Electronically delivered
January 21, 2022

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

RE: CCN: 245052
Cycle Start Date: December 22, 2021

Dear Administrator:

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

On December 22, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. Because your facility is designated as a Special Focus Facility (SFF). CMS's policy of progressive enforcement means that your facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 5, 2022.

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

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

payment for new admissions is effective February 5, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 5, 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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by February 5, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Moorhead Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 5, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 22, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

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

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

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

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

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

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

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

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, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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 12/20/21, to 12/22/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §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 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007		2/18/22

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

Electronically Signed | 01/30/2022

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

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E 007	Continued From page 1 *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address in their Emergency Preparedness Plan the patient population including, but not limited to, persons at-risk. This had the potential to effect all 24 residents currently residing in the facility. Findings include: Review of the facility's Emergency Preparedness Plan, revised 3/17/21, identified the patient population, including but not limited to persons at-risk, the type of services the facility had the ability to provide in an emergency, and continuity of operations was not addressed. During interview on 12/22/21, at 3:30 p.m. the facility's Physical Plant Director (PPD) confirmed the above findings.	E 007	1.No specific resident was identified. Updated the EPP to address the patient population including, but not limited to, persons at-risk, the type of services the facility has the ability to provide in an emergency, and continuity of operations. 2. All residents have the ability to be affected by the lack of addressing the patient population, the type of services the facility has the ability to provide in an emergency, and continuity of operations. They will be protected by updating this plan so that we are prepared in case of emergency. 3. Education on updating the EPP has been provided to the Physical Plant Director (PPD). 4. An audit will be done on the patient	

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E 007	Continued From page 2	E 007	population and the type of services the facility has the ability to provide in an emergency will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. These results will be sent to QAPI for review	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The	E 041		2/18/22

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E 041	Continued From page 3 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

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E 041	Continued From page 4 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator per NFPA 101 (2012 edition), The Life Safety Code, sections, 9.1.3 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.2. This deficient finding could have a widespread impact on the 24 residents residing within the facility. Findings include: On 12/22/2021, at 11:13 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Physical Plant Director (PPD), that the facility	E 041	1. No specific residents were identified. A monthly test of the generator at 30% of the generator kilowatt rating was done on 1/26/22. 2.All residents can be affected by the lack of proper monthly generator testing at 30% of the generator kilowatt rating. Generator testing has been completed to protect all residents 3.Education on proper monthly generator testing has been provided to the Physical Plant Director (PPD). 4. An audit will be done to ensure that proper documentation of monthly generator tests at 30% of the generator kilowatt rating will be done weekly x 8	

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E 041	Continued From page 5 could not provide or document information verifying that the emergency generator had be tested monthly at 30 percent of the generator kilowatt rating. An interview with the PPD verified these findings at the time of discovery.	E 041	weeks then monthly for 4 months, until 100% compliance is achieved. These results will be sent to QAPI for review	
F 000	INITIAL COMMENTS Moorhead Restorative Care Center is a Special Focus Facility. On 12/20/21, to 12/22/21, a standard recertification survey was conducted at your facility. Complaint investigations were 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 complaints were found to be SUBSTANTIATED: H5052149C (MN79264) with deficiencies at F677 and F686 H5052157C (MN58048) with deficiency at F686 H5052162C (MN56564) with deficiency at F677 H5052163C (MN56347) with deficiency at F686 AND The following complaints were found to be SUBSTANTIATED: H5052154C (MN74674) H5052155C (MN62868) H5052156C (MN59623) H5052158C (MN57537) H5052159C (MN57152) H5052160C (MN57071) H5052161C (MN56989) H5052164C (MN57738), however NO deficiencies were cited due to actions	F 000		

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F 000	Continued From page 6 implemented by the facility prior to survey: AND The following complaints were found to be UNSUBSTANTIATED: H5052150C (MN78262) H5052151C (MN75159) H5052152C (MN74974) H5052153C (MN74902) 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 that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		2/18/22

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F 580	Continued From page 7 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician was notified timely of a change in condition for 1 of 2 residents	F 580	1. On 12/21/22 R8□s care plan was reviewed and updated. On 12/22/22 R8□s primary physician was contacted to verify	

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 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 8 (R8) reviewed for notification of change. Findings include: R8's quarterly Minimum Data Set (MDS) dated 10/26/21, identified R8 was independent with decision making and had diagnoses which included cerebrovascular accident (stroke), hemiparesis (weakness on one side), aphasia (inability to speak or find words) and alcohol dependence. The MDS indicated R8 had no behavior concerns and required the assistance of one staff for activities of daily living (ADL's). cares. R8's care plan revised 5/27/21, identified R8 had a substance abuse disorder and was alcohol dependent as evidenced by history, with impaired judgement and poor impulse control. The care plan instructed staff to educate R8 on the risk associated with drinking alcohol, encourage activities and monitor R8 to ensure alcoholic beverages were not consumed. The care plan identified if staff suspected alcohol intoxication, staff were to contact the provider for increased monitoring and medication hold parameters. The care plan further instructed staff to hold aspirin, acetaminophen, gabapentin (pain medication), levetiracetam (seizure medication) and escitalopram (antidepressant) when R8 was intoxicated. The care plan identified staff were to complete room checks weekly for alcohol at different times of the week and staff were to intervene if they observed alcohol. R8's Order Summary Report dated 12/21/21, signed by the provider identified current orders included when R8 was intoxicated staff were to hold aspirin, acetaminophen, gabapentin, and	F 580	the orders of medications being held. Order was obtained and updated to reflect current order. Clarification also received on time hold of medications and blood glucose perimeters. 2.This physician notification has the potential to affect all residents. All resident charts will be audited to ensure that providers are notified if a change in condition has occurred. In addition, nursing staff were educated beginning on 1/26/22 on notification and what constitutes a change in condition and when provider should be notified. 3. Audits will be performed on physician notifications will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. 4. Audits will be reviewed by administrator or designee and then further discussion will take place at next QAPI meeting to review and recommend any necessary changes necessary. 5. 02/18/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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F 580	Continued From page 9	F 580		

escitilopram. The report instructed staff to monitor blood sugars every hour when R8 was intoxicated.

The orders lacked parameters for the length of time to hold medication or to complete hourly blood sugar checks.

Review of R8's progress notes from 9/8/21, to 12/21/21, revealed the following:

- 9/30/21, at 8:37 p.m. the nurse was informed by direct care staff R8 appeared intoxicated and R8 indicated a friend had provided him a drink while visiting. The note identified the nurse assessed R8's vital signs which were within normal limits and noted R8 was alert and oriented. The note lacked evidence the provider had been updated, any medications had been held and blood sugars had been monitored as ordered.

- 11/24/21, at 11:25 p.m. the note identified at 8:00 p.m. R8 was not in his room when the nurse went to administer R8's insulin. R8 was found in another resident's room drinking drinks that were in a pop bottle. The note identified R8 to be weak and not oriented. R8 agreed to take his insulin and the nurse administered. The supervisor was notified of R8's condition as the room smelled of alcohol. The nurse asked both residents if they had been drinking and they both denied. The drinks were taken from both residents and poured into the sink. Both residents shut themselves in the room with the lights off and door supported by a bed so staff were not able to enter. Staff were able to assist R8 to bed after the nurse was able to open the door. R8 had been noted to be confused and incoherent. The note lacked evidence the provider had been updated, any

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	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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

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F 580	Continued From page 10	F 580		

medications had been held and blood sugars had been monitored hourly.

Review of R8's medication administration records from 9/1/21, to 12/21/21 revealed the following:

-September 2021, identified on 9/30/21, no medication had been held or additional blood sugars had been checked.

-November 2021, identified on 11/24/21, no medication had been held or additional blood sugars had been checked.

During an interview on 12/21/21, at 10:37 a.m. licensed practical nurse (LPN)-A identified staff were expected to observe R8 for signs of alcohol impairment. LPN-A revealed if R8 had been suspected of drinking alcohol she would have completed an incident report and checked R8's vital signs. LPN-A stated she was unaware room checks were expected to be completed. LPN-A stated she had only been working in the facility for about two months and was not aware of any other interventions for R8.

During an interview on 12/21/21, at 3:43 p.m. LPN-D indicated on 11/24/21, R8 appeared to be impaired and smelled of alcohol. LPN-D contacted the director of nursing (DON) and received instruction to remove the alcohol. LPN-D stated he was unsure how R8 received the alcohol as he had not left the facility nor had any visitors during his shift. LPN-D indicated R8 refused to leave the other residents room when he entered to check R8's blood sugar and administer his insulin. LPN-D confirmed the provider had not been contacted and no further assessments had been completed on R8.

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 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 11 During an interview on 12/21/21, at 4:37 p.m. the DON indicated R8 had a history of alcohol abuse. DON stated staff were expected to notify the provider, follow the orders to hold medications and to follow the care plan as outlined when R8 was suspected to be intoxicated. DON confirmed she had been notified of the incident on 11/24/21, and had instructed the nurse to notify the provider and monitor R8. DON stated staff should have notified the provider when R8 was noted to be intoxicated for further instruction. DON confirmed R8's order for holding medications and checking hourly blood sugars when R8 was suspected of being impaired had no length of time identified. During an interview on 12/22/21, at 11:08 a.m. nurse practitioner (NP) identified she was R8's primary provider and indicated she had discussed with R8 the risks associated with alcohol use. NP stated she expected staff to contact her for further direction when R8 was intoxicated. NP confirmed she had not been notified of the 11/24/21, incident. NP stated she was not aware the orders to hold R8's medications and check hourly blood sugars lacked a length of time. A policy on change of condition was requested and not provided.	F 580		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		2/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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F 677	Continued From page 12 Based on observation, interview and document review, the facility failed to provide shaving assistance for 1 of 1 resident (R20) who was dependent on facility staff for grooming. Findings include: R20's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 11/20/21, identified R20 had diagnoses which included diabetes, Osteoarthritis and peripheral vascular disease. The MDS identified R20 had intact cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and personal hygiene. R20's SCSA Care Area Assessment (CAA) dated 11/20/21, identified R20 required extensive assistance with ADL's which included bed mobility, transfers and had a decline in condition related to recent COVID-19 diagnosis, and other medical conditions such as heart failure, diabetes, valgus deformity (deformity of foot/ankle) and chronic pain. R20's current care plan revised 12/9/21, revealed R20 had poor memory, was recently diagnosed with dementia, and required extensive assistance of two staff with bed mobility, dressing, bathing and grooming. R20's care plan lacked any indication of R20's preference for facial hair removal. R20's Visual/Bedside Kardex Report (nursing assistant care guide) dated 12/21/21, revealed R20 required extensive assistance with dressing, bathing and personal hygiene. R20's care guide lacked direction for facial hair removal.	F 677	1.R20 was identified as not having his facial hair removed. Resident discharged shortly after survey. Nursing staff were educated on 01/26/2022 regarding resident cares. 2.All residents have the potential to be affected in this area. This includes both female and male residents. Nurses were educated beginning on 1/26. Audits will be performed to ensure other residents are not affected by this practice and care plans will be updated will resident preferences as interviews are conducted. 3.Audits will be performed on grooming weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. 4.Audits will be reviewed by administrator or designee and then further discussion will take place at next QAPI meeting to review and recommend any necessary changes necessary. 5.02/18/2022	

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 12/22/2021

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F 677	Continued From page 13	F 677		

On 12/20/21, at 12:39 p.m. R20 was observed laying in bed, on his back, faced the television, his eyes were opened and he had thick white coarse facial hair approximately three (3) to five (5) millimeters (mm) in length, which covered his cheeks, chin, upper lip, jaw line and neck.

On 12/20/21, at 4:45 p.m. during a telephone interview with R20's family member (FM)-A, indicated R20 was oftentimes disheveled when she came to visit. FM-A stated she felt R20 had declined both physically and cognitively since his arrival to the facility approximately four months prior. FM-A stated prior to R20's admission to the hospital and subsequent admission to the facility, he used to be well groomed.

On 12/21/21, at 10:15 a.m. R20 was observed laying in bed on his back, R20's cheeks, chin, upper lip, neck and jaw line continued to be covered with thick white coarse facial hair 3-5 mm long facial hair. (NA)-C stood next to R20's bed, proceeded to assist him with incontinence cares, and left his room without offering assistance with facial hair removal.

- at 11:22 a.m. R20 was observed seated on on the side of his bed, with an over the bed table positioned in front of him, he held a sandwich with his right hand. R20's lower legs were covered with a white sheet, he wore gripper socks on both feet. R20's cheeks, chin, upper lip, neck and jaw line continued to be covered with thick white coarse facial hair 3-5 mm long facial hair.

- at 2:40 p.m. R20 was observed lying on his back in his bed, covered with a sheet from his mid lower legs to his upper torso. R20's cheeks, chin, upper lip, neck and jaw line continued to be

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

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F 677	Continued From page 14	F 677		

covered with thick white coarse facial hair 3-5 mm long facial hair.

On 12/22/21, at 7:07 a.m. R20 was observed laying on his back in bed, covered with a sheet from his ankles to his torso. R20's cheeks, chin, upper lip, neck and jaw line continued to be covered with thick white coarse facial hair 3-5 mm long facial hair.

