572C (MN00086477, however, a related licensing order was issued at 1980. The following complaints were found to be UNSUBSTANTIATED: H50525570C (MN00086941), and H50525573C (MN00088083). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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2 000	Continued From page 2 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. 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 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 necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must	2 255		1/3/23

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2 255	Continued From page 3 address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: 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 quality deficiencies identified during the survey that the facility was aware of or should have been aware of that had the potential to adversely affect all 39 residents which resided in the facility. Findings include: 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. During an interview on 12/1/22, at 3:05 p.m. the director of nursing (DON) stated the facility's QA committee and processes were currently undergoing some changes which included adding a QAPI director who oversees the committee and projects in the future. The DON indicated at the current time, she felt the facility lacked a formal QA process and the facility was reactive vs pro-active in identifying and addressing quality concerns. The DON indicated the facility was currently working on a couple QA projects which included call light response time, falls, staff general orientation and reporting to the state	2 255	1. It is the expectation of Moorhead Restorative Care Center that QAPI meetings are held at least Quarterly and as needed to identify, quantify, track, trend and correct any identified areas of improvement for the facility. It is the expectation that a routine procedure is utilized to ensure consistency and that accurate minutes are recorded and maintained. 2. This deficient practice has the potential to affect all residents. A QA template has been provided and implemented within the facility as a guided tool for QA meetings going forward. All current deficiencies have been added to the template for this facility as well as routinely monitored areas of concern. The policy entitled QAPI was reviewed and remains appropriate. 3. All team members expected to participate in QAPI will be educated on expectations of QAPI meetings, responsibility for data collection has been assigned. 4. Audits for compliance will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. Administrator or Designee is responsible for compliance.	

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2 255	Continued From page 4 agency. She indicated the current mechanism to obtain information for current projects was from information shared during morning report which was held Monday through Friday by facility leadership. The DON indicated there was no formal method of monitoring, data collection, or analysis of the aforementioned QA projects in place to ensure resident needs were consistently met. The DON was not able to provide evidence of actions plans with measurable goals and monitoring/auditing and evaluation of the identified projects. The facility provided an undated, 17 page document titled, QAPI Meeting Agenda, MRRC, which was identified as the facility's most recent QA meeting minutes. The QA meeting minutes identified the facility's most recent recertification survey was conducted on 8/17/21, however, the facility's most recent recertification surveys had been conducted on 6/16/22, and 12/22/21. The form listed data and information regarding infection however, the form listed staff responsible for infection control was not identified as an employee of the facility. Further, the form revealed resident council meeting had been held on June 27, 2022, listed an activity director who was not listed as an employee of the facility. The document revealed several sections for outstanding and current items which included topics of falls, OHFC (Office of Health Facility Complaints) and staff competency-training. However, the form lacked accurate, thorough data, method or means to track the data, comprehensive analysis, trends or actions. Review of facility policy titled, QAPI reviewed 12/5/19, identified the purpose of the policy was the facility was to maintain a Quality Assurance and Performance Improvement (QAPI)	2 255		

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2 255	Continued From page 5 Committee for continuous quality improvement of overall performance. The policy identified the committee was to monitor, sustain operational performance in clinical and non-clinical systems through self-identification and improvement areas where opportunities for improvement have been identified. The policy identified the critical functions of the QAPI committee included; review of operations, identify opportunities for improvement, prioritize opportunities for improvement, determine root cause, implement performance improvement projects. The policy identified the committee would conduct performance improvement projects, identify action items, collect and analyze data and implement corrective action. Based on interview and document review, the facility failed to ensure the quality assurance (QA) committee met on a quarterly basis throughout the past calendar year to work on improving patient care and correcting any identified areas of concern. This had potential to affect all 39 residents residing in the facility. Findings include: Review of an undated QAPI (Quality Assurance Performance Improvement) Meeting Agenda Moorhead RHCC identified several members of the committee had been present at the meeting, however lacked documentation the infection preventionist had been present. The agenda did not identify when the facility's committee had last met. During an interview on 12/1/22, at 3:05 p.m. the director of nursing (DON) indicated the facility's QA committee had met in July or August of 2022, though was unsure of the date. The DON	2 255		

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2 255	Continued From page 6 indicated she was unsure of when the facility's QA committee had met prior and stated they planned to be meeting quarterly going forward. The DON stated the facility recently hired a QA director who would be overseeing the facility's QAPI program and ensure the committee met quarterly. Review of facility policy titled, QAPI reviewed 12/5/19, identified the purpose of the policy was the facility to maintain a Quality Assurance and Performance Improvement (QAPI) Committee for continuous quality improvement of overall performance. The policy identified the committee was to meet monthly. SUGGESTED METHOD OF CORRECTION: The 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 area on a regular basis and make recommendations for any changes. The administrator will be responsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious	2 265		12/28/22

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2 265	Continued From page 7 accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician and power of attorney were notified of newly developed pressure ulcers for 1 of 1 resident (R33) reviewed for facility acquired pressure ulcers. R33's admission Minimum Data Set (MDS) dated 11/6/22, identified R33 had diagnoses which included debility (physical weakness), atrial	2 265	1. It is the expectation of Moorhead Restorative Care Center that all significant changes in condition will result in prompt notification to the Attending Physician and POA/Guardian when applicable. Notification has been provided to both parties regarding R33's pressure ulcer. 2. Failure to notify physician and responsible party with a resident's change in medical/mental condition and/or status	

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2 265	Continued From page 8 fibrillation, and hypertension. Identified R33 had moderately impaired cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and bathing. Identified R33 was always incontinent of bowel and bladder and was not on a toileting plan. Identified R33 was at risk for pressure ulcers and had a pressure relieving device for his bed and chair and was not on a turning and repositioning program. R33's admission Care Area Assessment (CAA) dated 11/6/22, revealed R33 had moderate cognitive impairment which limited his abilities to recognize his needs. Identified R33 required extensive assistance with ADL's, and was not able to remember the need to change position. Revealed R33 preferred to be lying in his bed or seated in a wheelchair and was to have a pressure relieving device on his bed and his wheelchair. Identified R33 was at risk for developing pressure ulcers and had no pressure ulcers at the time of the assessment. R33's admission skin assessment dated 10/31/22, revealed R33's skin was intact. R33's weekly skin review form dated 11/25/22, identified R33 had a small open area on his sacrum in which barrier cream was applied. During an interview on 11/30/22, at 9:05 a.m. with nurse manager (NM)-A, stated R33 had no pressure ulcers when he was admitted to the facility approximately one month prior. NM-A confirmed R33 currently had facility acquired pressure ulcers, one stage two on his sacrum and pressure ulcers to both heels which were unstagable due to deep tissue injury. NM-A stated she was not aware if R33's family had been	2 265	has the potential to impact all residents. Resident charts were audited for like occurrences and parties notified as necessary. 3. The policy entitled Change in a Resident's Condition or Status was reviewed and remains appropriate. All nursing staff will be educated regarding proper identification of a residents change in condition and prompt notification requirements on 12/28/22. 4. Audits for compliance will be completed on a random sample weekly x 4 weeks, and monthly x 3 months. Audits will be brought to and monitored through the QAPI meetings or further recommendations and ongoing monitoring. 5. Director of Nursing or designee responsible for compliance	

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

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2 265	Continued From page 9 notified of the pressure ulcers. During an interview on 11/30/22, at 9:16 a.m. Certified Nurse Practioner (NP)-A, stated she had met with R33 several times since his admission and was familiar with him. NP-A indicated she had been notified approximately a week ago R33 had redness on his buttocks, and felt it was due to R33's bowel and bladder incontinence. NP-A confirmed she had not been notified R33's sacrum was noted to have an open area on 11/25/22, and had not been notified of R33's bilateral heel deep tissue injury. R33's medical record lacked any documentation R33's practioner or family member/power of attorney had been notified of his pressure ulcers. During an interview on 12/1/22, at 10:29 a.m. the director of nursing (DON) indicated she would have expected R33's practioner and family member to be notified of any changes in R33's condition, which included newly developed pressure ulcers. During a telephone interview on 12/1/22, at 10:44 a.m. R33's family member (FM)-A indicated she was not been notified R33 had any pressure ulcers. FM-A stated she would have wanted to have been notified of any changes in R33's condition. Review of a facility policy titled, Change in a Resident's Condition or Status reviewed 11/30/21, identified it was the purpose of the policy the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the residents's medical/mental condition and/or status.	2 265		

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2 265	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to the physician notification. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 3 residents (R24) reviewed for activities. Finding include: R24's admission Minimum Data Set (MDS) dated 5/11/22, indicated R24's had diagnoses which included depression, anxiety disorder, bipolar disorder and was cognitively intact. R24 required extensive assistance of one or two staff for all activities of daily living (ADL's). R24's activities that were very important to her were listening to music and being around animals. R24's activities that were somewhat important to her were going outside for fresh air, doing her favorite activities,	2 565	1. It is the expectation of Moorhead Restorative Care Center that all patients have a comprehensive care plan developed upon admission and reviewed regularly by the IDT to include but not limited to preferred activities. Activities care plan was added for R24. 2. The deficient practice has potential to impact all residents. Resident care plans were reviewed and updated as needed. The policy entitled Activity Evaluation was reviewed, no updates required to remain compliant with CMS and MDH requirements. 3. Education will be provided to activity and MDS staff regarding the above policy with a focus on timeliness of development	1/10/23