On 12/21/21, at 10:25 a.m. during an interview NA-C stated R20 required extensive assistance with bed mobility, dressing, personal hygiene, and felt he was not able to recall information. NA-C indicated she was not aware of R20's shaving preference and did not offer to assist him with facial hair removal.

On 12/21/21, at 11:00 a.m. during an interview, LPN-A stated R20 required extensive assistance with his ADL's and indicated R20's cognition fluctuated over the coarse of the day. LPN-A stated she was not aware of R20's preference for facial hair removal.

On 12/21/21 at 11:40 a.m. during an interview, NA-A indicated R20 required extensive assistance with bed mobility, transfers and dressing. NA-A indicated R20's cognition would fluctuate over the course of the day and his needs should have been anticipated.

On 12/21/21, at 12:46 p.m. during a telephone interview with R20's family member (FM)-B indicated he had concerns with R20's cares not being completed routinely and R20's recent decline in cognition. He indicated R20 appeared disheveled, unshaven and generally unclean when he visited. FM-B indicated R20 used to take

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 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 15	F 677		

great care with grooming, and used to be clean shaven on his head and face. FM-B stated he felt it would bother R20 if he looked disheveled.

On 12/21/21, at 4:19 p.m. during an interview LPN-C stated R20 required assistance with all of his cares and felt R20 had a poor memory and indicated his cognition would fluctuate over the course of the day.

On 12/21/21, at 4:58 p.m. during an interview a trained medication aid (TMA)-B stated R20 required extensive assistance with all cares except for eating, he required set up assistance. TMA-B stated she felt R20 had memory loss and was not always able to recall events or his needs. TMA-B indicated she believed R20 was assisted to shave his face daily.

On 12/22/21, at 8:44 a.m. during an interview NA-B stated R20 was totally dependent for his ADL's and felt he had declined within the past month, following his COVID-19 illness. NA-B stated she felt R20 had memory loss and was not always able to recall instructions or events. She indicated R20 used his call light, but was not always able to recall what he wanted and his needs were to be anticipated. NA-B indicated R20 preferred to be clean shaven and should have been assisted with facial hair removal daily.

On 12/22/21, at 12:47 p.m. the director of nursing (DON) indicated she was not aware of R20's preference for facial hair removal. The DON stated R20's cognition had been fluctuating and overall declining since November when he had COVID-19. The DON indicated she expected R20's shaving preference to be identified and expected staff to assist with facial hair removal if

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 12/22/2021

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 677	Continued From page 16 he desired. A facility policy was requested, one was not provided.	F 677		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately and comprehensively assess, monitor, develop and implement pressure relieving interventions for 1 of 1 resident (R20) reviewed for current, worsening pressure ulcers. This deficient practice caused actual harm when R20's left heel stage three (3) pressure ulcer worsened to an unstagable ulcer, development of an unstagable pressure ulcer on the top left foot and an unstagable lateral right foot pressure ulcer which worsened in size. Stage 3 pressure ulcer; full thickness tissue loss. Subcutaneous fat may be visible but bone,	F 686	1.R20 was identified as having an ulcer lacking measurements. R20 was subsequently discharged from the facility shortly after survey. 2.All residents have the potential to develop skin impairments. Policies were reviewed. Nursing staff were educated on 01/26/2022 regarding skin assessments and wound measurement. Further education will continue, which will include tests to determine understanding. Audits on wound care will ensure that proper measurements on wounds and skin assessments are obtained going forward. 3.Audits will be performed on wound care	2/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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 686	Continued From page 17 tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling Unstagable ulcer; wound bed cannot be visualized due to the presence of slough or eschar Slough; non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Eschar tissue; dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. Findings include: R20's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 11/20/21, identified R20 had diagnoses which included diabetes, osteoarthritis and peripheral vascular disease. The MDS identified R20 had intact cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and personal hygiene. The MDS identified R20 was at risk for developing pressure ulcers and identified R20 had the following pressure relieving interventions in place; pressure relieving device for chair, bed, and application of non-surgical dressings and ointments/medications to areas other than feet. The MDS incorrectly identified R20 had no unhealed pressure ulcers or other open areas.	F 686	weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. 4.Audits will be reviewed by administrator or designee and then further discussion will take place at next QAPI meeting to review and recommend any necessary changes necessary. 5.02/18/2022	

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

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F 686	Continued From page 18	F 686		

R20's SCSA Care Area Assessment (CAA) dated 11/20/21, identified R20 required extensive assistance with ADL's which included bed mobility, transfers and R20 had a decline in condition related to recent COVID-19 diagnosis, and other medical conditions such as heart failure, diabetes, varus deformity (deformity of foot/ankle in which the lateral part of the foot faces downwards) and chronic pain. The CAA identified R20 was admitted to the facility with a pressure ulcer/injury to his left heel and right bottom of foot that received daily dressing changes. The CAA identified the following pressure relieving interventions were in place; pressure redistributing device to bed, wheelchair and staff were to offer repositioning periodically with toileting. Further, the CAA identified R20's skin would be checked weekly by licensed staff. The CAA lacked any characteristics of R20's pressure ulcers such as stage, tissue type, measurements and any signs of healing or worsening.

R20's medical record lacked any further comprehensive skin assessments.

R20's current care plan revised 12/9/21, revealed R20 had poor memory, was recently diagnosed with dementia, and required extensive assistance of two staff with bed mobility, transfers and dressing. The care plan revealed R20 had a potential for pressure ulcer development, had open wounds on his legs, and feet. R20's care plan did not address the bilateral unstageable foot pressure ulcers, use of a pressure redistributing device to bed or wheelchair, or repositioning periodically with toileting or list any pressure relieving interventions.

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

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F 686	Continued From page 19	F 686		

R20's Visual/Bedside Kardex Report (nursing assistant care guide) dated 12/21/21, lacked any pressure relieving interventions for staff to follow.

R20's current physician orders signed 12/21/21, revealed the following;

- order dated 12/18/21, for Prevalon boots (specialized pressure relieving boots) on right foot, very important to keep the Prevalon boot on to protect the foot, may remove to walk, one time daily.

- order dated 12/2/21, cleanse legs and feet with gentle soap and water. Apply Aquaphor (lotion) to entire leg, cover open wounds with Adaptic (is a primary dressing designed to help protect the wound while preventing the dressing from adhering to the wound.) Wrap entire leg (foot to knee) with Kerlix followed by ace wrap in a figure eight fashion. Change daily and prn (as needed) every day shift for ulcer.

On 12/20/21, at 11:41 a.m. R20 was interviewed, he indicated he had a sore on his right foot that he had long term and indicated his left foot sore was new since he was admitted to the facility. R20 then, abruptly changed subjects, talked about many random topics and was unable to answer further question or provide any more information.

On 12/20/21, at 12:39 p.m. R20 was observed laying in bed, on his back, faced the television. Both of R20's feet rested directly on a regular mattress, wrapped with ACE bandages and were covered with gripper socks. R20's left foot toes were pressed against the footboard of his bed

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20	F 686		

and his right foot rested on the mattress on the lateral aspect of his foot.

On 12/21/21, at 10:15 a.m. R20 was observed laying in bed on his back, nursing assistant (NA)-C stood next to R20's bed, on his left side and proceeded to assist R20 with incontinence cares. R20's bilateral legs were wrapped from his feet to his knees with ACE bandages and he wore gripper socks on his feet. Following incontinence cares, NA-C was observed to tell R20 to use his heels to help boost him up in bed. R20 then placed both heels on the mattress of the bed, and assisted NA-C to move himself up towards the head of his bed. R20 then rested both of his ACE wrapped feet on the bed, his left heel and lateral aspect of his right foot rested directly on the standard mattress. NA-C was not observed to offer R20 pressure relief to his feet, nor did she offer use of his Prevalon boots.

- at 10:45 a.m. R20 was observed laying in bed on his back, his bare legs and feet were visible on his bed. R20's left heel was laying directly on his standard mattress and his right foot rested on the mattress, directly on the lateral aspect of his foot. At that time, licensed practical nurse (LPN)-A was observed to cleanse R20's legs and feet, and proceeded to complete R20's dressing changes to his anterior left foot ulcer, left heel ulcer and two ulcers on the lateral aspect of his right foot. LPN-A donned clean gripper socks to both of R20's feet, was not observed to elevate or offload R20's feet, R20's left heel and lateral aspect of his right foot rested directly on the standard mattress.

-at 11:22 a.m. R20 was observed seated on the side of his bed, with an over the bed table

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21	F 686		

positioned in front of him, he wore gripper socks on both feet, his right leg was inverted and his lateral aspect of his foot rested directly on the floor.

- at 2:40 p.m. R20 was observed lying on his back in his bed, covered with a sheet from his mid lower legs to his upper torso. R20's left heel and lateral aspect of his right foot rested directly on the standard mattress.

On 12/21/21, at 10:25 a.m. during an interview NA-C stated R20 required extensive assistance with bed mobility, transfers, dressing and personal hygiene. NA-C indicated R20 was able to help turn himself and used his feet to help move him up in bed. NA-C indicated R20 had open ulcers on both of his feet which oftentimes would have drainage coming from them and leave spots on R20's sheets. NA-C indicated she felt R20 had a poor memory and his cognition would fluctuate over the course of the day. At 12:08 p.m. during a follow up interview, NA-C indicated R20 wore Prevalon boots at night when he was in bed and was not aware of any pressure relieving interventions in place such as elevating his feet in bed.

On 12/21/21, at 11:00 a.m. during an interview, LPN-A stated R20 required extensive assistance with his ADL's and indicated R20's cognition fluctuated over the course of the day. She indicated R20 required daily dressing changes to his bilateral foot ulcers, which had been present since R20's admission to the facility. LPN-A indicated she completed R20's dressing changes daily and felt the areas were improving by less drainage present on his old dressings LPN-A stated she did not complete R20's ulcer

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22	F 686		

measurements or assessments, believed R20's bilateral foot pressure ulcers were monitored by a wound clinic and R20's primary physician. At 12:10 p.m. during a follow up interview, LPN-A stated R20 was supposed to wear Prevalon boots when he was in bed, but refused to wear them. LPN-A indicated she did not feel R20's bilateral foot ulcers were pressure related and confirmed R20 had no pressure relieving interventions in place.

On 12/21/21 at 11:40 a.m. during an interview, NA-A indicated R20 required extensive assistance with bed mobility, transfers and dressing. NA-A indicated R20 required daily dressings to his feet and legs due to ulcers and indicated she thought R20 might have special boots but was not sure. She indicated R20 was able to move his extremities and was not aware of any pressure relieving interventions for his feet.

On 12/21/21, at 12:46 p.m. during a telephone interview with R20's family member (FM)-B indicated he had concerns with R20's cares not being completed routinely and R20's recent decline in cognition. FM-B indicated R20 had chronic foot ulcers to his right foot due R20's foot deformity, though was not aware of any history of foot ulcers to his left foot. FM-B indicated he was recently notified by the facility R20 would be seen by a podiatrist for foot care. FM-B indicated he had concerns R20 had not received routine cares and stated he had not observed R20's Prevalon boots or his feet off loaded during his visits.

On 12/21/21, at 2:45 p.m. R20's medical record was reviewed with the DON, she confirmed R20 had pressure ulcers of his left heel, lateral right foot and were last measured in the facility on

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 23	F 686		

10/12/21. The DON stated she believed R20 was admitted to the facility with the lateral right foot ulcer, however, was not sure if R20's left heel ulcer was present upon his admission. The DON stated she would expect R20's left heel and right foot pressure ulcers to be assessed weekly, which would include measurements, wound characteristics, indications of healing, and current treatment. Further, the DON confirmed R20's care plan did not identify any pressure relieving interventions in place for R20's bilateral foot pressure ulcers. At that time, a request was made to measure and assess R20's left heel and right foot pressure ulcers.

-at 2:59 p.m. observation was conducted with DON present. R20 was observed laying on his back in bed, his left heel and his right lateral aspect of his foot were laying directly upon R20's mattress and his left upper foot and toes were pressed against the foot board of his bed. The DON stated R20's feet did not have any pressure relief in place and indicated she would need to find someone to assist her to boost R20 up in bed to relieve the pressure from his left foot. At 3:06 p.m. NA- E entered R20's room, the DON stood on the right side of R20's bed took hold of a lift sheet which was underneath R20's mid-body. NA-E took hold of the lift sheet on the left side of R20, the DON and NA-E encouraged R20 to place his feet on the bed and push to assist to move up in bed. R20's left heel and right lateral aspect of his foot pressed against the mattress as R20 was boosted up in bed. NA-E immediately left R20's room. The DON proceeded to remove R20's ACE wraps and dressings for measurements, the following was observed;

- R20's top left foot, had moderate purulent

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 24	F 686		

drainage (yellow/greenish) and revealed an unstagable pressure ulcer which measured 3.0 centimeters (cm) by 2.0 cm and had an area of slough tissue on the wound bed that measured 0.2 by 0.2 cm. with the remaining wound bed presented with epithelial tissue. The DON stated the pressure ulcer started as a blood blister which had opened. The DON confirmed R20's top left foot pressure ulcer had worsened in size, had slough tissue and had purulent drainage.

- R20's left heel, had a minimal amount of purulent drainage and revealed an unstagable pressure ulcer which measured 1.3 cm by 1.2 cm and was covered with thick, hard, dark brown eschar tissue. The DON confirmed R20's left heel pressure ulcer had worsened by an increase in size and a wound bed was no longer able to be visualized due to the eschar.

- R20's lateral right foot lower pressure ulcer, no drainage and revealed an unstagable pressure ulcer which measured 2.3 cm by 1.2 cm, thick, dark reddish/brown tissue on the wound bed. The DON confirmed R20's right lateral pressure ulcer had worsened by an increase in size and a wound bed was no longer able to be visualized due to the thick, dark reddish brown tissue.

The DON confirmed all three of R20's pressure ulcers had worsened and stated R20 refused to wear the Prevalon boots. The DON confirmed R20 had no current pressure relieving interventions in place for his unstagable pressure ulcers.

On 12/22/21, at 7:07 a.m. R20 was observed laying on his back in bed, covered with a sheet from his ankles to his torso. R20's left heel and

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25	F 686		

lateral aspect of his right foot rested directly on the standard mattress.

Review of R20's podiatry progress notes from 9/28/21, to 12/16/21, revealed the following:

- 9/28/21, presented with an ulcerated right foot, unspecified severity, a stage 3 decubitus ulcer of left heel, varus deformity (deformity of foot/ankle in which the lateral part of the foot faces downwards) of right ankle and chronic osteomyelitis (infection of the bone) involving ankle and foot. The note revealed R20's right foot ulcer was debrided and recommended an MRI (magnetic resonance imaging) and a Prevalon boot or Heel Lift boot for the right foot to protect from pressure.

- 10/5/21, seen for a follow up visit. The note revealed R20 had swelling and redness of the right leg and foot, recommended to prevent R20 from putting pressure on his feet. The note lacked any information about R20's unstagable left heel pressure ulcer or top of left foot pressure ulcer.

- 12/16/21, seen for a follow up visit of his lateral right foot. Note revealed R20's lateral right foot pressure ulcer was shallow and appeared improved from previous visit. The note revealed R20's podiatrist emphasized the need to get all pressure off of the lateral foot. The note lacked any information about R20's unstagable left heel pressure ulcer or top of left foot pressure ulcer.

R20's podiatry notes lacked any further documentation of the status or progress towards healing/worsening of R20's left heel pressure ulcer.

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 26	F 686		

Review of R20's facility Skin and Wound Evaluation from 8/31/21, to 10/12/21, revealed the following;

-8/31/21, indicated R20 had a diabetic ulcer of his left heel which measured 0.8 cm long by 0.5 cm wide and had no indication of depth. The wound evaluation lacked any characteristics of R20's left heel ulcer such as a description of the ulcer's wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify when R20's left heel ulcer developed or whether R20's left heel ulcer was healing or had worsened.

-8/31/21, indicated R20 had a diabetic ulcer on the sole of his right foot which measured 2.4 cm by 1.8 cm and had no indication of depth. The wound evaluation lacked any characteristics of R20's dorsum right foot ulcer, such as a description of the ulcer's wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify whether R20's right foot ulcer was healing or had worsened.

- 9/21/21, indicated R20 had a diabetic ulcer of his left heel which measured 0.6 cm by 0.4 cm and had no indication of depth. The wound evaluation lacked any characteristics of R20's left heel ulcer such as a description of the ulcers wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify when R20's left heel ulcer developed or whether R20's left heel ulcer was healing or had worsened.

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27	F 686		

- 10/12/21, indicated R20 had a diabetic ulcer of his left heel which measured 1.4 cm by 0.8 cm and had no indication of depth. The wound evaluation lacked any characteristics of R20's left heel ulcer such as a description of the ulcers wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify whether R20's left heel ulcer was healing or had worsened.

-10/12/21, indicated R20's dorsum right foot (part of foot facing upwards) had an unidentified area which measured 0.8 cm by 0.6 cm and had no indication of depth. The wound evaluation lacked any characteristics of R20's dorsum right foot ulcer, such as a description of the ulcers wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify whether R20's right foot ulcer was healing or had worsened.

R20's medical record lacked any further ongoing evaluation of R20's left heel pressure ulcer. In addition, R20's medical record did not identify the presence or assessment of R20's lower left anterior foot pressure ulcer (top left foot.)

On 12/21/21, at 4:19 p.m. during an interview LPN-C indicated she felt R20 had a poor memory and indicated his cognition would fluctuate over the course of the day. LPN-C indicated R20 received daily dressing changes to both of his feet and ACE wraps for edema management. LPN-C stated he was not aware of any pressure relieving interventions in place for R20's unstagable pressure ulcers of his left heel, top of

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28	F 686		

left foot and lateral right foot.

On 12/21/21, at 4:58 p.m. during an interview trained medication aid (TMA)-B stated R20 required extensive assistance with all cares except for eating, he required set up assistance. TMA-B stated she felt R20 had memory loss and was not always able to recall events or his needs. TMA-B stated R20 had ACE wraps on daily for edema management and had ulcers on both of his feet. TMA-B stated she was unaware of any pressure relieving interventions in place for R20's unstagable pressure ulcers of his left heel, top of left foot and lateral right foot.

On 12/22/21, at 7:55 a.m. during an interview, LPN-B stated R20 had ACE wraps on daily for edema management and had ulcers on both of his feet, but had not seen R20's unstagable pressure ulcers on his feet. LPN-B stated she was unaware of any pressure relieving interventions in place for R20's unstagable pressure ulcers of his left heel, top of left foot and lateral right foot.

On 12/22/21, at 8:44 a.m. during an interview, NA-B stated R20 was totally dependent for his ADL's and felt R20 had memory loss and was not always able to recall instructions or events. NA-B indicated R20 was supposed to wear Prevalon boots when in bed for pressure ulcers on his feet, but he refused to wear them. NA-B stated she was not aware of any pressure relieving interventions in place for R20's unstagable pressure ulcers of his left heel, lateral right foot and top of left foot.

R20's practioner progress notes were reviewed from 9/1/21, to 11/24/21, revealed the following:

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29	F 686		

-9/1/21, revealed R20 was seen in the facility for an initial visit at the facility. The note revealed R20 had a skin ulcer of right foot with necrosis to the bone. The note lacked any characteristic of his right foot ulcer and lacked any direction or recommendations. The note lacked any documentation of R20's unstagable left heel pressure ulcer.

-9/2/21, revealed R20 was seen in the facility for a routine visit, had cellulitis right lower extremity, right lower extremity wound with Mepilex dressing (is indicated for use on moderately exuding wounds, leg and foot ulcers, pressure injuries, under compression, graft and donor sites and traumatic wounds) and requested a wound care consult.

-10/13/21, revealed R20 was seen in the facility for weight gain related to fluid retention. The note revealed R20 had chronic ulcers on his feet and required an MRI. The note lacked any further direction regarding R20's chronic ulcers and lacked any documentation of R20's unstagable left heel pressure ulcer.

-10/27/21, revealed R20 was seen at the facility, examination revealed right foot and left heel skin deep ulcers, with fat layer exposed. The progress note revealed direction to continue dressing and wrapping legs per wound care clinic instructions.

-11/11/21, revealed R20 was seen in the facility for a routine visit, examination revealed skin thickness deep right foot ulcers, top of left foot ulcer and ulcer of left heel with fat layer exposed. The progress note revealed direction to continue dressing, wrapping of legs and to follow up with

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 30	F 686		

wound care clinic.

-11/24/21, revealed R20 was seen in the facility for a routine visit, discussed dementia diagnosis and concerns with worsening. The note did not identify R20's right or left foot pressure ulcers were reviewed at the time of the visit.

On 12/22/21, at 3:45 p.m. during a telephone interview, R20's primary physician, medical doctor (MD)-A stated she was aware R20 had pressure ulcers of his lateral right foot, left heel and top of left foot. MD-A stated she had last seen R20 at the facility on 12/21/21, though had not been able to visualize his feet. MD-A stated she had not been told of any changes to R20's left heel pressure ulcer, lateral right foot pressure ulcer or top of left foot ulcer. She indicated R20 was routinely seen by a podiatrist for wound care, however, she would expect the facility to assess and monitor R20's pressure ulcers routinely, at least weekly for any changes. MD-A stated any pressure on R20's left heel or the lateral right foot could certainly cause further injury and she would expect the facility to routinely implement pressure relieving interventions to prevent worsening.

On 12/22/21, at 7:37 a.m. a telephone call was placed to R20's podiatrist, a message was left for a return call. A return call was received on 12/23/21, at 9:28 a.m. from R20's podiatrist. He confirmed he had last seen R20 on 12/16/21, for follow up management of his lateral right foot pressure ulcer. The podiatrist stated he did not visualize R20 had an unstagable pressure ulcer of his left heel and foot during the last two visits and would have wanted to be notified of any changes. The podiatrist stated he had seen R20 three times since September for management of

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 31 R20's lateral right foot chronic pressure ulcer and had felt the wound looked better than when he first saw it. He stated he had not been made aware of the increase in size and did not see the thick, hard dark tissue at the time of R20's most recent visit. He stated he expected the facility to assist R20 to keep all pressure off of his lateral right foot and had ordered Prevalon boots to be worn when not up walking. The podiatrist stated he felt it was imperative to R20's healing to prevent any pressure on his right foot and would now expect R20's left heel to be offloaded at all times. R20's podiatrist stated he felt any pressure on R20's lateral right foot, left heel or any pressure to his feet would worsen existing pressure ulcers and could cause new ones to form. A policy was requested, one was not provided.	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 comprehensively reassess, for root cause analysis following falls, and failed to implement interventions prevent further falls for 1 of 2 resident (R13) who had a fall with a fracture and remained at risk for falls	F 689	1.The two residents identified were R13 and R20. R20 was subsequently discharged from the facility. The interventions on care plan and Kardex were updated for R13. Nursing staff were educated on these changes. Audits will be	2/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32 and of 1 of 2 residents (R20) who had a recent fall and who remained at risk for falls. R20's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 11/20/21, identified R20 had diagnoses which included diabetes, Osteoarthritis and peripheral vascular disease. The MDS identified R20 had intact cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and locomotion. The MDS identified R20 was unable to maintain his balance during transitions without physical assistance. The MDS identified R20 used a walker and wheelchair for mobility and occasionally ambulated with assistance of two staff. The MDS did not identify R20 had any falls since the last assessment. R20's SCSA Care Area Assessment (CAA) dated 11/20/21, identified R20 required extensive assistance with ADL's which included bed mobility, transfers and had a decline in condition related to recent COVID-19 diagnosis, and other medical conditions such as heart failure, diabetes, values deformity (deformity of foot/ankle) and chronic pain. The CAA identified R20 was at risk for falls related to impaired mobility, medication use and wounds on his feet. R20's current care plan revised 12/9/21, revealed R20 had poor memory, was recently diagnosed with dementia, and required extensive assistance of two staff with bed mobility, transfers and mobility. The care plan revealed R20 was at high risk for falls and used a full mechanical lift for all transfers. The care plan revealed the following fall interventions were to be implemented, call light within reach with prompt answering, wearing	F 689	initiated per below. 2.This has the potential to affect all residents that reside inside MRHCC. Fall prevention policies has been reviewed and updated as necessary. Nursing staff were educated on 01/26/22 regarding fall prevention, fall history, fall assessments, and care planning. As well as interventions to prevent falls. 3.DON or designee will perform audits on falls weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. 4.Audits will be reviewed by administrator or designee and then further discussion will take place at next QAPI meeting to review and recommend any necessary changes. 5.02/18/2022	

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 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 33	F 689		

gripper socks when ambulating or in the wheelchair. The care plan lacked any information or updated interventions resulting from R20's fall in the facility.

R20's Visual/Bedside Kardex Report (nursing assistant care guide) dated 12/21/21, revealed R20 was dependent on two staff and the use of full body mechanical lift for all transfers, required extensive assistance with bed mobility and had the following safety interventions; reminders to use his call light, gripper socks on when walking or in wheelchair, clear path to his bathroom. R20's Kardex lacked any indication R20 had fallen in the facility, or any updated interventions following his fall.

Review of R20's Resident Fall Risk Assessment dated 8/24/21, identified R20 was alert, had a history of one to two falls in the last three months, was ambulatory and continent. R20's risk assessment revealed medications he received and diagnosis which could potentially increase risk for falls. The assessment identified R20 fall risk score was a nine, however, the form did not identify what the fall risk score meant.

Review of R20's facility incident report dated 11/4/21, identified at 5:00 p.m. R20 was found seated on the floor of his room between his wheelchair and his bed, faced the door to his room. The incident report identified R20's bed was too high and resident did not have gripper socks on, though had them on earlier in the morning. The incident report identified R20 had been transferring himself from his wheelchair to his bed, missed the bed and slipped down. The report revealed R20 had been educated on the positioning of his bed for a safe transfer. The

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 34	F 689		

incident report did not identify R20's needs for physical assistance with transfers and other mobility or any indication of R20's cognition/memory recall.