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2 565	Continued From page 11 and keeping up with the news. R24's least favorite activities were reading books, news papers, magazines, doing group activities, and religious activities. Review of R24's care area assessment (CAA) dated 5/11/22, indicated R24 preferred group activities and being active in activities. The CAA indicated R24's activity functional status would be addressed in her care plan with overall objectives to maintain her current level of functioning. Review of R24's Activity Data Collection (Admission) dated 5/9/22, indicated R24's leisure activities were reading, watching TV drama shows, listening to 80's music, visiting with family, going to church and enjoyed being with dogs. Review of R24's careplan revised on 11/10/22, lacked any documentation of what R24's activity preferences, approaches, or goals were for activities. During an interview on 11/29/22, at 2:30 p.m. with director of activities (DA) she confirmed the above findings and indicated the activity/preference assessments were to be completed within seven days of a residents admission. The DA indicated the information from the the assessment was shared with only activity staff and indicated most of the residents were able to tell staff what they wanted to do for activities. The DA verified R24 currently did not have a activity careplan developed due to not having the training when she was hired. The DA indicated she did not know how to complete a care plan and was currently not doing them. The DA indicated most residents were only in the facility for a few weeks and did not require a care plan.	2 565	of a comprehensive care plan as well as routine review of said care plan per CMS requirements. 4. Audits of the comprehensive care plan will be completed weekly x 4 weeks then monthly x 3 months. All deficiencies will be corrected upon identification and findings brought to monthly QAPI committee for further review and recommendations. 5. MDS or Designee responsible for compliance	

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2 565	Continued From page 12 During an interview on 11/29/22, at 2:55 p.m. the activity aid (AA)-A indicated she documented all activity participation under the progress notes in the medical record. AA-A confirmed she had no written direction or activity careplan to follow and indicated she just knew what each resident enjoyed for activities. During an interview on 12/01/22, at 2:07 p.m. with director of nursing (DON) confirmed R24's care plan lacked any documentation of R24's activity focus, goals, or interventions. DON indicated she would expect staff to do a base line care plan within 48 hours of admission and a comprehensive care plan done within fourteen days after the assessment had been completed. She stated she would expect staff to complete care plans and to include activities focus, goals and interventions. Review of facility policy titled, Activity Evaluation undated, indicated staff would have evaluated residents within 14 days of admission and would develop an individual activities care plan (separate or as part of the comprehensive care plan). The policy identified each resident's activity care plan would have been related to his/her comprehensive assessment and would reflect his/her individual needs and the care plan would have identified if the resident was capable of pursuing activities without intervention from facility. The policy indicated the activity evaluation would have been part of the resident's medical record and should have been updated as necessary, but at least annually. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and	2 565		

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2 565	Continued From page 13 procedures to ensure the facility followed care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance with providing cares as directed by the care plan.. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum: A. the resident's legal name and preferred name; B. previous address; C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if any; I. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and	2 620		12/28/22

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2 620	Continued From page 14 clergy member; M. hospital preference; and N. name of attending physician. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident advanced directives were accurately documented in the resident's paper and electronic medical record (EMR) to reflect the residents current wishes for 1 of 1 resident (R23) reviewed for advanced directives. Findings include: R23's quarterly Minimum Data Set (MDS) dated 11/4/22, identified R23 had diagnoses which included diabetes, congestive heart failure, chronic obstructive pulmonary disease and end stage renal disease. The MDS identified R23 had intact cognition. Review of R23's Order Summary Report signed 11/1/22, revealed an order dated 8/15/22, which identified R23 was a DNR (do not resuscitate). Review of R23's care plan revised 11/18/22, identified he had a POLST (physician orders for life sustaining treatment) and had signed DNR orders. Review of R23's POLST form signed 8/17/22, identified R23 wanted CPR (cardiopulmonary resuscitation), however further on the form, it was revealed R23 requested comfort-focused treatment which was to allow for a natural death.	2 620	1. It is the expectation of Moorhead Restorative Care Center to ensure that residents advanced directives will be honored. To ensure this; it is the expectation that the facility maintains accurate medical records both paper and EHR. On 12/1/22 it was identified that R23 advanced directive did not match the EHR. Upon identification of this, R 23 was reviewed, and records updated to reflect resident's wishes. 2. The deficient practice has potential to impact all residents. An audit was completed of resident's POLST against the EHR, any discrepancies were clarified and updated to EHR as needed. To prevent recurrence, upon admission, significant change and during each care conference the POLST form will be reviewed, and preferences honored; and then checked against the EHR for accuracy. 3. The policy entitled Advanced Directives was updated to reflect review of both the EHR and the signed POLST with each care conference including baseline care plan meeting. Social services and Licensed Nurses will be educated advanced directives with focus on accurate transcription from document to EHR.	

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2 620	Continued From page 15 During an interview on 11/29/22, at 3:50 p.m. R23 stated he did not want any life saving measures to be implemented if needed. R23 stated he wanted to be a DNR and had signed the form identifying his desire when he was admitted to the facility several months ago. During an interview on 12/1/22, at 9:59 a.m. the director of social services indicated she was responsible for obtaining a resident's life sustaining wishes. She confirmed she had met with R23 upon his admission and he had requested to be DNR. The director confirmed R23's POLST form had an x marking the box to provide CPR. She indicated she had accidentally checked that box instead of the one below which identified DNR request. During an interview on 12/1/22, at 10:19 a.m. the director of nursing (DON) indicated it was part of the facility's social service directors' admission process to obtain a resident's POLST wishes. The DON stated she would have expected each resident's POLST to accurately reflect the resident's wishes and would also correlate with the doctor's orders. Review of a facility policy titled, Advanced Directives revised December 2016, identified advanced directives would have been respected in accordance with state law and facility policy. The policy revealed upon admission, residents would have been provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chose to do so. SUGGESTED METHOD OF CORRECTION:	2 620	4. Audits will be completed weekly x 4 weeks, then monthly x 3 months. Audits will be brought to and monitored through the QAPI meetings or further recommendations and ongoing monitoring. 5. Social Services or designee responsible for compliance	

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2 620	Continued From page 16 The director of nursing (DON) or designee should review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records a re consistent and maintained accurate throughout the medical record upon admission, quarterly, and with any significant change such as the election of a hospice benefit. The DON should also ensure a process for inputting this changed data appropriately into the electronic medical record. Staff should be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee should review the resident affected, and all other current residents to ensure accuracy of code status and audit any newly admitted resident EMR. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 620		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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.	2 830		1/3/23

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2 830	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 3 (R8) residents identified at risk for falls to prevent further falls. Findings include: R8's quarterly Minimum Data Set (MDS) dated 11/3/22, identified R1 had moderate impaired cognition and had diagnoses which included diabetes mellitus, borderline personality disorder (a mental illness characterized by a distorted self-image, impulsiveness, unstable and intense relationships, and extreme emotions) and depression. Indicated R1 required limited assistance for transfers and extensive assistance for toileting. R8's fall assessment dated 10/28/22, identified R1 was at high risk for falls due to impaired cognition, medications, and previous falls. R8's fall assessment indicated R8 was incontinent of bladder and required staff assistance with transfers. Review of R8's care plan revised 10/20/22, revealed R8 was at high risk for falls related to immobility and weakness. The care plan revealed fall interventions which included call light in reach, bed in low position at night and a fall mat next to the bed. Review of 8's adverse event reports from	2 830	1. It is the expectation of Moorhead Restorative Care Center that with each fall the care plan is reviewed and interventions are implemented as appropriate to meet the individual safety needs. R8's care plan has been reviewed and all identified interventions are in place. 2. The deficient practice has the potential to impact all residents. Resident charts reviewed to ensure interventions in place as necessary. 3. All nursing staff will be educated on facility policy for Fall and Managing Fall risk with focus on the evaluation of a fall and implementation of ongoing interventions to prevent future falls. 4. Audits of fall interventions will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. DON or designee responsible for compliance	

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2 830	Continued From page 18 10/13/22, to 11/29/22, revealed the following: -10/13/22, R8 had an unwitnessed fall at 10:30 p.m. The event report identified staff found R8 on the floor The report revealed another resident informed staff R8 had self transferred from her bed and fell onto the floor. The report identified R8 had been sent to the emergency room (ER) to be evaluated related to R8 having an unwitnessed fall. The report further reveled R8 had not received any injuries from the fall. The report lacked immediate interventions to prevent future falls. -10/17/22, R8 had a witnessed fall at 9:30 p.m. event report revealed R8 had call light on and when staff entered the room R8 was standing by her bed and was starting to sit down so staff lowered R8 to the floor. The report lacked immediate interventions to prevent future falls. -10/18/22, R8 had an unwitnessed fall at 4:20 a.m. The report revealed R8 was found on the floor next to her bed. The report revealed R8 stated "I don't like this bed it is possessed I'm not going back. The report revealed an immediate intervention to place a fall mat on the floor next to the bed. During an observation on 11/28/22, at 7:00 p.m. R8 was lying in bed. No fall mat next to the bed. During an observation on 11/29/22, at 3:12 p.m. R8 was lying on her stomach in bed and slid to the floor to her knees next to the bed. No fall mat next to R8's bed. Surveyor alerted licensed practical nurse (LPN-A) that R8 was on the floor. When LPN-A arrived R8 had gotten to a standing position and was attempting to get back into bed so LPN-A assisted R8 into bed. R8 was assessed	2 830		

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2 830	Continued From page 19 by nurse practioner (NP) and was sent to the ER for bilateral knee pain. X-ray report dated 11/29/22, revealed R8 had a contusion to her right knee. During an interview on 11/29/22, at 3:22 p.m. LPN-A indicated R8 was suppose to have a fall mat on the floor next to her bed due to R8 frequently puts herself on the floor and has had falls out of bed. LPN-A confirmed R8 did not have a fall mat next to the bed prior to her fall. During an interview on 11/30/22, at 1:01 p.m. nursing assistant (NA-D) indicated R8 has placed herself on the floor and has had some falls. NA-D further indicated she had not been aware R8 was supposed to have a fall mat on the floor next to the bed and stated she had never seen a mat on the floor next to R8's bed. During an interview on 11/30/22, at 1:13 p.m. clinical manager (CM) stated R8 has placed herself on the floor and has had falls out of bed. CM confirmed R8 was to have a fall mat on the floor next to her bed. CM confirmed there was no fall mat next to R8's bed at the time of the fall. During an interview on 11/30/22, at 1:29 p.m. director of nursing (DON) stated R8 had placed herself on the floor and has had falls. DON verified R8 was to have a fall mat next to her bed. DON confirmed R8 had not had a fall mat next to her bed during her fall on 11/29/22. DON stated her expectation was R8's fall interventions including the fall mat would have been implemented. A facility policy titled Falls and Fall Risk, Managing reviewed 10/22, indicated according to the MDS, a fall was defined as: unintentionally	2 830		

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2 830	Continued From page 20 coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. The policy indicated in conjunction with the attending physician , staff would identify and implement relevant interventions, to try to minimize serious consequences of falling. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers 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: 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 B. a resident who has pressure sores	2 900		1/3/23

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2 900	Continued From page 21 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement interventions to promote healing and prevent worsening of pressure ulcers for 1 of 1 resident (R33) reviewed with a current stage two pressure ulcer on the sacrum (tailbone area) and two deep tissue injury pressure ulcers on both heels. Stage two pressure ulcer: partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister. Deep Tissue Injury (DTI) : is an injury to a patients underlying tissue below the skin's surface that results from prolonged pressure in an area of the body. Similar to a pressure sore, a deep tissue injury restricts blood flow in the tissue causing the tissue to die. Findings include: R33's admission Minimum Data Set (MDS) dated 11/6/22, identified R33 had diagnoses which included debility (physical weakness), atrial fibrillation, and hypertension. Identified R33 had moderately impaired cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and bathing. Identified R33 was always incontinent of bowel and bladder and was not on a toileting plan. Identified R33 was at risk for pressure	2 900	1. It is the expectation of Moorhead Restorative Care Center that all patients skin is assessed upon admission and weekly thereafter. It is the expectation that upon identification of a new skin concern or risk for skin concerns notifications are made and interventions are implemented. It is the expectation that all wounds are measured and documented at least every 7 days to monitor progress. R33's plan of care has been reviewed and updated to reflect appropriate interventions. Notifications have been made to POA and medical provider. 2. This deficient practice has the potential to impact all residents. Resident charts were reviewed and care plans updated as needed. Policy entitled Prevention of Pressure Ulcers, and the policy entitled Pressure Ulcer/Skin Breakdown Protocol were reviewed and remain appropriate. 3. All licensed staff will be educated on weekly skin checks and notification of change in skin condition to the DON, provider and POA. All nursing staff will be educated on preventative measures for skin breakdown. Nursing management or designee will be educated on use of the skin and wound companion app for PCC to allow for ease of tracking and availability for consult from remote providers/consultants as needed.	

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	00938	A. BUILDING: _____ B. WING _____	C 12/01/2022

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2 900	Continued From page 22 ulcers and had a pressure relieving device for his bed and chair and revealed R33 was not on a turning and repositioning program. Identified R33 was at risk for pressure ulcers and had a pressure relieving device for his bed and chair however was not on a turning and repositioning schedule and incorrectly identified R33 had a current pressure ulcer at the time of admission. R33's admission Care Area Assessment (CAA) dated 11/6/22, revealed R33 had moderate cognitive impairment which limited his abilities to recognize his needs. Identified R33 required extensive assistance with ADL's, and was not able to remember the need to change position. Revealed R33 preferred to be lying in his bed or seated in a wheelchair and was to have a pressure relieving device on his bed and his wheelchair. Identified R33 was at risk for developing pressure ulcers and had no pressure ulcers present at the time of the assessment. Review of R33's care plan revised 11/22/22, revealed R33 had a potential/actual impairment to his skin and identified the following interventions: barrier cream, pressure reducing devices for his chair, bed and heel protectors to protect his skin. R33's admission skin assessment dated 10/31/22, identified R33's skin was intact. Review of R33's Braden scale (an assessment tool for predicting the risk of pressure ulcers, based on the total scores given in the categories of sensory perception, moisture, activity, mobility, nutrition, and friction and shear) dated 10/31/22, identified R33 was at low risk for developing pressure ulcers. R33's weekly skin review form dated 11/25/22,	2 900	6. Audits will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 4. DON or designee responsible for compliance	

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2 900	Continued From page 23 identified R33 had a small open area on his sacrum in which barrier cream was applied. The form lacked identification, staging, measurements, tissue characteristics or causative factors of R33's open area. R33's medical record lacked any further skin assessments or identification of any other open areas. During an observation on 11/28/22, at 2:44 p.m. R33 was lying in bed on his back, his face was pale gray in color, his eyes were closed and he was covered with a yellow blanket. During an observation on 11/28/22, at 5:36 p.m. R33 was observed lying in bed on his back, his face was pale gray in color, his eyes were closed. He was covered with a yellow blanket from his feet to his mid chest. -at 5:56 p.m. R33 was observed lying in the same position, his face was pale gray in color, his eyes were closed and he was covered with a yellow, fuzzy blanket. At that time, nursing assistant (NA)-B and NA-F entered his room, indicated to R33 it was time for him to eat. NA-B and NA-F removed the yellow blanket, which revealed R33's bilateral heels had been resting directly on the standard mattress with no off-loading (heels hovered over the bed by a pillow or use of pressure relieving heel protectors) devices in place. R33 was boosted up in bed by NA-B and NA-F, covered with a yellow blanket and the head of bed was elevated to a sitting position. R33's meal tray was placed on an over the bed table, which was then moved in front of R33. On 11/29/22, at 2:56 p.m. R33 was observed lying in bed on his back, his eyes were closed	2 900		

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2 900	Continued From page 24 and he was covered from his feet to his mid-chest with a fuzzy yellow blanket. -at 3:22 p.m. R33 remained lying in the same position, his eyes were closed and he was covered from his feet to his mid-chest with a fuzzy yellow blanket. During an observation on 11/30/22, at 7:00 a.m. R33 was lying in bed on his back, his eyes were closed, and he was covered with a yellow blanket from his feet to his mid-chest. - at 7:30 a.m. R33 was observed to lying in the same position, his eyes were closed and he was covered with a yellow blanket from his feet to his mid-chest. R33 was not observed to make any independent changes in position. -at 7:56 a.m. R33 was observed to remain lying in the same position, his eyes were closed and he was covered with a yellow blanket. At that time, NA-B and NA-K entered his room, indicated they were going to assist him with morning cares. At 8:00 a.m. registered nurse manager (NM)-A entered R33's room and indicated she was there to assist with morning cares. NA-B removed the yellow blanket, which revealed R33 wore a hospital gown, gripper socks and both of his heels rested directly on the standard mattress. At that time, NM-A confirmed R33 had a standard mattress with no pressure relieving devices. R33 was assisted to turn to his right side by NM-A who held onto R33's body, while NA-B removed R33's urine soaked soiled incontinent brief. R33 had an open area on his sacrum and redness which completely surrounded the open area. At that time, NM-A stated she was unaware R33 had a pressure ulcer.	2 900		

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2 900	Continued From page 25 - At 8:17 a.m. the NM-A assessed and measured R33's sacral pressure ulcer which revealed R33 had a stage two (2) pressure ulcer which measured a surface area of 3.1 centimeters (cm). NM-A stated the redness surrounding R33's stage 2 pressure ulcer was non-blanchable (reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device), on the lower right side of the wound, extending several cm's from the open area. She confirmed R33's non-blanchable skin was indicative of further skin breakdown. NM-A proceeded to cleanse the wound, applied Cavalon Barrier Cream (cream used to help protect and repair the skin of anyone suffering from incontinence), to R33's open area and applied a Cavilon wand (transparent film designed to protect intact or damaged skin from urine, feces, other body fluids, adhesive trauma and friction), to the surrounding redness. -At 8:33 a.m. NM-A picked up R33's right foot, palpated the entire area of his heel (approximately the size of golf ball) and confirmed R33's entire right heel, was completely and significantly boggy (refers to abnormal texture of tissues characterized by sponginess, indicative of a deep tissue injury/unstagable pressure ulcer). NM-A then picked up R33's left heel, which revealed a forming blister with hardened edges, that measured approximately 2.0 cm in length and 3.5 cm in width. NM-A palpated the inside the blister which revealed bogginess. NM-A confirmed R33 had bilateral unstagable (suspected deep tissue injury) pressure ulcers on his heels. NM-A then proceeded to check the rest of R33's skin for any further pressure ulcers and none were found. On 11/30/22, at 9:05 a.m. during an interview with	2 900		