Review of R20's Fall Assessment date 11/28/21, identified R20 was at moderate risk for fall based on the following information; R20 had a recent fall, used narcotic medication and had no memory recall within the last seven days prior to the assessment. The fall assessment identified R20 was frequently incontinent, had no behaviors, was confined to a chair, was unable to independently come to a standing position and a decrease in muscle coordination. The fall assessment lacked any fall interventions or a review of R20's prior falls.

On 12/20/21, at 12:39 p.m. R20 was observed laying in bed, on his back, faced the television, his eyes were opened, he wore a white short sleeved shirt, had ACE wraps on and gripper socks. R20's bed was raised approximately 30 inches from the ground and he had a rolling over the bed table positioned to the left of his bed.

On 12/20/21, at 4:45 p.m. during a telephone interview with R20's family member (FM)-A, indicated R20 was oftentimes disheveled when she came to visit. FM-A stated she felt R20 had declined both physically and cognitively since his arrival to the facility approximately four months prior. FM-A stated prior to R20's admission to the hospital and subsequent admission to the facility, he used to be very sharp mentally and took care with his appearance. FM-A stated R20 had recently fallen in the facility, though was unsure what the cause was or what the facility had implemented to prevent further falls. FM-A

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35	F 689		

indicated she felt R20 was no longer able to retain information given to him consistently. FM-A indicated R20's bed was raised off the floor, so he could sit at the side of his bed with his feet on the floor, as R20 was over six feet, six inches tall. However, she indicated she was not sure if R20 was at risk for sliding off of his bed.

On 12/21/21, at 10:15 a.m. R20 was observed laying in bed on his back, R20's bed was raised approximate 30 inches from the floor. (NA)-C stood next to R20's bed, proceeded to assist him with incontinence cares, and left his room. R20 remained laying in bed, bed was raised approximately 30 inches from the floor.

- at 11:22 a.m. R20 was observed seated on on the side of his bed, with an over the bed table positioned in front of him, he held a sandwich with his right hand. R20's lower legs were covered with a white sheet, he wore gripper socks on both feet and his left foot was positioned on the floor with a bed sheet between his foot and the floor. R20's right foot dangled from the bed. R20 leaned on the rolling over the bed table, as he ate the sandwich and watched the television. R20's bed was elevated approximately 30 inches from the ground, his left foot touched fully on the ground.

-at 12:01 p.m. R20 was observed to push off of his over the bed table with his left hand, the table moved slightly, he then moved his legs onto the bed, and laid on his back. R20's call light was on his left side, within his reach, was not observed to be be on. R20's bed remained elevated approximately 30 inches from the ground.

- at 2:40 p.m. R20 was observed laying on his

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 36	F 689		

back in his bed, covered with a sheet from his mid lower legs to his upper torso.

- at 5:00 p.m. R20 was observed laying in bed on his back, his eyes were closed, call light was within reach on his left side. R20's bed was raised approximately 40 inches off of the ground.

On 12/22/21, at 7:07 a.m. R20 was observed laying on his back in bed, covered with a sheet from his ankles to his torso. R20's bed was raised approximately 30 inches from the floor.

On 12/21/21, at 10:25 a.m. during an interview NA-C stated R20 required extensive assistance with bed mobility, dressing, personal hygiene, and felt he was not able to recall information. NA-C indicated R20's bed was kept raised due to R20's height and wanting to sit at the side of his bed. She stated R20 required the use of a full mechanical lift for all transfers and was not supposed to bear weight on his feet. NA-C indicated R20 had no falls in the facility and was not sure if he was at risk for falls.

On 12/21/21, at 11:00 a.m. during an interview, LPN-A stated R20 required extensive assistance with his ADL's and indicated R20's cognition fluctuated over the coarse of the day. LPN-A stated R20 preferred to keep his bed elevated off of the floor due to his height and wanting to sit at the edge of his bed. She indicated R20 was non-weight bearing at that time due to his foot ulcers and used a full mechanical lift for all transfers. LPN-A indicated she was not aware of any falls and indicated she was not aware of any fall interventions in place for R20.

On 12/21/21 at 11:40 a.m. during an interview,

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 37	F 689		

NA-A indicated R20 required extensive assistance with bed mobility, transfers and dressing. NA-A indicated R20's cognition would fluctuate over the course of the day and his needs should be anticipated. NA-A stated she was not aware if R20 had any falls since his admission and indicated R20 was not weight bearing at that time and required the use of a full mechanical lift.

On 12/21/21, at 12:46 p.m. during a telephone interview with R20's family member (FM)-B indicated he had concerns with R20's cares not being completed routinely and R20's recent decline in cognition. He indicated R20 would appear disheveled, his room would be in disarray and he oftentimes would be either laying in bed or seated at the edge of the bed. FM-B indicated he was notified R20 had fallen in September, but was not told what had happened and was not aware of any interventions in place to mitigate his risk for falls. FM-B indicated R20's bed was usually elevated approximately 30 inches from the floor, as he was so tall and he could easily sit at the edge of the bed. However, FM-B indicated with R20's changing cognition and decline in his self care, he felt R20 was at high risk for fall and for slipping out of his bed.

On 12/21/21, at 4:19 p.m. during an interview LPN-C stated R20 required assistance with all of his cares and felt R20 had a poor memory and indicated his cognition would fluctuate over the course of the day. LPN-C indicated she was not aware of R20 having any falls, nor was she aware of any fall prevention interventions in place.

On 12/21/21, at 4:58 p.m. during an interview a trained medication aid (TMA)-B stated R20

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 12/22/2021

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 689	Continued From page 38	F 689		

required extensive assistance with all cares except for eating, he required set up assistance. TMA-B stated she felt R20 had memory loss and was not always able to recall events or his needs. TMA-B indicated she was not aware of R20 having any falls since his admission, and indicated he should have gripper socks on for general safety.

On 12/22/21, at 8:44 a.m. during an interview NA-B stated R20 was totally dependent for his ADL's and felt he had declined within the past month, following his COVID-19 illness. NA-B stated she felt R20's had memory loss and was not always able to recall instructions or events. She indicated R20 used his call light, but was not always able to recall what he wanted and his needs were to be anticipated. NA-B indicated R20 had not fallen when she was working and was not aware if he had fallen since his admission. NA-B indicated she R20 preferred his bed raised approximately 30 inches from the ground so he could sit at the edge of his bed with his feet on the floor. NA-B indicated she felt R20 was at risk for falls and made sure she routinely checked on him. NA-B indicated he had not observed R20 attempting to transfer himself.

R13

R13's admission Minimum Data Set (MDS) dated 11/17/21, identified R13 was cognitively intact and had diagnoses which included end stage renal

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 12/22/2021

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 689	Continued From page 39	F 689		

disease, diabetes mellitus and dependence on renal dialysis. R13's MDS indicated he required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. The MDS identified R13 had one fall with no injury since admission.

R13's care plan revised 12/20/21, identified R13 required extensive assistance of one to two staff with most ADL's which included transfers, bed mobility, toileting and walking. The care plan indicated R13 was at moderate risk for falls due to gait/balance issues and had multiple falls since admission. The care plan instructed staff to anticipate and meet resident's needs, ensure R13's call light was within reach and staff were to encourage R13 to use his call light.

Review of R13's fall risk assessments from 11/11/21, to 12/20/21, revealed the following:

- 11/11/21, R13's fall risk assessment determined R13 to be high risk for falls due to a history of falls, hypoglycemic (used to treat Diabetes Mellitus) medication use, sometimes had memory impairment, exhibited loss of balance while standing, required hands on assistance to move from place to place and decrease noted in muscle coordination.

- 12/20/21, R13's fall risk assessment determined R13 to be at moderate risk for falls due to history of falls, hypoglycemic medication use, sometimes had memory impairment and exhibited loss of balance while standing.

Review of R13's progress notes from 11/11/21, to 12/21/21, revealed the following:

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40	F 689		

- 11/15/21, at 5:16 a.m. R13 had an unwitnessed fall while in his room. R13 stated he was sitting on the bed when he fell. R13 was assisted back to bed, vital signs and neurological checks were completed and noted to be within normal limits (WNL).

- 11/23/21, at 2:27 p.m. post fall follow- up charting: R13 had a small skin tear which reopened on his left elbow and staff cleaned, dried and treated. R13's neurological checks and vital signs were WNL. The progress note lacked information when the fall occurred or how the fall happened.

- 12/20/21, at 3:10 a.m. R13 was found at 1:15 a.m. in the hallway a few steps from his door lying on the floor with his head against the wall and his feet faced the doorway to his room. R13's call light had been within reach and he had not used it. R13 stated he got up because he wanted to go smoke and he fell on the way. Three staff assisted R13 off the floor and it was noted R13 had a swollen right elbow. R13 complained of pain and rated his pain at a seven on a scale of one to ten. Tylenol 500 mg. was administered to R13. R13's vital signs and neurological signs were checked and found to be WNL. R13 had been placed on oxygen due to sats had dropped to 88% . The nurse practitioner (NP) and director of nursing (DON) were notified of the fall.

- 12/20/21, at 3:22 p.m. R13 had been sent to the ortho clinic earlier that morning at 9:15 a.m. for assessment of his right arm due to swelling and pain noted. R13 returned to the facility with an order for surgery.

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 41	F 689		

Review of the progress notes lacked evidence of a comprehensive assessment of R13's falls to determine a root cause of his multiple falls, and lacked documentation of appropriate interventions implemented to minimize his falls.

Review of facility incident reports from 11/15/21, to 12/21/21, revealed the following:

- 11/15/21, at 2:38 a.m. unwitnessed fall- staff went to answer R13's call light and found him on the floor. R13 stated he had been sitting on the bed and he fell out of bed. An abrasion was noted to the top of his scalp. R13 was assisted to bed with the use of a hoyer (total body) lift.

- 11/23/21, at 2:30 a.m. R13 was found sitting on the floor next to his bed with both legs stretched forward. R13 stated he rolled from the bed. R13 was transferred, assessment completed and R13 was noted to be bleeding from an old wound present on his left elbow. The wound was cleansed and treated.

No incident report had been provided for the fall which occurred on 12/20/21.

Review of the incident reports lacked evidence of a comprehensive assessment of R13's falls to determine a root cause of his multiple falls, and lacked documentation of appropriate interventions implemented to minimize his falls.

On 12/21/21, at 2:57 p.m R13 returned from his ortho clinic appointment and was noted to have a splint covered with ace wrap to his right arm. Licensed Practical Nurse (LPN)-A applied the gait belt to R13's waist while he was in his wheelchair, assisted R13 to stand, pivoted R13 to his right

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 42	F 689		

side and assisted R13 to sit on the edge of his bed. LPN-A removed the gait belt from R13's waist and assisted him to lay in the bed. LPN-A ensured R13's call light was within reach and reminded R13 to call for assistance when needed. R13 verbalized understanding.

On 12/20/21, at 4:35 p.m. R13 stated he had fallen and broke his arm during the night. R13 indicated he had been at the clinic earlier that day and they had planned on surgery in the near future to repair his arm. R13 stated he had not used the call light prior to his fall the night before. R13 indicated he was aware he was expected to call staff for assistance however he did not want to bother the staff. R13 stated staff frequently reminded him to use his call light and he was aware he could have fallen without staff assistance.

On 12/21/21, at 2:54 p.m. nursing assistant (NA)-D stated R13 was alert and oriented and required assistance of one staff with transfers. NA-D indicated staff frequently reminded R13 to use his call light and R13 understood he should have called for assistance and yet he continued to self transfer despite the reminders. NA-D stated he had been informed of R13's fall on 12/20/21, and knew R13 had injured his right arm. NA-D indicated he ensured R13 had his call light within reach after providing cares to R13.

On 12/21/21, at 3:18 p.m. trained medication aid (TMA)-B stated R13 was alert and oriented and required assistance from staff with all ADL's. TMA-B indicated she had been informed of R13's fall on 12/20/21, and was aware he had injured his right arm. TMA-B stated staff frequently reminded R13 to use his call light however he

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 43	F 689		

continued to self transfer. TMA-B indicated she had only been aware of R13's fall on 12/20/21, and had not heard of any other falls prior to that time.

On 12/22/21, at 8:38 a.m. LPN-A stated R13 was at risk for falls and indicated R13 had fallen a couple of nights ago and had broken his right arm. LPN-A stated when a fall occurred, she assessed the resident, provided treatment as necessary and notified the family. LPN-A stated she was not sure what the facility expectations were after a resident fall occurred and confirmed the facility did not have a process in place to follow after a resident had a fall to determine root cause and add new interventions to prevent future falls.

On 12/22/21, at 12:20 p.m. DON confirmed R13 was at risk for falls and stated R13 had four or five falls since admission to the facility. DON confirmed she had been unable to determine the exact number as the facility lacked a process for tracking or trending falls. DON confirmed the facility had not completed an incident report on R13's latest fall on 12/20/21. The DON stated her expectation was for staff to complete an assessment of R13 after a fall occurred which included checking vital signs and neurological checks, treat R13 if any injuries had occurred, notify the physician and DON. DON verified the facility lacked a process to assess each fall for root cause and to implement new interventions to prevent future falls.