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2 900	Continued From page 26 NM-A, confirmed R33 had no pressure ulcers when he was admitted to the facility approximately one month prior. She indicated R33 had been declining in the past few weeks and had required increased assistance. NM-A stated she was not aware R33 had any skin breakdown on his sacrum or heels. NM-A indicated R33 should have been assisted to reposition every two hours, his heels should have been off-loaded and his skin should have been checked weekly for signs of breakdown. On 11/30/22, at 9:16 a.m. during an interview, R33's Certified Nurse Practioner (NP)-A, stated she had met with R33 several times since his admission and was familiar with him. She indicated R23 had experienced a decline in the last few weeks with dizziness, low blood pressures and has had some bloody stools which the facility had been monitoring. NP-A indicated R33 had been in bed more often than when he was first admitted and seemed to prefer to be in his room. NP-A stated she had not been aware R33 had a pressure ulcer on his sacrum, and she was not aware R33 had DTI to his bilateral heels. NP-A indicated she had been notified approximately a week ago R33 had redness on his buttocks, and felt it was due to R33's bowel and bladder incontinence. She indicated barrier cream should have been applied routinely to prevent further breakdown. NP-A stated she had not assessed R33's sacrum at that time. NP-A stated she expected R33's skin to be assessed weekly, and she expected R33 to have pressure relieving interventions in place such as routine repositioning, the use of heel protectors or Prevalon boots to his heels. NP-A confirmed R33's boggy heels were indicative of deep tissue injuries, as they were not able to stage the pressure ulcers since they had not opened yet.	2 900		

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2 900	Continued From page 27 On 11/30/22, at 8:10 a.m. during an interview, NA-B indicated R33 required extensive assistance with bed mobility, and used a full mechanical lift for transfers. NA-B stated R33 was always incontinent of bowel, bladder and did not typically use his call light for assistance. She indicated R33 was supposed to be repositioned every two hours and confirmed that morning he had last been checked and changed at approximately 5:00 a.m., a total of 2 hours and 56 minutes from when she entered his room that morning. NA-B stated she was not aware R33 had a pressure ulcer on his buttocks and was not aware of the DTI to his heels. On 12/1/22, at 8:40 a.m. during an interview, NA-A indicated R33 had required assistance with bed mobility, transfers, and dressing since his admission. She stated R33 was assisted with repositioning and was to be checked and changed every two hours as he was totally incontinent of bowel and bladder. NA-A stated she felt R33 refused assistance with cares frequently and indicated he needed a lot of encouragement to allow staff to assist him. NA-A indicated she was not aware R33 had any pressure ulcers and was not aware of any pressure relieving interventions for his heels. Review of R33's progress notes from 10/31/22, to 12/1/22, revealed the following: - 10/31/22, revealed R33 was seen by NP-A for an initial visit for his admission following a 30 day inpatient hospital stay. The note indicated R33 had been hospitalized with a recent heart attack which required surgical intervention. The note revealed R33 complained of dizziness, had weakness and would have therapy work with him	2 900		

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2 900	Continued From page 28 to improve his mobility and ADL function. The note indicated NP-A completed a comprehensive review R33 and identified his skin was intact and free of ulcers. -10/31/22, an admission summary note revealed R33 had declined to have his skin checked and had agreed to have the nurse complete a skin assessment the following day. - 11/11/22, a nursing note revealed R33 had refused a shower, skin check and was sleeping. -11/12/22, a nursing note revealed R33 was in bed all day, required extensive assistance with turning and repositioning, toileting and personal hygiene. Review of R33's medical record lacked any documentation of R33's bilateral heel DTI's. On 12/1/22, at 10:29 a.m. during an interview, the director of nursing (DON) indicated she expected a skin assessment to have been completed when R33's stage two pressure ulcer was first observed on 11/25/22, per the skin note. The DON confirmed R33's Braden scale which was completed upon admission revealed R33 was at minimal risk for skin breakdown. She indicated R33 had declined in the past few weeks related to his medical condition, which the facility had been monitoring. The DON indicated R33 had been in his bed more often than when he was first admitted. The DON confirmed R33's admission MDS incorrectly identified he had a pressure ulcer upon admission, medical record lacked routine skin monitoring and indicated she would expect his skin to be checked weekly. She indicated R33 should have had pressure relieving interventions in place for his heels, to include	2 900		

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2 900	Continued From page 29 Prevalon boots and to off-load his heels from the bed as needed. The DON confirmed she was not aware R33 had any pressure ulcers and indicated NM-A had recently returned to the facility and would be implementing weekly wound/skin rounds. On 12/1/22, at 10:44 a.m. during a telephone interview, R33's family member (FM)-A indicated she was not aware R33 had any pressure ulcers and had recently been notified R33 was transferred to the hospital. FM-A stated she would have wanted to be notified of any changes in R33's condition. Review of a facility policy titled, Prevention of Pressure Ulcer Injuries reviewed 9/29/21, revealed it was the purpose of the procedure to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The policy revealed resident's skin was to be comprehensively assessed upon admission, and should be inspected daily with cares. The policy identified the following prevention strategies; prevention, nutrition, mobility/repositioning, support surfaces and pressure redistribution, device related pressure injuries and monitoring. Review of a facility policy titled, Pressure Ulcer/Skin Breakdown - Clinical Protocol, revised 7/12/22, identified nursing staff and practioner would assess and document an individuals significant risk factors for developing pressure ulcers. In addition, the nurse should complete a full assessment of newly admitted residents, identify cause of any skin breakdown, implement treatment/management measures and monitoring the effectiveness and healing.	2 900		

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2 900	Continued From page 30 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents 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 should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 900		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a clean and sanitary condition of the kitchen floor, ceiling ventilation system, walk in cooler and freezers to promote sanitation in the kitchen. In addition, the facility failed to maintain the water and ice	21015	1. It is the policy of the facility to ensure proper food safety requirements, including maintaining a clean and sanitary condition of the kitchen floor, ceiling, ventilation system, walk in cooler and freezers to promote sanitation in the kitchen. In	1/3/23

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21015	Continued From page 31 machine to prevent potential contamination for all 39 of 39 residents who currently resided in the facility. Findings include: On 11/28/22, at 1:05 p.m. during an initial tour of the facility kitchen area with dietary manager (DM) the following concerns were identified: Floor: - the entire kitchen floor coverings and directly underneath the freezers, coolers, cabinets, stove area, and counter top food preparation areas were noted to be sticky and dirty. In addition, the floor coverings had several dust particles, dirt particles and dried food particles present on the entire surface of the kitchen floor. Walk in cooler: - upon entering the walk in cooler, the ceiling had visible droplets of water hanging and was dripping onto the floor. The floor had a large puddle of water on the walk way from the ceiling which was observed to be continuously dripping water. Chest freezer: - the chest freezer had a heavy build up of frost around the upper part of the freezer which extended all the way around the back and the sides of the freezer. The bottom of the freezer had large amounts of debris and food particles on the bottom of the freezer and was unclean. Inside the chest freezer was a half of a box of caramel rolls, which was uncovered, exposed to the elements and had freezer burn present on some of the caramel rolls. Meat freezer: - The bottom of the freezer had large amounts of	21015	addition, to maintain the water and ice machine to prevent potential contamination for residents who currently resided in the facility. The equipment has been serviced to ensure compliance. 2. All residents who resident in the facility have the potential to be affected by contamination on equipment that is not maintained properly. Dietary equipment has been inspected and serviced to ensure compliance. Facility policy's were reviewed and remain appropriate. 3. The Director of Maintenance was re-educated on potential for increased visual observation of ice machine and the potential for increased cleanings based on mineral content, and in addition to ensure equipment is maintained to ensure compliance. Dietary Manager was also re-educated on maintaining a clean and sanitary condition in the kitchen and dining areas. 4. Audits will be completed weekly x 4 weeks and monthly x 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification and brought to, reviewed by and ongoing recommendations provided through to the monthly quality assurance committee team for further expected review and monitoring. 5. Dietary Service Manager/Maintenance Director	

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21015	Continued From page 32 debris and food particles present and was unclean. Ceiling vent: - the large ceiling vent located in the middle of the kitchen by the clean dishes had moderate buildup of gray/brown dust and dirt particles on the grates of the vent. Ice/water machine: - the water and ice machine located in the main dining room of the facility had encrusted black substance around the water dispenser. On 11/30/22, at 9:11 a.m. during the kitchen tour of the facility kitchen area with DM the following concerns were identified: Floor: - the entire kitchen floor coverings and directly underneath the freezers, coolers, cabinets, stove area, and counter top food preparation areas were noted to be sticky and dirty. The floor coverings had several dust particles, dirt particles and dried food particles present on the entire surface of the kitchen floor. Walk in cooler: - upon entering the walk in cooler, the ceiling had visible droplets of water hanging and was dripping onto the floor. The floor had a large puddle of water on the walk way from the ceiling which was observed to be continuously dripping water. Chest freezer: - the chest freezer had a heavy build up of frost around the upper part of the freezer which extended all the way around the back and the sides of the freezer. The bottom of the freezer	21015		

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21015	Continued From page 33 had large amounts of debris and food particles present and was unclean. Inside the chest freezer was a half of a box of caramel rolls, which were uncovered, exposed to the elements and had freezer burn present on some of the caramel rolls. Meat freezer: - The bottom of the freezer had large amounts of debris and food particles on the bottom of the freezer and was unclean. Ceiling vent: - the large ceiling vent located in the middle of the kitchen by the clean dishes had moderate buildup of gray/brown dust and dirt particles on the grates of the vent. Ice/water machine: - the water and ice machine located in the main dining room of the facility had encrusted black substance around the water dispenser. Review of daily cleaning schedule undated, indicated staff were to sweep/mop the kitchen floor and the walk-in cooler. Review of monthly cleaning schedule dated 2022, indicated staff were to clean behind and under major appliances, wash vents and wipe down walk in cooler. DM confirmed the above findings during the kitchen tour and indicated the above areas should be cleaned daily. During an interview on 11/30/22, at 9:32 a.m. the DM confirmed the above findings and indicated dietary staff had daily cleaning assignments, although the assignments had not been	21015		

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	00938	A. BUILDING: _____ B. WING _____	C 12/01/2022

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21015	Continued From page 34 completed on a routine basis. The DM confirmed the walk in cooler had been leaking water since last March 2022. DM verified he had notified the maintenance director and administrator of the leaking cooler at that time and was directed to deal with it. The DM indicated he had not been trained on how/when to defrost the freezers and verifed it had been about seven months since the chest freezer had been defrosted and cleaned. The DM indicated he would expect staff to complete their daily check lists for cleaning, sweeping/mopping the floors and maintaining and cleaning the freezers. The DM stated he would expect the walk in cooler to be fixed and maintained. During an interview on 11/30/22, 10:30 a.m. the maintenance director (MD) confirmed he had been notified of the leak in the walk in cooler about six months ago or longer. The MD indicated he had notified the owner of the leaking walk in cooler and was told he would seek contractors to repair the leak in the cooler. The MD stated he was not certain who was responsible for maintaining and cleaning the kitchen equipment and ice/water machine. Review of facility policy titled, Cleaning and Sanitation of Dining and Food Service Areas undated, indicated the nutrition and food service staff would maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. On 11/30/22, a policy for cleaning ice/water dispenser was requested however was not provided. SUGGESTED METHOD OF CORRECTION:	21015		

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21015	Continued From page 35 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. 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: 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, including identification of any patterns in residents, locations or pathogens in real time to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 39 residents who resided in the facility.	21375	1. It is the expectation of Moorhead Restorative Care Center that an infection prevention program including surveillance, documentation, monthly QA review for trends is maintained by the IPC and overseen/audited by the DON/designee. It is the expectation that all suspected or confirmed illnesses of staff and residents are tracked and sufficient data is documented to follow federal requirements and allow for comprehensive	1/10/23

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21375	Continued From page 36 Findings include: Review of the facility's infection control surveillance program was conducted on 11/30/22, at 1:04 p.m. with registered nurse infection preventionist (RNIP)-A. The infection logs included the following columns: resident name, room number, admit date, type of infection, surveillance definition met, symptoms, onset date, antibiotic name, class, dose, route, frequency provider, antibiotic start date, antibiotic end date, transmission on based precautions required, and date symptoms resolved. The infection logs lacked necessary documentation for adequate surveillance of illnesses in the facility which should include: identification of all illnesses tracked, diagnostics preformed, test dates, type of tests, specimen source, results, if antibiotic resistant organism, time outs preformed, and dates resolved were not identified. A staff surveillance log was requested to determine possible communicable diseases in the facility including COVID-19, however was not provided. During an interview on 11/30/22, at 1:04 p.m. review of the facility's infection control plan and surveillance log was completed with RNIP-A. RNIP-A confirmed no surveillance, tracking or trending had been completed since October 2022, and indicated she was not provided the time required to maintain the infection control program. RNIP-A confirmed no diagnostic testing was tracked on her surveillance logs, or time outs, or infection results. RNIP-A confirmed the surveillance log was not kept up to date and	21375	review. 2. The deficient practice has potential to affect all residents. An ADHOC QAPI with facility DON, consulting RN, consulting clinical manager, and facility DOR was conducted and reviewed by the governing body. It was identified that ongoing education would be required to ensure compliance. Facility infection prevention program policies, procedures and tracking/surveillance tools were gathered and reviewed, DON expressed an understanding of provided education/information for ongoing implementation and enforcement. The facility will transition all resident illness tracking to the integrated Infection Control tab in point click care which meets or exceeds criteria for data tracking and provides real time trending reports including but not limited to trends in infection type, trends by location etc. It additionally allows for the attachment of supporting diagnostics, assessments, ABT timeouts and creates a stop sign alert on the EHR for each resident with an open suspected or confirmed case to alert staff to active infections. DON/Admin will utilize consulting entities ongoing as needed or as determined by the governing body for education and oversight to ensure compliance. 3. Education will be provided to all licensed staff and members of QA committee on expectations of illness tracking and infection prevention. Education will include but is not limited to appropriate use of the infection control within PCC for reporting/following up on/trending active infections, oversight of	

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21375	Continued From page 37 stated no other staff member was responsible for tracking infections in the facility. RNIP-A verified she had not been tracking viral or other illnesses not treated with anti-infective agents. RNIP-A confirmed the facility residents had viral or other illnesses not treated with anti-infective agents occasionally. Additionally, RNIP-A confirmed she had not tracked any of the staff illnesses, however indicated the facility had no COVID-19 positive residents or staff in the past four weeks. During an interview on 12/1/22, at 11:10 a.m. DON confirmed RNIP-A was responsible for tracking all infections in the facility. DON indicated she was not aware of how the facility should conduct their surveillance of infections in the facility however stated she was aware the facility was expected to track all illnesses. DON confirmed not all necessary components were being tracked with the infection control surveillance program. The facility policy titled Infection Control Policy, undated, identified a system of surveillance was designed to identify possible communicable diseases or infections before they could spread to other persons in the facility. The facility policy titled Surveillance For Infections, reviewed 1/18/22, identified the infection preventionist would conduct ongoing surveillance for health care associated infections and other epidemiological significant infections that had substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The policy identified the infections would include routine surveillance which would include evidence of transmissibility in a healthcare environment, processes and	21375	floor staff documentation to identify and report infections as appropriate, and monthly QA oversight of IPC programming and standard infection prevention practices. Education will be completed on 12/28/22. A posttest will be completed to ensure staff understanding of education provided. Any failed tests will be followed up with immediate reeducation. 4. Audits will be conducted every regular business day as routine part of Clinical Standup. All audits will be brought to QAPI for review. 5. Infection Preventionist or designee responsible for compliance	

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21375	Continued From page 38 procedures that prevent or reduce the spread of infection, and pathogens associated with serious outbreaks. The policy indicated the surveillance should include any or all of the following information to help identify possibly indicators of infections which included; laboratory records, including culture result, and multi-drug-resistant reports that required immediate attention. The policy identified for residents with infections, to collect the following data which included: identifying information, diagnoses, date of onset, infection site, pathogens, invasive procedures, and treatment measures. The policy identified targeted surveillance should use facility-created tools for a daily recording on individual infection report, monthly collection from individual reports and monthly summarization of data by unit and pathogen. 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 for water borne pathogens. In addition, the DON or designee could review/revise policies on infection control regarding oxygen tubing. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		1/5/23

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21426	Continued From page 39 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a tuberculosis skin test (TST) or chest X-rays were conducted and the results documented for 3 of 5 new employees (nursing assistant (NA)-C, NA-J, licensed practical nurse (LPN)-D) reviewed for tuberculosis (TB) screening as directed by the Centers for Disease Control and Prevention. In addition, the facility failed to review and update their TB infection control (IC) program policy and provide a facility TB risk assessment. Findings Include: The facility lacked components required for	21426	1. It is the expectation of Moorhead Restorative Care Center that all employees have TB tests documented, prior to working. The DON or Designee will ensure the 3 staff members identified have documented TB tests. 2. All residents have the potential to be affected. The infection control nurse (ICN), director of nursing (DON) and/or designee will review policies and procedures related to the TB Infection control program, TB risk assessment and screening and testing for tuberculosis for employees. Facility staff will be educated on the TB regulations, symptom screening, and the	

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21426	Continued From page 40 health care workers' (HCW) TB screening. A review of personnel records for five newly hired employees revealed the following: A baseline TB screening as well as a two step TST was not available for review in NA-C, and NA-J personal records. The records lacked documentation of any TB screening and two step mantoux ever being done. The personal record for LPN-D lacked a TB screening and two step mantoux ever being done. The Regulations For Tuberculosis Control In Minnesota Health Care Settings dated July 2013, identified an employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The facility lacked a current TB risk assessment, and when asked one was not provided. During an interview on 11/30/22, at 1:20 p.m. registered nurse infection preventionist (RNIP)-A indicated she was not responsible for the facility TB infection control program and was not certain who was responsible for it. RNIP-A confirmed she had not completed a facility TB risk assessment. During an interview on 12/1/22, at 11:20 a.m. director of nursing (DON) stated RNIP-A was responsible for the TB infection control program, and she would expect all staff upon hire would have had a TB screening and two step TST completed. DON indicated she was unaware what a TB risk assessment was, and verified she	21426	two-step Mantoux process. In addition the ICN, DON and/or designee will complete the TB risk assessment. 3. HR and staffing coordinator will require TB tests from employee's prior to starting work on the unit. The ICN, DON and/or designee will audit staff personnel records to ensure compliance. 4. The ICN, DON and/or designee will take their findings/education to the Quality Assurance Performance Improvement (QAPI) committee weekly x 4 weeks, and monthly x 3 months.	