On 12/22/21, at 12:47 p.m. the director of nursing (DON) confirmed R20's fall on 11/4/21, had not identified a potential root cause for his fall, and confirmed R20's medical record lacked a

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44 comprehensive assessment of R20's fall, his fall risk and failed to identify fall interventions. The DON stated R20's cognition had been fluctuating over the course of the day since he had COVID in November and indicated R20 would not be able to recall instructions given to him routinely. The DON stated R20 preferred to have his bed elevated from the ground in order to be able to sit on the edge of his bed. She indicated R20 was able to transfer himself upon admission, and felt he may not always recall he needs assistance with transfers due to decline in his strength. The DON indicated R20's current fall interventions included to keep his call light within reach, wear gripper socks when up and confirmed R20's care plan lacked fall interventions related to his fall in November. The DON stated due to R20's changing cognition she felt he was at high risk for falls and should have further fall interventions in place, such as gripper socks on in bed, assistance with sitting on the edge of bed, grab bars to aid in positioning. A policy for falls prevention was requested and was not provided.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the dialysis access site	F 698	1.The two residents identified were R10 and R13. R10 has subsequently	2/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 45 was consistently monitored and assessed for 2 of 2 residents (R10 and R19) reviewed for dialysis. Findings include: R10's quarterly Minimum Data Set (MDS) dated 11/15/21, identified R10 had diagnoses which included debility (physical weakness) end stage renal disease, anemia, diabetes and heart failure. The MDS identified R10 was cognitively intact and received supervision with activities of daily living (ADL's) of transfers, dressing, and bed mobility. The MDS identified R10 received dialysis care during the seven day look back period. R10's admission MDS dated 8/16/21, identified R10 had diagnoses which included debility, end stage renal disease, hear failure, chronic respiratory disease and diabetes. The MDS identified R10 received extensive assistance with transfers, toileting, and required supervision with dressing, bed mobility and personal hygiene. The MDS identified R10 received dialysis care. R10's admission Care Area Assessment (CAA) dated 8/16/21, identified R10 was recently hospitalized with a pulmonary infection, received dialysis and was fatigued after dialysis sessions. The CAA revealed R10 received dialysis three times a week, fatigued easily, was alert and oriented though had some mild forgetfulness. The CAA lacked documentation of R10's fistula (intravenous access for dialysis) and required monitoring of thrill and bruit (an auditory method of check fistula patency). R10's current care plan revised 10/19/21, revealed R10 had end stage renal disease,	F 698	discharged. R13□s care plan updated to reflect current interventions including monitoring post dialysis treatments. Nursing staff were educated on 01/26/22. 2.Resident's receiving outpatient dialysis would be affected by this deficient practice. 4 residents have been identified as being affected by this practice. Care plans will be updated and residents who go for outpatient dialysis will have a post dialysis assessment completed. Nursing staff educated on 1/26/21. 3. DON or designee will perform audits on post dialysis assessments will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. 4.Audits will be reviewed by administrator or designee and then further discussion will take place at next QAPI meeting to review and recommend any necessary changes. 5.02/18/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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 698	Continued From page 46	F 698		

received hemodialysis and had diabetes. The care plan lacked documentation of R10's fistula site, or any required monitoring of thrill and bruit or post dialysis assessment.

R10's nursing assistant care guide printed 12/22/21, lacked any indication R10 received dialysis, or had a fistula.

R10's physician orders, signed 11/30/21, identified R10 received dialysis three times a week. R10's care plan lacked any documentation of R10's fistula or direction for monitoring R10's access site for bleeding or for checking bruit and thrill.

R10's medical record lacked any documentation R10's fistula bruit and thrill was routinely monitored.

On 12/20/21, at 3:12 p.m. during an interview, R10 stated he received dialysis three times a week from at a dialysis clinic in a neighboring town. R10 stated he had a fistula site on her upper left arm, lifted the sleeve to his top and revealed a thick white bandage approximately four inches long and three inches wide on his upper left arm. He indicated the dialysis clinic monitored his fistula and stated the facility nursing staff had never looked at his dialysis site since his admission. R10 stated he had no episodes of profuse bleeding from the site, though had a low blood pressure on a couple of occasions which required medication from the dialysis center. R10 stated the facility was not currently monitoring his access site, nor were they checking his blood pressure upon return to the facility.

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 12/22/2021

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 698	Continued From page 47	F 698		

On 12/21/21 at 12:12 p.m. during an interview licensed practical nurse (LPN)-A stated R10 received dialysis three times a week. LPN-A indicated R10 took care of his own access site and stated she did not check his fistula upon return. LPN-A confirmed she did not check R10's fistula bruit and thrill for function, indicated no order was in place to do so. LPN-A indicated the dialysis center would call if R10 had any complications from his run and would let her know if he required further monitoring.

On 12/21/21, at 4:43 p.m. during an interview LPN-C stated he believed R10 had a fistula on his left upper arm and received dialysis three times a week. LPN-C indicated he would usually check R10's vital signs upon return from dialysis if needed. He indicated if there were complications, such as hemorrhaging or low blood pressure, during dialysis the center would call and notify them of needed monitoring. LPN-C confirmed he did not monitor R10's fistula site and had never checked R10's bruit and thrill.

On 12/21/21, at 5:08 p.m. during an interview, trained medication aid (TMA)-B stated R10 received dialysis three times a week and would bring back a red folder following his appointment. She indicated she would check R10's vital signs upon return when he had issues with low blood pressures. She stated she did not routinely check R10's vital signs upon return and stated licensed nursing staff would check R10's fistula site.

On 12/22/21, at 7:24 a.m. during an interview, LPN-B stated the facility did not have a current practice in place for monitoring residents post dialysis prior to that day. LPN-B stated she felt residents who received dialysis should get a full

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 48	F 698		

set of vital signs upon return, should have their access site monitored for bleeding and their access site (fistula) should be checked daily for bruit and thrill.

On 12/22/21, at 8:26 a.m. during a telephone interview with Sanford Dialysis registered nurse, charge nurse (RN)-A, confirmed R10 received dialysis three times a week at their clinic. RN-A stated she would expect R10's fistula to be monitored for bleeding upon his return to the facility along with his vital signs. She indicated R10 had a history of low blood pressure following his dialysis runs, and felt it was important R10's blood pressure was monitored upon his return. RN-A stated she usually contacted the facility if R10 had any complications during his session, but felt it was very important the facility routinely monitored him. RN-A stated it was a standard of practice to check R10's fistula's bruit and thrill and monitor his fistula due to risk for bleeding, low blood pressure, infection and death if complications were not identified in a timely manner.

On 12/22/21, at 8:38 a.m. TMA-A confirmed R10 received daily three times a week and indicated there were no processes in place for monitoring R10's fistula or check his vitals signs post dialysis.

R13

R13's admission Minimum Data Set (MDS) dated 11/17/21, identified R13 was cognitively intact and had diagnoses which included end stage renal

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 49	F 698		

disease, diabetes mellitus and dependence on renal dialysis. R13's MDS indicated he required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. The MDS identified R13 received dialysis.

R13's care plan revised 12/20/21, identified R13 required dialysis related to renal failure. Interventions listed included: do not draw blood or take blood pressure in arm with graft, encourage resident to go to dialysis appointments, monitor labs and report to doctor as needed, monitor/document/report as needed any signs or symptoms of infection to access site: redness, swelling, warmth or drainage and wok with resident to relieve discomfort for side effects of the disease and treatment. The care plan lacked instruction to staff to monitor dialysis site for bleeding or any other adverse reactions.

Review of R13's physician orders signed on 11/24/21, identified R13 was prescribed a Diabetic Diet. The orders lacked orders for dialysis treatments or monitoring parameters.

Review of R13's progress notes from 11/17/21, to 12/21/21, revealed a lack of any post-dialysis assessments.

Review of R13's dialysis post-observation records from 11/17/21, to 12/21/21, revealed the following:

-11/26/21, at 12:50 p.m. R13's blood pressure (BP) was 173/66 and the dressing to his fistula (an access for dialysis) site to his left upper arm was clean, dry and intact. The record revealed

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 12/22/2021

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 698	Continued From page 50	F 698		

the thrill (a rumbling sensation you can feel) and bruit (a rumbling sensation you can hear) were noted.

R13's electronic health record (EHR) lacked any further dialysis post-observation records.

On 12/20/21, at 4:35 p.m. R13 stated he received dialysis three times a week on Monday, Wednesday and Friday. R13 stated he attended dialysis on Sunday, Tuesday and Thursday of the current week due to the holiday coming up. R13 indicated the nursing staff checked his blood sugar and escorted him to the dining room once he returned from dialysis. R13 stated no other actions had been completed by the nursing staff such as checking his dialysis site for bleeding or checking his vital signs. R13 lifted his left arm and pointed to his dialysis site which was covered by a bandage and stated the bandage was still in place from the dialysis run the day before and nursing staff had not checked the site nor removed the bandage yet.

On 12/21/21, at 11:46 a.m. licensed practical nurse (LPN)-A entered R13's room after R13 returned from dialysis, checked R13's blood sugar and administered insulin to R13's right abdomen area. LPN-A picked up the folder which contained information about R13's dialysis run and placed it on the desk at the nurse's station.

On 12/21/21, at 11:50 a.m. LPN-A stated when R13 returned from dialysis she would check his blood sugar and scan the information from the dialysis center into R13's EHR. LPN-A indicated she was not aware of what the process was at the facility for completing post- dialysis assessments. LPN-A confirmed she had not

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 51	F 698		

completed a post-dialysis assessment on R13 and further stated she had never completed one at the facility since she began her employment there.

On 12/21/21, at 3:18 p.m. trained medication aid (TMA)-B stated when R13 returned from dialysis she gave the folder from the dialysis center to the nurse and the nurse checked R13's blood sugar. TMA-B indicated she had not observed a nurse complete any other tasks such as checking R13's vital signs or checking his dialysis site and further stated the facility had no dialysis post-assessment process in place. TMA-B stated the nurses typically left the bandage on R13's left arm for a couple of days.

On 12/22/21, at 12:20 p.m. director of nursing (DON) confirmed the facility did not complete post- dialysis assessments which included monitoring of R13's access site and vital signs when R13 returned from dialysis. DON stated the facility received the dialysis run information from the dialysis center and scanned it into R13's EHR.

On 12/22/21, at 1:06 p.m. the director of nursing (DON) stated the facility had no current policy or procedure in place for post dialysis assessments, fistula/site monitoring and was currently in the process of educating staff and implementing post dialysis assessments. The DON confirmed it was a professional standard of practice for residents who received hemodialysis to be monitored for complications such as bleeding, low blood pressure post dialysis and their access site should be checked daily. The DON confirmed R10's care plan lacked any information of R10's access site or post dialysis needs.

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 52 Review of a facility policy titled, Dialysis Care, adopted 2/12/20, revealed it was the policy of the facility each resident who received the care and provisions of dialysis were consistent with the professional standards of practice. The policy identified it was the facility's responsibility to assess and monitor residents who received dialysis for any complications by checking vital signs, medication management and monitoring residents dialysis access sites.	F 698		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		2/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 53 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure pharmacy recommendations were addressed in a timely manner for 4 of 5 residents (R20, R15, R9 and R12) reviewed for unnecessary medications. Findings include: R20's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 11/20/21, identified R20 had diagnoses which included diabetes, Osteoarthritis and peripheral vascular disease. The MDS identified R20 had intact cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and personal hygiene. The MDS identified R20 received antidepressant, anticoagulant, diuretic, and opioid medications seven of seven days during the look back period. R20's SCSA Care Area Assessment (CAA) dated 11/20/21, identified R20 required extensive assistance with ADL's which included bed mobility, transfers and had a decline in condition	F 756	1.The following residents were identified as being affected by this practice R20, R15, R9, R12. R20 R20 subsequently discharged from the facility. Resident R9 saw Psychiatric NP on 01/26/2021. Hgb A1C drawn and resulted on 12/27/2021. R15 pharmacy recommendations sent to primary physician to physician on 12/17/2021 to be addressed returned on 12/17/2021. R12□s pharmacy recommendations sent to primary physician on 12/12/2021. Primary physician addressed pharmacy recommendations on 12/17/2021. DON confirmed primary physician signature on 12/17/2021. All December pharmacy reviews were returned. Pharmacy medication review policy updated on 01/21/2022. DON and ADON were educated on 1/21/22 2.This has the potential to affect all residents. All pharmacy recommendations will be reviewed within 7 days. Audits will be completed monthly to ensure that	

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 54 related to recent COVID-19 diagnosis, and other medical conditions such as heart failure, diabetes, valgus deformity (deformity of foot/ankle) and chronic pain. The CAA's identified R20 received several different medications which included, antidepressant, anticoagulant, diuretic, and opioid medications. Review of R20's Consultant Pharmacist Medication Review from 8/26/21, to 11/29/21, revealed the following: - 8/26/21, revealed the pharmacy consultant had a recommendation for separation of calcium and vitamin C, no response was documented. - 9/13/21, revealed the pharmacy consultant recommended R20's practioner address the use of Cinnamon at the current dose, (which was too high,) requested Digoxin level (medication used to treat atrial fibrillation, lab helps determine therapeutic level) and requested a basic metabolic panel (a blood test that measures your sugar (glucose) level, electrolyte and fluid balance, and kidney function. Glucose is a type of sugar your body uses for energy. Electrolytes keep your body's fluids in balance.) The recommendations lacked documentation R20's primary practioner addressed the recommendations. Review of R20's November 2021, consultant pharmacist medication review, dated 11/29/21, revealed the facility pharmacy consultant requested R20's practioner address recommendations made in September. The forms revealed R20's practioner addressed the recommendations on 12/6/21, decreased R20's cinnamon, ordered a Digoxin level and indicated	F 756	residents are receiving appropriate medication. Staff involved educated on 01/21/2022. 3.Audits will be performed on pharmacy recommendations and response, monthly x 6 months, until 100% compliance is achieved. 4.Audits will be reviewed by administrator or designee and then further discussion will take place at next QAPI meeting to review and recommend any necessary changes necessary. 5.02/18/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 55	F 756		

R20 had a basic metabolic panel drawn on 11/15/21.