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21426	Continued From page 41 was unable to find any updated or reviewed TB policies for the facility. The facility policy titled Tuberculosis Infection Control Program revised August 2019, identified the facility TB IC program included early identification, isolation and transfer of persons with active tuberculosis and included the following components: -assignment of responsibility for the oversight of TBIC. -an annual TB risk assessment (TBRA) and TB risk classification based on the information obtained from the TBRA. -Screening and surveillance of residents and employees for latent tuberculosis infection (LBTI) and active TB as appropriate for the current TB risk classification. -The medical director, director of nursing services, and the IP will review the TBIC program annually with the Infection Control committee. The policy lacked identification of who was designated to oversee the TB program. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee could review policies and procedures related to the TB Infection control program, TB risk assessment and screening and testing for tuberculosis for employees. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit staff personnel records to ensure compliance. In addition the ICN, DON and/or designee could complete the TB risk assessment. The ICN, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for	21426		

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21426	Continued From page 42 a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 1 of 3 residents (R24) who was dependent on staff for activities. Findings include: R24's admission Minimum Data Set (MDS) dated 5/11/22, indicated R24's had diagnoses which included depression, anxiety disorder, bipolar disorder and was cognitively intact. R24 required extensive assistance of one or two staff for all	21435	1. It is the expectation of Moorhead Restorative Care Center that all residents are routinely provided with meaningful activities concurrent with their level of ability. R24's preferences were reviewed, care plan updated for staff reference and a schedule of 1:1 activity for this resident was developed. 2. The deficient practice has the potential to impact all residents. Resident charts were reviewed to ensure activity care planning and documentation were	1/10/23

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21435	Continued From page 43 activities of daily living (ADL's). R24's activity preferences that were very important were listening to music and being around animals. R24's preferences that were somewhat important were going outside for fresh air, doing favorite activities, and keeping up with the news. R24's least favorite activities were reading books, news papers and magazines, group activities, and religious activities. Review of R24's care area assessment (CAA) dated 5/11/22, indicated R24 preferred group activities and being active in activities. The CAA indicated R24's activity functional status would be addressed in her care plan with overall objectives to maintain her current level of functioning. Review of R24's Activity Data Collection (Admission) dated 5/9/22, indicated R24's leisure activities were reading, watching TV drama shows, listening to 80's music, visiting with family, going to church and enjoyed being with dogs. Review of R24's Activity Participation Review dated 10/26/22, indicated R24 preferred one on one activities and enjoyed live music events. The review identified R24's activities remained appropriate, goals were met and to continue until next quarter. Review of R24's careplan revised on 11/10/22, lacked any documentation of what R24's activity preferences, approaches, or goals were for activities. Review of R24's Progress Notes from 9/1/22, to 12/1/22, revealed the following: - 10/19/22, activity aid visited with R24 about the show she was watching while nursing assistant	21435	present. The policy entitled Activity Assessment was reviewed and remains appropriate 3. Education will be provided to activity staff regarding policy and procedure related to assessing, care planning and implementing resident preferences in activities to ensure person centered care. Activity staff will develop and maintain a schedule for activities which will be reviewed during routine business days at morning stand up. The activities staff will also notify the IDT if a resident is refusing participation to determine if action can be taken or CP updates warranted. 4. Audits will be completed of activity documentation with a focus on participation and activities related to resident preference. Audits will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. Activities Director or Designee responsible for compliance	

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21435	Continued From page 44 (NA) did her nails. - 10/25/22, activity aid stopped in and asked R24 if she would like to attend bingo and R24 declined. - 11/3/22, activity director (AD) indicated R24 was confused and required one to one supervision while in activity today. The progress notes lacked documentation R24 offered or attended activities on a routine basis. During observation on 11/28/22, from 1:52 p.m. to 7:15 p.m. - at 1:52 p.m. R24 was laying in bed on her back covered with a blanket, bed in low position, mat on floor next to bed, call light in reach and the TV was on. - at 5:41 p.m. R24 remained the same. Review of the facility November 2022, activity calendar, indicated staff were to have a beach ball activity at 2:00 p.m. and one on one visits at 3:30 p.m. R24 was not observed attending any activities through out the evening. During observation on 11/29/22, from 8:17 a.m. to 3:56 p.m. - at 8:17 a.m. R24 was seated in her wheelchair in the dining room and was eating her breakfast independently. - at 10:05 a.m. R24 was laying in bed covered with a blanket, bed in low position and call light within reach. - at 2:09 p.m. R24 was laying in bed covered with blanket, had her cell phone in her hand, bed in low position, head of bed elevated, mat on floor and was independently eating chips. - at 2:17 p.m. R24 remained the same and	21435		

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21435	Continued From page 45 continued to eat her chips. - at 2:46 p.m. R24 remained the same while a housekeeper cleaned her room and R24 told the housekeeper she was hungry. - at 3:02 p.m. R24 remained in her room while lying in bed, bed in low position, mat on floor, call light within reach and was talking to herself repeatedly. - at 3:28 p.m. R24 remained lying in bed, when licensed practical nurse (LPN)-A entered her room and gave R24 a snack and immediately left the room. - at 3:47 p.m. R24 was yelling out loudly, when registered nurse (RN)-C entered R24's room and began talking with R24 about taking her blood pressure. RN-C proceeded by taking R24 blood pressure and immediately left the room. - at 3:56 p.m. R24 was yelling out loudly, when RN-C entered her room asking R24 if she would like to get up, go to the dining room, or if she wanted a cup coffee and R24 declined. Review of the facility November activity calendar, indicated staff were to have this day in history/daily devotions at 9:30 a.m., board/card games at 10:00 a.m., bingo at 2:00 p.m., and one on one activities at 3:30 p.m. R24 was not observed attending any activities through out the day or having one on one activities with staff. During observations on 11/30/22 from 7:20 a.m. to 1:30 p.m. -at 7:20 a.m. R24 was laying in bed, bed was in low position, call light within reach and R24 was talking to herself repeatedly. - at 8:23 a.m. R24 remained the same and was yelling out loudly while talking to herself repeatedly. - at 8:31 a.m. R24 remained the same, when the director of social services (DSS) entered R24's	21435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00938	A. BUILDING: _____ B. WING _____	C 12/01/2022

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21435	Continued From page 46 room and asked R24 if she would like to eat breakfast in her room or the dining room. R24 indicated she would like to eat in her room and the DSS immediately left R24's room. - at 8:34 a.m. R24 was seated on the edge of her bed, when the dietary manager (DM) entered R24's room with a room tray, set the tray on the bedside table, assisted R24 as needed and immediately left the room. - at 8:37 a.m. R24 remained the same, when the director of rehab (DR) entered R24's room and asked R24 if she would like to get up. R24 yelled at the DR to get out of her room and DR immediately left her room. While DR was walking down the hallway, R24 then yelled at her to shut the door. The DR turned around and proceeded to shut R24's door. - at 8:50 a.m. R24 door remained closed and and she continued to talk to herself. - at 10:54 a.m. R24 was laying in bed on her back, bed in low position, mat on floor and appeared to be resting. - at 11:05 a.m. R24 remained the same. - at 1:30 p.m. R24 remained the same. Review of the facility November activity calendar for 11/30/22, indicated staff were to have shopping lists at 9:30 a.m., shopping for residents at 10:00 a.m., bowling at 2:00 p.m., and one on one visits at 3:30 p.m. R24 was not observed attending any activities through out the day or having one on one activities with staff. During an interview on 11/30/22, at 2:15 p.m. nursing assistant (NA)-D indicated R24 enjoyed visiting, having her hair and make up done. NA-D indicated R24 had recently had an increase in behaviors with yelling out and staff would offer her a snack, to watch videos on her phone or call her son. NA-D indicated R24 did not like to go to	21435		

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21435	Continued From page 47 the activity room and usually stayed in bed. During an interview on 11/30/22, at 2:30 p.m. with director of activities (DA) confirmed the above findings and indicated R24 preferred one on one activities. The DA indicated facility staff completed one to one activities daily, although the DA could not identify which activities R24 preferred. The DA stated resident activity/preference assessments were to be completed within seven days of admission and were shared verbally with activity staff only. The DA indicated most of the residents could inform staff what they wanted to do for activities and confirmed staff documented activity participation in the resident's progress notes. The DA stated activity staff did not have a schedule for doing one on ones activities for residents and her expectation were for staff to offer residents activities daily and residents should have been receiving one on one activities on a daily basis. During an interview on 11/30/22, at 2:55 p.m. the activity aid (AA)-A indicated R24 liked to visit about her son, write letters and enjoyed being out and about within the facility. AA-A stated R24 was receptive to activities however would occasionally refuse. The AA-A indicated all activity participation was documented under progress notes in the medical record. AA-A confirmed she had no written direction or activity careplan to follow and indicated she just knew what each resident liked for activities. During an interview on 12/01/22, at 2:07 p.m. with director of nursing (DON) confirmed the above findings and indicated she would expect staff to offer the residents activities and to follow the careplan.	21435		

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21435	Continued From page 48 Review of facility policy titled, Activity Evaluation undated, indicated staff would have evaluated residents within 14 days of admission and would have developed an individual activities care plan (separate or as part of the comprehensive care plan). The policy identified each residents activities care plan would have been related to his/her comprehensive assessment and would have reflected his/her individual needs. The policy indicated the care plan would have identified if the resident was capable of pursuing activities without intervention from facility. The policy indicated the activity evaluation would have been part of there resident's medical record and should have been updated as necessary, but at least annually. SUGGESTED METHOD OF CORRECTION: The activity director could train all staff to ensure each resident's assessed activity preferences are honored, and then audit to ensure this is occurring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21435		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.	21535		1/3/23