Review of R20's medical record lacked documentation a pharmacy review was conducted for October, 2021.

R15

R15's quarterly Minimum Data Set (MDS) dated 11/19/21, identified R15 had moderate cognitive impairment and had diagnoses which included Parkinson's Disease, Heart Failure and Diabetes Mellitus. The MDS indicated R15 received antipsychotic medication each day during the assessment reference period. The MDS lacked documentation of a drug regimen review.

Review of current physician orders signed 10/28/21, revealed R15 received the following medications:

- Isosorbide Dinitrate (medication used to prevent chest pain) 60 milligrams (mg.) one time daily.

- Metformin HCL (medication used to treat Diabetes Mellitus) 1000 mg. twice a day.

- Seroquel (Quetiapine Fumerate) (medication used to treat schizophrenia, bipolar and major depressive disorder)25 mg. twice daily.

Review of R15's Consultant Pharmacist's Medication Review (CPMR) forms from 6/28/21, to 12/17/21, revealed the following:

- 6/27/21, recommendation was made to clarify and update the medication administration record

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 56	F 756		

(MAR) to administer Isosorbide Dinitrate 30 mg. extended release (ER). Physician acknowledged and confirmed the order on 6/30/21. Recommendation made for direction on the scheduling of Metformin 1000 mg. times to be administered at meal times. The physician acknowledged and confirmed the order on 6/30/21.

- 7/19/21, the facility lacked the form for July 2021.

- 8/26/21, recommendation was made for the physician to clarify if Isosorbide 60 mg. should be the ER formulation or not. The form lacked any response or signature from the physician.

- 9/22/21, recommendation was made for the physician to re-evaluate prescribing Quetiapine due to antipsychotic medications (are a class of medicines used to treat psychosis and other mental and emotional conditions) have the potential for a direct drug interaction for someone who has Parkinson's Disease. The form lacked any response or signature from the physician.

- 10/29/21, recommendation was made to have a Tardive Dyskinesia (Tardive dyskinesias (TDs) are involuntary movements of the tongue, lips, face, trunk, and extremities that occur in patients treated with antipsychotic medications) assessment completed as necessary. The form lacked any response or signature from the physician.

- 10/29/21, recommendation was made for the physician to clarify if Isosorbide 60 mg. should be the ER formulation or not. The form lacked any response or signature from the physician.

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 12/22/2021

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F 756	Continued From page 57	F 756		

- 11/29/21, the facility lacked the form for November 2021.

- 12/17/21, recommendation was made for the physician to re-evaluate prescribing Quetiapine due to antipsychotic medications have the potential for a direct drug interaction for someone who has Parkinson's Disease. The form lacked any response or signature from the physician.

- 12/17/21, recommendation was made for the physician to clarify if Isosorbide mono 60 mg. should be the ER formulation or not. The form lacked any response or signature from the physician.

Review of facility form titled Patient Summary Report printed on 12/22/21, revealed the following:

- 6/28/21, irregularities identified- see report.

- 7/19/21, irregularities identified- see report.

- 8/26/21, irregularities identified- see report.

- 9/22/21, irregularities identified- see report.

- 10/29/21, irregularities identified- see report.

- 11/29/21, no irregularities identified.

- 12/17/21, irregularities identified- see report.

R9

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 12/22/2021

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 756	Continued From page 58	F 756		

R9's quarterly Minimum Data Set dated 10/27/21, identified R9 had cognition intact and diagnoses included hypertension (HTN), diabetes mellitus (DM), renal insufficiency, and depression. The MDS identified R9 required supervision with dressing and had unstable balance during transfers and walking. The MDS indicated R9 received antianxiety medication and antidepressants seven of seven days during the assessment reference period.

Review of R9's current physician orders signed 12/22/21, revealed R9 received the following medications:

-Nystatin Suspension (antifungal medication used to fight infections caused by fungus) 100,000 unit/milliliter (ml) give 5 ml by as needed (PRN) for thrush.

-Bupropion Hydrochloride (HCL) (antidepressant) tablet extended release (ER) 24 hour give 150 milligrams (mg) by mouth at bedtime for depressive disorder single episode. Revision date 5/25/21.

-Buspirone (Buspar) (antianxiety medication used to treat imbalance of chemicals in the brain) HCL tablet 15 mg tablet give 15 mg by mouth three times a day for depressive major single episode. Revision date 5/25/21.

-Venlafaxine (Effexor) (antidepressant medication used to treat imbalance of chemicals in the brain) HCL ER capsule 24 hour 75 mg give 1 capsule by mouth in the morning for depression. Revision date 5/25/21.

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 12/22/2021

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 756	Continued From page 59	F 756		

-Divalproex (Depakote) (used to treat manic depressive disorders) Sodium Capsule Delayed Release Sprinkle 125 mg give 2 capsule by mouth three times a day for major depression/skin eruption. Revision date 5/25/21.

-Metformin (decreased blood glucose/sugar levels) HCL tablet 500 mg give my mouth two times a day for DM.

R9's Consultant Pharmacist's (CP) Medication Reviews from 6/2021 through 12/2021, identified the following:

-6/28/21, No irregularities identified.

-7/19/2021, No irregularities identified.

-8/26/21, No irregularities identified.

-9/22/21, and again on 12/17/21, Nystatin 5 ml PRN. Identified the medication did not include the frequency of use on the medication administration record (MAR). Staff were directed to contact the provider and update the MAR with the intended frequency as soon as possible but no later than 30 days.

-10/29/21, No irregularities identified.

-11/29/21, Bupropion, Effexor, Depakote, and Buspar had not been reduced recently. Consulting pharmacist (CP)-A suggested a psychiatric nurse practioner should have addressed these medications and if not she could have as soon as possible but no later than 60 days.

-12/6/21, Metformin 500 mg tablet take 1 tab by

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 12/22/2021

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 756	Continued From page 60	F 756		

mouth twice a day. R9's most recent AIC (hemoglobin is a protein that carries oxygen form the lungs to the cells of the body that has sugar attached to it) had been 6.1 percent. Staff were directed to repeat the A1C at next lab draw and if similar value consider re-assessing the ongoing need for the metformin.

R9's lab review identified 6/9/20, had been the last Hemoglobin AIC that was drawn with results of 6.1 percent.

Facility primary physician visit dated 12/22/21, at 1:50 p.m. identified R9 had been in need of blood work and a hemoglobin A1C was then ordered.

R9's medical record lacked documentation R9's primary physician was updated or followed up on the CP recommendations.

R12

R12's significant change MDS dated 11/13/21, identified R12 had cognition intact and required extensive assitance needed with bed mobility, walking, dressing, toileting, and personal hygiene. The MDS indicated R12's diagnoses included coronary heart disease (CAD), HTN, DM, pneumonia, arthritis, anxiety, depression, and post traumatic stress syndrome (PTSD). The MDS identified R12 received insulin and antidepressants seven of seven days during the look back period.

Review of R12's current physician orders signed 12/28/21, revealed:

-Metoprolol Tartrate (used to relax blood vessels, slow heart rate to improve blood flow to decrease

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 61	F 756		

blood pressure) tablet 25 mg give 0.5 mg by mouth two times a day for stented coronary artery.

-Zolpidem Tartrate (sedative used to treat insomnia and indicated for short term use only) tablet 10 mg give 10 mg by mouth as needed at bedtime for primary insomnia.

-Nitroglycerin (used to treat chest pain to increase blood flow to the heart) tablet sublingual give 0.4 mg sublingually every 5 minutes as needed for check pain.

R12's CP Medication Reviews from 6/2021 through 12/2021, identified the following:

-9/22/21, and again on 10/29/21, Nitroglycerin 0.4 mg SL tab PRN as directed. CP recommended the maximum 3 doses/episode should be included on the medicaion administration record (MAR) no later than 30 days.

-10/29/21, Metoprolol Tartrate 25 mg tablets are immediate release and should be ideally administered with meals or directly after meals to increase oral absorption. CP recommended "include food" should have been added to the actions.

-10/29/21, Zolpidem 10 mg every bedtime (HS) PRN was used for a psychological condition and needed to be revaluated within the first 14 days of starting. CP recommended in order to continue this medication a re-evaluation date to reassess should have been added, medication continued, and then re-evaluate again in 60 days.

-11/29/21, No irregularities identified.

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 12/22/2021

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

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F 756	Continued From page 62	F 756		

-12/17/21, No irregularities identified.

Monthly CP reviews for June, July, and August 2021, were requested and not provided.

R12's medical record lacked documentation R12's primary physician had been updated or followed up on the CP recommendations.

On 12/22/21, at 10:56 a.m. during a telephone interview, the facility pharmacy consultant, indicated she felt in the past it had been a struggle to get the facility to have the physicians address her pharmacy recommendations in a timely manner. She indicated she had thought R20 had a review completed in August with no recommendations and October she made recommendations to address her comments from September. The pharmacy consultant indicated she expected her pharmacy recommendations to be addressed as soon as possible, but no later than 60 day.

On 12/22/21, at 12:35 p.m. director of nursing (DON) stated she started reviewing the pharmacy recommendations in November 2021, and indicated she was not aware who reviewed them prior to that time. DON confirmed the facility had not followed up on the recommendations from July 2021, September 2021, October 2021, and December 2021 and verified there had been repeated recommendations due to the facility's lack of follow-up.

On 12/22/21, at 12:47 p.m. the director of nursing (DON) indicated she would expect residents medications to be reviewed monthly and would expect pharmacy recommendations to be

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 12/22/2021

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 756	Continued From page 63 addressed in a timely manner. The DON indicated the facility had identified issues with pharmacy consultants completing monthly reviews and their recommendations being addressed timely a couple of months ago. She confirmed R20's recommendations from September had not been not addressed until December. A facility policy titled, Pharmacy Medication Review, reviewed 4/3/18, identified it was the facility's policy to have the consultant pharmacist review residents medications for dose reductions to ensure all medications were properly ordered, discontinued and monitored. The policy revealed the facility would ensure the provider would address pharmacy recommendations in a timely manner.	F 756		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide therapeutic diet as prescribed by the physician for 1 of 2 (R1) residents reviewed for therapeutic diet. Findings include:	F 808	1.Resident R1 was identified as having an incorrect diet order. On 12/31/2021 MD order obtained for clarification for R1. Order changed from surgical soft to regular diet, regular texture, regular/thin consistency, small bite size, no hard	2/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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F 808	Continued From page 64 R1's Admission Record printed 12/22/21, identified R1 had been admitted to the facility on 6/11/21, with the diagnoses of visual loss, neuropathy unspecified (disease of the nerves), cataract, glaucoma, dysfunction of the bladder, rectal prolapsed, and benign prostatic hyperplasia (prostate enlargement). R1's quarterly Minimum Data Set (MDS) dated 9/16/21, identified R1's cognition was intact and required one staff assistance for grooming cares and required supervision for eating. The MDS indicated R1 had no swallowing disorder or signs or symptoms of a swallowing disorder. The MDS identified R1 had no known weight loss or gain. The MDS section that identified dental had been left blank. R1's admission Care Area Assessment (CAA) dated 6/24/21, identified R1 was missing most teeth and the remaining teeth were notably broken. R1's care plan revised 6/11/21, identified R1 had a nutritional problem or potential for one related to risk of choking and weight loss due to difficulty chewing, fear and resistance to weight gain, and risk for dehydration due to laxative use, advanced age and decreased mobility. The care plan instructed staff to assist R1 with meal set up and explain what was on his plate utilizing the clock method when the meal was delivered. The care plan indicated staff were to provide and serve the diet as ordered; regular diet with regular textures and regular consistencies. R1's current physician Order Summary Report dated 12/21/21, identified the prescribed diet	F 808	breads, no raw cabbage, and only creamed corn. 2.All residents have the potential to be affected. Order updated on 12/31/2021. Staff education took place on 02/01/2022, and will be continued. Audit all resident charts to maintain accuracy of diet orders. 3.Audits will be performed on diet compliance weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. 4.Audits will be reviewed by Dietician or designee and then further discussion will take place at next QAPI meeting to review and recommend any necessary changes necessary. 5.02/18/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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 808	Continued From page 65	F 808		

order for R1 was a soft/surgical diet.

R1's dietary card dated 12/17/21, identified R1's diet as regular/regular, cut up meat for resident, divided plate, set up assistance.

Review of R1's Nutrition Data forms from 8/28/21, to 12/17/21, revealed the following:

- 8/28/21, R1's Nutrition Data (Admission) form identified R1 received a diet of regular with mechanical soft textures.

- 12/17/21, R1's Nutrition Data (Quarterly) form identified R1 as being on a regular mechanical soft diet with regular consistencies.

During an observation on 12/20/21, at 12:12 p.m. R1 was observed during the noon meal with a fish sandwich, potato wedges, and coleslaw.

During an observation on 12/20/21, at 5:25 p.m. R1 was observed to have a divided plate, with mashed potatoes, mixed vegetables, cucumbers, and a slice of ham which had not been cut up. R1 was observed to feel around his plate for his food and pick up his slice of ham and take a bite. R1 was observed to hold the slice of ham in his hand and continued to work on consuming it slowly.

During an observation on 12/21/21, at 12:41 p.m., R1 was served a tuna fish sandwich, cucumber slices, tomatoes slices, and green grapes.

During an observation on 12/21/21, at 5:40 p.m., R1 was served country fried steak, mashed potatoes, carrots, and green grapes.

During an interview on 12/20/21, at 3:31 p.m. R1

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 66	F 808		

stated he did not have any teeth as they had been surgically removed down to the roots several months ago. R1 indicated he had been told his jaw bone was too weak to handle dentures which was why he did not have any. R1 stated he received an American diet and occasionally had his meat ground up however was unsure how often that happened. R1 indicated at times it was hard for him to eat the meat. R1 stated he needed to keep "munching things" until they became small enough or he would have had trouble swallowing.

During an interview on 12/20/21, at 4:35 p.m. nursing assistant (NA)-H stated staff were to let R1 know where his food and drinks were on the plate using the clock method. NA-H stated R1 was on a regular diet.

During an interview on 12/21/21, at 11:19 a.m. dietary manager (DM) identified he completed the nutritional assessments and the dietician added the information to the dietary slip which went out with each resident meal. DM indicated the direct are staff documented the residents' intakes and reported to him if any changes or concerns were noted. DM indicated the dietician came to the facility weekly and together they reviewed residents' nutritional status. DM stated R1 was not currently on an altered diet and R1 received a regular diet. DM described a mechanical soft diet consisted of cutting up food and each dietary slip should have indicated what size to cut it to. After further review, DM confirmed R1's dietary slip lacked information R1 was on a mechanical soft and the sheet identified he was on a regular diet with meats to be cut up. DM confirmed R1 had been receiving the regular diet since he started working a couple months ago instead of the

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 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 67 ordered mechanical soft diet. DM stated the facility had no special menus to follow for a resident who had been prescribed a mechanical soft diet. During an interview on 12/21/21, at 3:55 p.m. registered dietician (RD) confirmed R1 was on a mechanical soft diet. RD stated she expected all meats were to be cut up unless they were already in a ground texture. RD confirmed foods such as grapes and cucumbers should not have been served to someone on a mechanical soft diet. RD stated the diets which included the texture of the food for each resident should have been listed on their dietary slip for staff to follow. RD confirmed if a resident had been served the wrong diet which included a mechanical soft diet or pureed diet there would be an increased risk for choking. During an interview on 12/21/21, at 6:43 p.m. R1 stated the chicken he ate at his evening meal was tough around the edges however he was able to eat the softer meat inside. R1 indicated he attempted to eat the grapes however the skin was too hard for him. During an interview on 12/22/21, at 10:35 a.m. the director of nursing (DON) stated the nursing staff completed a communication form which identified each resident's diet and the forms were sent to dietary staff. DON indicated she expected staff would follow orders to ensure correctly prescribed diets were followed. DON confirmed R1's diet was a mechanical soft and stated R1 had the potential for choking or aspiration when the prescribed diet had not been followed.	F 808		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		2/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 68 §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: §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:	F 880		

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 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 69 (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 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 observation, interview, and document review the facility failed to ensure appropriate personal protective equipment (PPE) practices were followed when entering an isolation room for 1 of 1 residents (R326) who had been on isolation precautions and while providing meal service to 5 of 10 residents (R1, R2, R14, R16, R30) in the dining room. This deficient practice had the potential to affect all 24 residents currently residing in the facility.	F 880	1.Resident R326 had isolation cart due to unvaccinated status. Staff were educated on proper donning of PPE prior to entering a resident□s room when an isolation cart is present. Residents R1, R2, R14, R16, R30 were exposed to potential illness related to improper donning of mask. All staff were reeducated on the process of proper donning of PPE on 1/26/22. 2.This has the potential to affect all residents that reside in MRHCC. Policies	

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	245052	A. BUILDING _____ B. WING _____	C 12/22/2021

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F 880	Continued From page 70 Findings include: R326's Admission Record dated 12/21/21, identified R326 had been admitted to the facility on 12/17/21, with the diagnoses of diabetes mellitus (primary), history of COVID-19 (secondary), schizoaffective disorder, blood clot of lower extremity, anemia, and chronic constipation. R326's progress note dated 12/17/21, identified R326 had been admitted to the facility with history of COVID-19 pneumonia and deep vein thrombosis (blood clot). R326 had been placed on isolation with all services being provided in R326's room. During an observation and interview on 12/20/21, at 12:40 p.m. nursing assistant (NA)-D obtained the noon meal from the enclosed cart located in hallway outside of R326's room. NA-D with the meal tray in his hand used his other hand to moved a housekeeping cart that had been parked in front of the door to R326's room. NA-D entered R326's room holding the meal tray without donning a gown or gloves, walked passed the housekeeper who was in the room in full PPE and set the meal tray down on the bedside table. NA-D moved a dirty glass from the bedside table to the nightstand. NA-D set up the meal tray and positioned the bedside table in front of R326 who was in bed with the head of bed elevated. Observed on the door to R326's room were 2 signs one which read "STOP, see charge nurse" and the other which read "Isolation PPE, staff to don gloves, goggles, mask, and gown, then doff gloves, goggles, gown, and mask". NA-D exited R326's room and sanitized his hands. NA-D confirmed he had not been wearing PPE and	F 880	were reviewed. Staff were educated on 01/26/2021 on appropriate PPE when entering rooms with isolation carts. Staff were also educated on proper placement of mask, so that it covers both mouth and nose when they are within 6 feet of resident. 3.Audits will be performed on infection control related specifically to proper PPE placement. These will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. 4.Audits will be reviewed by administrator or designee and then further discussion will take place at next QAPI meeting to review and recommend any necessary changes. 5.02/18/22	

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F 880	Continued From page 71	F 880		

stated he should have worn all the PPE when entering R326's room. NA-D indicated it was the facility protocol staff were to wear all PPE any time there was a sign on the resident's door identifying isolation.

Review of the facility policy titled Personal Protective Equipment Using Protective Eyewear, Using Gloves, and Using Gowns, undated identified the objective was to prevent the spread of infections.

Review of the facility policy titled Contact Precautions dated 3/23/21, identified contact precautions included the use of gloves and gowns when entering the isolation room. Staff were to don gloves prior to contact with the resident or the residents environment, wear a gown if substantial contact with the resident or environment was anticipated. Staff were to remove gloves and gown prior to leaving the resident room. Disease was more likely to be transmitted and occur between a health care worker and a resident.

MASKS

On 12/20/21, from 11:50 a.m. to 1:00 p.m. during the noon meal service in the main dining room the following was observed:

-at 11:50 a.m. the dietary assistant (DA)-A stood by the the steam table cart with goggles on, hair covered, and a mask worn loosely which hung below her nose. The DA-A grabbed a glass of

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F 880	Continued From page 72	F 880		

juice (uncovered) from the cart, walked over to a table and placed it on the table in front of R1. DA-A stood next to R1 who was unmasked, conversed briefly and walked back to the cart.

-at 11:55 a.m. DA-A grabbed a glass of juice (uncovered), stood next to R16 and placed it on the table. DA-A grabbed the bottle of hand sanitizer and walked over to R14. DA-A stood next to R14 who was unmasked, bent over with mask which remained loosely placed and hung below her nose and asked R14 if he wanted to sanitize his hands. DA-A verbally instructed him to rub his hands together.

-at 12:00 p.m. DA-A walked over to R2 with her mask in the same position worn loosely, stood next to R2 who was unmasked, bent over, and asked her what she would like to drink. DA-A stood next to R2, placed a glass of juice on the table, and conversed with her for approximately two minutes.

-at 12:05 p.m. DA-A stood next to R30 who was unmasked, placed a glass of juice (uncovered) on table in front of him, bent over, and asked if he wanted anything else to drink. R30 requested a cup of coffee. DA-A delivered a cup of coffee to R30. DA-A stood next to R30, visited with him while she opened two coffee creamers and placed them in his coffee cup. DA's mask remained in the same position.

- at 12:10 p.m. DA-A stood at the steam table in dining room and continued to wear mask remained loosely which hung below her nose. Nursing Assistant (NA)-C wore a properly positioned face mask which covered the nose, stood next to DA-A, and handed her a breakfast

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F 880	Continued From page 73	F 880		

tray. NA-C was not observed to provide education to DA-A to cover the nose with the mask.

-at 12:15 p.m. to 12:50 p.m. DA-A transferred plates of food onto the food cart. The dietary manager (DM) wore a properly positioned face mask which covered the nose and stood on the other side of the steam table during the entire observation. DM was not observed to provide education to DA-A to cover the nose with the mask.

-at 12:30 p.m. DA-A reached up and pulled up her mask over her nose, however the mask remained loose, and after she sanitized her hands the mask slid back down below her nose.

-at 12:45 p.m. business office manager (BOM) entered the dining room, wore a properly positioned face mask which covered the nose, stood next to DA-A, and asked if R30 had eaten his meal. DA-A's mask remained positioned loosely, which hung below her nose responded no. BOM was not observed to provide education to DA-A to cover the nose with the mask.

-at 1:00 p.m. DA-A remained in the dining room and her mask continued in the same position. Five residents remained in the dining room while DA-A cleaned off the dirty dishes from the dining room tables.

During an interview on 12/21/21, at 12:02 p.m. NA-A stated staff expected to wear a mask that covered our mouth and nose while they worked; especially when present were around residents and staff. NA-A stated wearing a mask helped prevent the spread of any germs such as COVID-19.

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F 880	Continued From page 74	F 880		

During an interview/observation on 12/21/21, at 12:37 p.m. DA-A stated the mask had been hard to keep over her nose. DA indicated staff were expected to keep our mask over the nose especially when close to residents, visiting, and delivered food to help prevent the spread of infection. During the interview DA-A's mask remained positioned loosely, which hung below her nose then DA-A re-positioned the face mask to cover the nose and walked away

During an interview on 12/21/21, at 12:54 p.m. the facility cook (C)-A stated staff were expected to wear a mask over the mouth and nose especially when present around the residents and during meal service to help prevent the spread of infection.

During an interview on 12/22/21, at 7:52 a.m. DM stated all dietary staff were expected to wear a mask which covered the mouth and nose and goggles or a face shield when meals were served and when out among residents. DM identified this practice helped prevent infection.