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21535	Continued From page 49 In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete timely tardive dyskinesia (TD) screenings (assessment for involuntary movements) for 1 of 3 residents (R17) reviewed for unnecessary medications, who received a routine dose of an antipsychotic medication. Findings Include: R17's significant change Minimum Data Set (MDS) dated 10/22/22, identified R17 had moderate cognitive impairment with disorganized thinking that fluctuated and had diagnoses which included: dementia, depression and diabetes mellitus. Identified R17 required extensive assistance with transfers, dressing, personal hygiene and toilet use. Indicated R17 had verbal behavioral symptoms daily, and rejected cares four to six days. Identified R17 received antipsychotic medication six of the last seven days routinely. Review of R17's Care Area Assessment (CAA)	21535	1. It is the expectation of Moorhead Restorative Care Center that all patients are routinely assessed for side effects/efficacy/need for use of psychotropic medications. It is the expectation that an AIMs or equivalent assessments are completed for residents taking antipsychotics upon admission, every 6 months and with medication changes related to the antipsychotic medication. An assessment has been completed on R17. 2. All patients have the potential to be affected by the deficient practice. Residents with antipsychotics were reviewed and AIMs were updated as needed. The policy entitled Antipsychotic Medications was updated to reflect AIMs assessments upon admit, q 6 months and as needed with antipsychotic use. 3. All licensed nurses will receive education on psychotropic medication use with emphasis on routine monitoring and	

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21535	Continued From page 50 dated 10/26/2, identified R17 received antipsychotic medication. Identified an actual psychotropic drug use problem/need. R17's CAA identified R17 took the medications for depression and dementia with behavioral disturbances and a referral to psych was warranted. R17's care plan revised 7/26/22, identified R17's activities of daily living (ADL) self-care needs were related to confusion and limited mobility and R17 required extensive assistance with bed mobility, bathing, dressing and personal hygiene. R17's care plan identified R17 had impaired cognitive function/dementia or impaired thought processes, and to administer medications as ordered and monitor/document for side effects and effectiveness. R17's care plan indicated R17 used anti-anxiety medications and antidepressant medication however lacked identification of R17's antipsychotic medication use. Review of R17's Order Summary Report signed 10/18/22, identified the following: -Seroquel 25 milligram (mg) give 0.5 tablet by mouth at bedtime related to major depressive disorder, order date 10/17/22. -Seroquel 25 mg give 0.5 tablet by mouth every six hours as needed for agitation, order date 10/17/2. Review of R17's medication administration record (MAR) dated 11/1/22, to 11/29/22, identified the following: -Seroquel 50 mg, give 50 mg by mouth two times a day, related to major depressive disorder, single episode unspecified, encephalopathy unspecified, start date 10/24/22, end date 11/2/22. -Seroquel 50 mg, give 75 mg by mouth two times	21535	assessments. 4. Audits of appropriate assessment/monitoring for psychotropic will be completed weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations. 5. DON or designee responsible for compliance	

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21535	Continued From page 51 a day for depression, start date 11/3/22. Review of R17's medical record identified the record lacked a tardive dyskinesia assessment had been completed prior to start of antipsychotic medication use. During a telephone interview on 12/1/22, at 1:32 p.m. pharmacist consultant (PC)-A confirmed she was aware R17 did not have an tardive dyskinesia assessment completed and indicated her usual process was to allow the facility about a month to complete the assessment. PC-A stated she would expect tardive dyskinesia assessments to be completed on admission, every six months and with a medication change. PC-A indicated she had made a recommendation for the facility to complete a tardive dyskinesia assessment on 11/28/22. During an interview on 11/30/22, 3:05 p.m. director of nursing (DON) confirmed R17 did not have an Abnormal Involuntary Movement Scale (AIMS) (an assessment used to assess tardive dyskinesia) completed. During a follow up interview on 12/1/22, at 1:49 p.m. DON indicated her expectation was for staff to complete an AIMS assessment upon admission and with any medication changes. DON confirmed R17 should have had one completed when his Seroquel was started, to get a baseline tardive dyskinesia assessment. The facility policy titled Antipsychotic Medication Use, undated, identified nursing staff should monitor and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician which included: tardive dyskinesia. The	21535		

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21535	Continued From page 52 policy failed to identify what assessment would be used and frequency to monitor for tardive dyskinesia. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident ' s entire drug medication regimen is managed and monitored to promote or maintain the resident ' s highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer ' s recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident ' s use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframes for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment;	21830		12/28/22

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21830	Continued From page 53 notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility;	21830		

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21830	Continued From page 54 (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for	21830		

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21830	Continued From page 55 damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure preferences for shaving were honored and implemented for 1 of 2 residents (R2) reviewed for choices. Findings include: R2's quarterly Minimum Data Set (MDS) dated 9/2/22, identified R2 had intact cognition and had diagnosis which included dementia without behavioral disturbance and bipolar disorder. The MDS indicated R2 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, toileting and personal hygiene tasks which consisted of::combing hair, brushing teeth and shaving. R2's care plan dated 7/8/22, identified R2 required extensive assistance with personal hygiene and oral cares. The care plan indicated R2 had intact cognitive and had to request facial hair removal when desired. During an observation on 11/28/22, at 2:46 p.m. R2 was lying on his back in bed and was observed to have thick facial stubble noted on his chin and upper lip which extended to the jaw line. During an observation on 11/29/22, at 9:02 a.m. R2 was in the dining room eating breakfast and continued to have thick facial stubble on his chin	21830	1. It is the expectation of Moorhead Restorative Care Center that all residents' preferences are honored and/or given reasonable accommodation to meet their needs including but not limited to maintaining appearance with facial hair/grooming. R2 was offered facial hair/grooming. R2's care plan was reviewed and updated to reflect preferences. 2. The deficient practice has the potential to impact all residents. All other residents were reviewed for preferences related to facial grooming/appearance. Care plans and tasks were reviewed and updated as needed. 3. The policy entitled Self Determination and Participation was reviewed and remains appropriate. All Nursing Staff will receive education on the policy with a focus on preferences and grooming on 12/28/22, 4. Audits for compliance will be completed on a random sample weekly x 4 weeks, and monthly x 3 months. Audits will be brought to and monitored through the QAPI meetings or further recommendations and ongoing monitoring. 5. Social Services or designee responsible for compliance	

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21830	Continued From page 56 and upper lip which extended to the jaw line. During an interview on 11/29/22, at 10:56 a.m. R2 indicated staff typically only shaved him once a week when he received his bath. R2 stated he wanted staff to shave him at least every other day without having to ask. R2 indicated he had informed the staff his shaving preferences several times however, they continued to only offer shaving weekly. During an interview on 12/1/22, at 10:22 a.m. nursing assistant(NA-D) indicated R2 required assistance from staff to shave. NA-D stated staff shaved R2 weekly during his bath. NA-D indicated male residents should have been offered to shave daily. During an interview on 12/1/22, at 10:27 a.m. trained medication aide (TMA-A) indicated she had assisted R2 with cares earlier that morning and confirmed she had not offered shaving to R2. TMA-A stated staff typically had only offered R2 assistance with shaving weekly with his bath unless the resident asked. During an interview on 12/1/22, at 10:31 a.m. clinical manager (CM) confirmed R2 required extensive assistance with shaving and had only been offered shaving weekly with his bath. CM stated her expectation would be staff would have offered R2 to be shaved daily. During an interview on 12/1/22, at 10:47 a.m. director of nursing (DON) confirmed R2 required extensive assistance from staff to shave. DON stated her expectation was R2 should have been offered to be shaved daily without having to request it from staff.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21830	Continued From page 57 A facility policy titled Self Determination and Participation revised 2/21, identified each resident was allowed to choose activities, and schedule health care and healthcare providers, that were consistent with his or her interests, values, assessments and plans of care, including: daily routine such as sleeping walking,eating, exercise, and bathing schedules; personal care needs, such as bathing methods, grooming styles and dress. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	21980		12/28/22

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	00938	A. BUILDING: _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 58 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than 2	21980	1. It is the expectation of Moorhead Restorative Care Center that all alleged	

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21980	Continued From page 59 hours, an allegation of abuse to the State Agency (SA) for 3 of 3 residents (R4, R13, R26) reviewed for abuse. Findings include: R4 R4's quarterly Minimum Data Set (MDS) dated 11/2/22, identified R4 had diagnosis which included cerebral vascular accident (CVA), hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms. legs, and facial muscles) and seizure disorder. Indicated R4 had severe cognitive impairment and required limited assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R4's care plan revised 9/3/22, revealed R4 had a mood problem related to feeling unsafe with another resident at the facility. The care plan directed staff to limit exposure to the resident R4 felt unsafe around. The facility SA report dated 9/2/22, at 7:08 p.m. indicated R4 stated there was unwanted kissing between R4 and R14. The report identified R4 and R14 were placed on frequent checks to ensure well-being. During an interview on 12/1/22, at 9:24 a.m. registered nurse (RN-D) stated on 9/2/22, while R4 was eating breakfast around 8:00 a.m. RN-D noticed three red marks on R4's neck. RN-D stated she asked R4 what happened to her neck and R4 stated "R14 had placed hickeys on her neck" and she did not like it. RN-D was unsure of what time the allegation of abuse was reported to the administartor.	21980	violations will be reported immediately, but no later than 2 hours to the state agency (SA). Notification for (R4, R13, R26) has been completed in regard to these incidents. 2. Failure to timely report allegations of abuse to the state agency has the potential to impact all residents who resident at Moorhead Restorative Care Center. All recent incidents and accidents were reviewed to identify any allegations that had not been reported. 3. The policy titled Abuse Prevention Program revised 6/22/22 was reviewed and remains appropriate. All staff education on the facility Abuse Prevention Program, specifically timely reporting, will be completed on 12/28/22 4. Audits for compliance will be completed on accidents, incidents, grievances, and allegations to ensure no other residents were impacted by failure to report timely. Audits will be done weekly x 4 weeks, then monthly x 3 months. Audits will be brought to and monitored through the QAPI meetings or further recommendations and ongoing monitoring. 5. LNHA/DON/SSC will be responsible for compliance.	

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21980	Continued From page 60 During an interview on 12/1/22, at 9:41 a.m. trained medication aide (TMA-B) indicated she noticed three red marks on R4's neck around 8:30 a.m. on 9/2/22. TMA-B indicated she had informed RN-D R4 identified the red marks were from R14 and R4 did not like having the red marks present on her neck. During an interview on 12/1/22, at 9:55 a.m. administrator stated he had been made aware of the allegation of abuse before 10 a.m. on 9/2/22. Administrator confirmed the allegation of abuse had not been reported to the SA within two hours. Administrator stated his expectation would have been the allegation of abuse would have been reported to the SA within two hours. R13 R13's quarterly MDS dated 8/27/22, identified R13 was cognitively intact and had diagnoses which included: diabetes mellitus type two, hypertension and chronic kidney disease. Indicated R13 was independent with activities of daily living (ADLs). identified R13 had received insulin injections seven of past seven days and antidepressant medication seven of seven days. R13's Care Area Assessment (CAA) dated 5/27/22, identified R13 was cognitively intact and was able to make his needs known. Indicated R13 had some behavioral symptoms which included social inappropriateness. R13's care plan revised 6/13/22, identified R13 was independent with bed mobility, transfers, dressing and toilet use. R13's care plan indicated R13 had behavioral problem which included fixation on specific staff followed by repeated	21980		

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21980	Continued From page 61 allegations of perceived retaliation of unknown origin that could not be substantiated. During an interview on 11/28/22, at 2:30 p.m. R13 stated he had made a report to a nurse, unidentified, who had filed a report with the facility regarding concerns with registered nurse Infection preventionist (RNIP)-A who had mistreated him and placed something in his water. During a follow up interview on 11/28/22, at 2:40 p.m. with an interpreter present, R13 identified he was afraid of RNIP-A. R13 stated he believed RNIP-A was trying to poison him as he had witnessed her place eye drops in his water the last Sunday morning of September. R13 indicated he had been refusing medications from RNIP-A. R13 stated he just wanted to stay in his room because he was afraid and felt the facility had not done anything to resolve the issue. Review of the SA reports and grievance log provided by the facility lacked documentation of a report filed related to R13's allegation. On 11/28/22, at 7:28 p.m. surveyor reported to administrator R13 indicated he had been mistreated by a staff member and was afraid of her. Administrator confirmed no SA report had been filed regarding R13's allegation and stated he would interview R13. During an interview on 11/29/22, at 8:27 a.m. administrator indicated the director of social services (DSS)-A and himself interviewed R13 with an interpreter present on the evening of 11/28/22. A grievance form was completed after the interview and both the administrator and DSS-A interviewed RNIP-A. Administrator	21980		

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21980	Continued From page 62 stated the plan going forward was to have another nurse administer R13's eye drops. Administrator confirmed R13 alleged during their interview RNIP-A placed eye drops in his water and was afraid of her. Administrator confirmed the facility had not completed a SA report of alleged abuse. During an interview on 11/29/22, at 8:41 a.m. DSS-A confirmed when interviewed, R13 had reported he believed RNIP-A had placed eye drops in his water and stated he was afraid of taking medications from her. DSS-A stated the facility was unsure if the allegation was accurate and indicated R13 was not always truthful. DSS-A stated RNIP-A stated she had not placed eye drops in R13's water and indicated R13 and RNIP-A did not like one other. DSS-A confirmed she had been aware R13 had been refusing medications from RNIP-A prior to the surveyor reporting the allegation. DSS-A confirmed R13 requested a grievance form be filed. DSS-A confirmed the facility had not filed an abuse allegation report to the SA. Review of R13's Concern Or Problem Resolution Form dated 11/28/22, identified R13 had a concern RNIP-A placed eye drops in his water to poison him. R13 identified the date of occurrence on 9/27/22. R13 was now afraid to take medications from RNIP-A. The form identified a different staff member would now provide medications to R13. During an interview on 11/30/22, at 11:41 a.m. director of nursing (DON) indicated she was aware of R13's allegation of abuse and the facility had interviewed RNIP-A and R13. DON stated as a result of the allegation, the facility now had another nurse administering R13's medications.	21980		

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21980	Continued From page 63 DON-A stated she had been aware R13 refused medication from RNIP-A and had been aware of his accusation regarding eye drops placed in his water for about a month. DON confirmed if R13 said he had been mistreated and felt afraid of RNIP-A, it would have been considered an allegation of abuse and it should have been reported to the SA. During a follow-up interview on 12/1/22, at 1:05 p.m. administrator confirmed the facility had not submitted a vulnerable adult report to the SA within the required time frames and stated they had submitted a vulnerable adult report today to the SA. Administrator indicated after further review of R13's grievance form, he felt it was more of an allegation of abuse than they thought in the beginning since R13 had expressed he did not feel safe. R26 R26's significant change in status assessment (SCSA) Minimum Data Set (MDS) dated 10/25/22, identified R26 had diagnoses which included knee replacement, arthritis, anemia and hypertension. Indicated R26 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and dressing. R26 had other behaviors directed towards others four (4) to six (6) days but not daily, which interfered with her care and/or disrupted her living environment (these could include hitting, scratching self, rummaging, or verbal symptoms like screaming). R26's care plan revised 10/25/22, revealed R26's safety was at risk, was a potential for abuse due to current medical conditions, need for	21980		

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21980	Continued From page 64 assistance with cares, mobility and her husband had had "escalated behaviors towards resident." The care plan revealed when R26's husband visited, frequent checks were to be completed. Review of facility state agency (SA) report dated 11/29/22, at 9:43 a.m. identified on 11/27/22, at 12:00 in R26's room, she had "received verbal abuse from her husband." The report identified a witness as nursing assistant (NA)-A. The report identified when staff heard verbal altercations in the residents room, they would intervene, and if necessary ask the husband to leave. During an interview on 12/1/22, at 8:28 a.m. NA-A indicated R26's husband visited daily and she had heard R26's husband yell at her in the past once, when she did not remember something he had said. NA-A indicated on 11/27/22, she had passed by R26's room and noticed she had looked upset. NA-A indicated she had asked R26 if anything was wrong, and R26 told her to forget about it. NA-A indicated she felt R26 was upset by her husband at times and was concerned he was verbally abusing her. She indicated she had not observed R26 crying or any changes in her mood, however she indicated R26 appeared upset when her husband visited. NA-A indicated she had not reported her concern to anyone until morning report on 11/29/22, as R26 had declined to say anything. NA-A indicated she completed frequent checks on R26 when her husband was at the facility and encouraged her to keep her door open. During an interview on 12/1/22, at 9:49 a.m. the director of social services stated she was made aware of an allegation R26's husband had verbally abused R26 on 11/27/22. She indicated she had met with R26 regarding the allegation	21980		

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21980	Continued From page 65 and R26 denied any abuse or concerns. She indicated R26 has had no observed changes in her mood or behavior within the last few weeks. The director indicated she had met with R26's husband on several occasions when he had become verbally aggressive towards her, and had hit a wall out of frustration during a conversation with her. She stated she had never seen R26's husband act aggressive towards her or yell at R26 in the past and had not observed R26 appear fearful when her husband was visiting. . The director of social services indicated she had met with R26 to assess her psychosocial needs, the facility had implemented frequent checks for R26 while her husband was visiting, and immediately after he left. She indicated she was reaching out to see if R26 would talk with a mental health practioner in addition to working with the county regarding concerns with R26's husbands cognitive status and safety in the community. During an interview on 12/1/22, at 10:22 a.m. the director of nursing (DON) stated she was notified of the allegation of verbal abuse of R26 by her husband on 11/29/22, during morning report. The DON stated she would have expected to be notified immediately when facility staff observed the concern. The DON indicated R26's husband visited daily, and had not observed R26's husband acting abusive towards her. During an interview on 12/1/22, at 12:58 p.m. the facility administrator stated he had been made aware of the allegation during morning report on 11/29/22, and had submitted a report to the SA immediately. The administrator stated he expected to be notified of all allegations of abuse immediately and indicated a SA report should have been completed within two hours of the	21980		

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21980	Continued From page 66 allegation. However, he indicated he had not been aware of the allegation until two days afterwards. A facility policy titled Abuse Prevention Program revised 6/22/22, indicated all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were to be reported immediately, but no later than 2 hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or no later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the state agency. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) DAYS	21980		

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on 11/30/2022. At the time of this survey, Moorhead Restorative Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. Moorhead Restorative Care Center was built in three stages. In 1963 the original 1-story building was constructed without a basement and was determined to be Type II (111) construction. In 1998 a 1-story addition was constructed to the northeast of the east wing of the original building and was determined to be Type V (111) construction. In 2009 a dayroom addition was constructed to the northeast corner of the original building and a dining room addition to the southeast of the original dining room was constructed. These additions are Type II (000), 1-story without a basement. The building is fully sprinkler protected and has a fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 39 at the time of the survey.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 The requirements at 42 CFR, Subpart 483.70(a) are MET:	K 000		