Review of an undated facility policy titled Personal Protective Equipment - Using Face Masks identified the purpose was to guide the use of masks to prevent transmission of infectious agents through the air. Staff were to apply the face mask so that it covered the nose and mouth while they preformed treatment or services for the resident.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 21, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: LZD411

Dear Administrator:

The above facility was surveyed on December 20, 2021 through December 22, 2021 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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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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 12/22/2021. At the time of this survey, Moorhead Rehab & HCC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/30/2022

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

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

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K 000	Continued From page 2 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 78 beds and had a census of 23 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide unobstructed access to the means of egress as required by the NFPA 101 (2012 edition), Life Safety Code sections, 19.2, 7.1.10.1., 7.1.10.2.1, & 7.1.6.4 These deficient findings could have a patterned impact on the residents within the facility.	K 211	1.No residents were identified. Vending machine, table, and chairs in the main dining room have been relocated and are no longer obstructing exit access. The blinds on the exit door that is located in the main dining room have been removed. The snow and ice have been removed in all areas of egress discharge.	3/10/22

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K 211	Continued From page 3 Findings include: 1. On 12/22/2021, at 1:05 PM, observations revealed there is a vending machine, table, and chairs located in the main dining room that are obstructing exit access of the means of egress from the dining room. 2. On 12/22/2021, at 1:05 PM, observations revealed that the exit door that is located in the main dining room has blinds attached to the door that are covering the egress panic bar hardware making the panic bar not readily visible in the event of an emergency. 3. On 12/22/2021, at 1:50 PM, observations revealed that the snow and ice had not been removed in two sections of the egress discharge sidewalk located outside the exit by nursing station number 2. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 211	2.All residents have the potential to be affected by this deficiency. Physical Plant Director and maintenance assistant have been educated on NFPA 101 Life Safety Code sections 19.2, 7.1.10.1, 7.1.10.2.1 & 7.1.6.4, rules pertaining to means of egress. 3. An audit to ensure that means of egress are free from obstructions will be performed Daily for 1 week, weekly for 1 month, then monthly x 11 months. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the battery-operated emergency light per NFPA 101 (2012 edition), Life Safety Code section 7.9.3.1.1.	K 291	1. There are no specific residents identified. The annual 90-minute annual test/inspection was done on the battery-operated emergency lights. The	3/10/22

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K 291	Continued From page 4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/22/2021, at 11:43 AM, a review of available battery-operated emergency lighting testing documentation and interview with the Maintenance Supervisor it was observed that the facility could not provide information or documentation the annual 90-minute test/inspection for all of the battery powered emergency lights located within the facility. 2. On 12/22/2021, at 11:43 AM, a review of available battery-operated emergency lighting testing documentation and interview with the Maintenance Supervisor it was observed that the facility's emergency lighting testing documentation that was provided for the last 6 months since their last survey had conflicting information for devices located within the facility. Two of the six documents had only three devices listed which conflicted with the other documents that listed four devices. The documentation also had differing device names being used to identify the facility's emergency lights. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 291	battery-operated emergency lights have been counted, labeled with the numbers, 1, 2, 3, 4. 2.All residents have the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition) Life Safety Code section 7.9.3.1.1, rules pertaining to emergency lighting. 3. An audit to ensure emergency lighting testing will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. well as proper labeling of lighting equipment will be done . Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		3/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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

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K 321	Continued From page 5 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility per NFPA 101 (2012 edition), The Life Safety Code, sections 8.7.1.1, 8.7.1.3, 19.3.2.1, and 19.3.2.1.3. These deficient findings could have an isolated impact on the residents within the facility.	K 321	1. There were no specific residents identified. A new ceiling tile has been cut to fill the area around the electrical conduit, and a special fire rated caulking has been ordered to fill in any gap. All excess combustibles and unused items from the therapy area have been removed. 2.All residents could be affected. Physical Plant Director and maintenance assistant	

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 321	Continued From page 6 Findings include: 1. On 12/22/2021, at 1:19 PM, it was revealed by observation that there are vertical penetration around electrical conduit that are located within the Physical Therapy mechanical room. 2. On 12/22/2021, at 1:32 PM, it was revealed by observation that there is an area of the Physical Therapy room that is open to the rest of the therapy area including the reception and waiting areas that is greater than 100 square feet that is being used as a storage room for excess combustibles, walkers, wheelchairs, and unused therapy equipment. This area that is being used as a storage room is not protected through fire rated construction and is also not protected by a self-closing door. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 321	have been educated on NFPA 101 (2012 edition) Life Safety Code sections, 8.7.1.1, 8.7.1.3, 19.3.2.1, & 19.3.2.1.3, rules pertaining to hazardous areas. 3. An audit to ensure that all areas are protected by a fire barrier with a 1-hour fire rating will be performed Daily for 2 weeks, weekly for 4 weeks, then monthly x 4 months. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance. 5.The new ceiling tile was filled in on 1/12/22. The fire rated caulking will be used once received.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission	K 341		3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 341	Continued From page 7 paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of NFPA 101 (2012 edition), The Life Safety Code, sections 19.3.4.1 and 9.6, as well as NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 17.7.4.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/22/2021 at 12:19 PM, observation revealed, that the smoke detectors located in the linking corridor between the care center and the senior apartments was installed in the direct air flow which was within 36 inches of a HVAC vent diffuser. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 341	1. No residents were identified. A special baffle will be constructed to remove the smoke detector from direct air flow. 2. All residents have the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition) Life Safety Code sections, 19.3.4.1 & 9.6, as well as NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 17.7.4.1. 3. An audit to ensure that all smoke detectors are installed in a compliant fashion will be performed weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance. 5.The baffle will be installed by 2/18/22.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345		3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 8 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.3.1, and 14.4.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/22/2021, at 10:50 AM, it was revealed by a review of available fire alarm test and inspection documentation and an interview with Maintenance Supervisor, that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. 2. On 12/22/2021, at 10:50 AM, it was revealed by a review of available fire alarm test and inspection documentation and an interview with Maintenance Supervisor, that the facility could not provide any current documentation verifying that an annual fire alarm inspection had been completed. 3. On 12/22/2021, at 10:50 AM, it was revealed by a review of available fire alarm test and	K 345	1. No specific residents were identified. The annual fire alarm inspection was completed, the semi-annual inspection of all initiating devices, and the sensitivity test / inspection of all smoke detection devices. 2. All residents had the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.3.1, and 14.4.5.3, rules pertaining to fire alarm system - testing and maintenance. 3.An audit to ensure the completion of all fire alarm inspections will be performed monthly x 2 months, then every 6 months x 12 months. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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

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K 345	Continued From page 9 inspection documentation and an interview with Maintenance Supervisor, that the facility could not provide any current documentation verifying that a sensitivity test/inspection of all smoke detection devices had been completed. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 345		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.1.1, and NFPA 13 (2010	K 351	1. No specific resident was identified. The quick response type of fire sprinkler heads have been separated from the standard response fire sprinkler heads.	3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 351	Continued From page 10 edition) Standard for the Installation of Sprinkler Systems, section 8.3.3.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/22/2021 at 1:19 PM, observation revealed that there are quick response type of fire sprinkler heads located in the Physical Therapy reception area that are in the same compartment as standard response fire sprinkler head. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 351	2. All residents had the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section , 8.3.3.2. An additional fire sprinkler head box was installed in the Physical Therapy mechanical room to resolve the issue. 3. An audit to ensure proper storage of sprinkler heads will be performed weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. . Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 353	Continued From page 11 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review, and staff interview, the automatic sprinkler system is not maintained in accordance with NFPA 101 (2012 edition) The Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition) the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, sections 5.4.1.4 and 5.4.1.4.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/22/2021, at 1:35 PM, it was revealed that there were 6 unsecured fire sprinkler heads that were not protected from being damaged, stored within the spare sprinkler head box that is located in the Physical Therapy mechanical room 112. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 353	1. There were no residents identified. The unsecured fire sprinkler heads have been secured by installing an additional fire sprinkler head box in the Physical Therapy mechanical room. 2. All residents had the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, sections 5.4.1.4 and 5.4.1.4.2 3. An audit will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. to ensure proper storage of sprinkler heads will be achieved. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 521	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire and smoke damper systems per NFPA 101 (2012 edition) Life Safety Code, sections 9.2 and 19.5.2.1, NFPA 80 (2010 edition) the Standard for Fire Doors and Other Opening Protectives, sections 19.4.9, 19.4.10 and 19.5.5, NFPA 90A (2012 edition) the Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.8.1, and NFPA 105 (2010 edition) the Recommended Practice for the Installation of Smoke-Control Door Assemblies, sections 6.5.11, 6.5.12 and 6.6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/22/2021 at 12:00 PM, during a review of all available fire damper test and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that the fire and smoke damper testing and inspections have been completed within the last 4 years. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 521	1. No specific residents were identified. Summit Fire Protection has been contacted and the fire and smoke damper testing and inspection will be completed. 2.All residents had the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, sections , 9.2, and 19.5.2.1, NFPA 80 (2010 edition), the Standard for Fire Doors and Other Opening Protectives, sections 19.4.9, and 19.4.10 and 19.5.5, NFPA 90A (2012 edition) the Standard for the Installation of Air Conditioning and Ventilating Systems, section 5.4.8.1, and NFPA 105 (2010 edition) the Recommended Practice for the Installation of Smoke-Control Door Assemblies, sections 6.5.11, 6.5.12 and 6.6.6 3. An audit will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. fire and smoke damper testing is completed will be performed . Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 712 SS=F	Fire Drills	K 712		3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 712	Continued From page 13 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/22/2021, at 11:00 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct 1 of 2 fire drills for the overnight shift within the last 6 months since their last survey was conducted. 2. On 12/22/2021, at 11:00 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility had not transmitted a fire alarm signal or indicate that notifcation devices were used during the fire drill.	K 712	1.There were no specific residents identified. A fire drill was conducted and a fire alarm signal was transmitted. 2. All residents had the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, sections , 19.7.1.2 and 19.7.1.4 3. An audit to ensure that fire alarm tests are being conducted will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. . Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 712	Continued From page 14 An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 712		
K 751 SS=F	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the privacy curtains in the facility do not meet the requirements for Furnishing, Bedding, and Decorations for use in health care occupancies in accordance with provisions of the NFPA 101 (2012 edition), Life Safety Code, sections 10.3.1 and 19.7.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings Include: 1. On 12/22/2021, at 12:13 PM during the facility tour, observations revealed that the privacy divider curtain located in resident room 401 did not have any labeling attached to them stating	K 751	1. There were no specific residents identified. The privacy divider located in room 401, 402 and the 200 wing spa room have been removed and replaced with a new divider that is fire retardant. 2. All residents have the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, sections 10.3.1, and 19.7.15.1 3. An audit to ensure that all furnishing, bedding, and decorations are inherently fire retardant will be performed weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. Results of the audit will be reported at	3/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 751	Continued From page 15 that it is "inherently fire retardant". 2. On 12/22/2021, at 12:14 PM during the facility tour, observations revealed that the privacy divider curtain located in resident room 402 did not have any labeling attached to them stating that it is "inherently fire retardant". 3. On 12/22/2021, at 1:45 PM during the facility tour, observations revealed that the privacy divider curtain located in the 200 wing spa did not have any labeling attached to them stating that it is "inherently fire retardant". An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 751	QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 761		3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 761	Continued From page 16 Based on a review of available documentation and staff interview, the facility failed to conduct the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6 , and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/22/2021, at 11:50 AM, it was revealed by a review of available fire door test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide any current documentation verifying that the fire door inspection had been completed within the last 12 months. An interview with the Maintenance Supervisor verified this finding at the time of discovery.	K 761	1.No residents were identified. All Fire Doors have been inspected. 2.All residents have the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, and 19.7.6, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1.3. 3. An audit to ensure that all fire doors will be inspected will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 901		3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 901	Continued From page 17 by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/22/2021, at 11:30 AM, during a review of available documentation and an interview with Maintenance Supervisor, it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	1.There are residents identified. The Utility Risk Assessment was updated 2.All residents have the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 99 92012 edition), Health Care Facilities Code, section 4.1 3. An audit to ensure that the utility risk assessment is updated will be performed monthly for 6 months. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to monitor conditions affecting the	K 911	1.No residents were identified. An electrical outlet cover has been put in	3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 911	Continued From page 18 facility's electrical system per NFPA 101 (2012 edition) Life Safety Code, section 9.1.2, and NFPA 70, (2011 edition), National Electrical Code, section 422.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 12/22/2021, at 12:34 PM, during the facility tour, observations revealed that there is an electrical outlet located behind the white front loading clothes washer in the laundry room that is missing the outlet cover and is exposing live electrical connections. 2. On 12/22/2021, at 1:02 PM, during the facility tour, observations revealed that there is a ceiling fan that is located in the main dining room that has exposed live electrical wires protruding from the base of the fan and where it connects to the ceiling. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 911	place behind the washer in the laundry room. A replacement canopy for the ceiling fan in the main dining room has been ordered and will be installed. 2. All residents have the potential to be affected.Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, sections 9.1.2, and NFPA 70 (2011 edition), National Electrical Code, section 422.4. 3. An audit will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved to make sure that all systems are in safe condition and wire covers are in place. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this	K 918		3/10/22

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 918	Continued From page 19 capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator per NFPA 101 (2012 edition), The Life Safety Code, sections, 9.1.3 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.2. This deficient finding could have a widespread impact on the residents within the facility.	K 918	1.No residents were identified. A monthly test of the generator at 30% of it's kilowatt load was completed on 1/26/21 2.All residents have the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, sections 9.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems,	

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/22/2021**

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K 918	Continued From page 20 Findings include: On 12/22/2021, at 11:13 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide or document information verifying that the emergency generator had been tested monthly at 30 percent of the generator kilowatt rating. An interview with the Maintenance Supervisor verified these findings at the time of discovery.	K 918	section 8.4.2. 3. An audit to ensure that generator testing is being done will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of	K 920		3/10/22

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K 920	Continued From page 21 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to monitor conditions affecting the facility's electrical system per NFPA 101 (2012 edition) Life Safety Code, section 9.1.2, NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6 (2) & (3), 10.2.4, and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 12/22/2021, at 12:42 PM, during the facility tour, observations revealed that there is a white front loading clothes washer that is plugged into a multi-plug power tap located in the laundry room. 2. On 12/22/2021, at 12:42 PM, during the facility tour, observations revealed that there is an extension cord plugged into a multi-plug power tap located in the laundry room below the suspended heater. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 920	1. No residents were identified. The extension cord and multi-plug power tap in the laundry room have been removed. 2.All residents had the potential to be affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition), Life Safety Code, sections 9.1.2, and NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6 (2) &(3), 10.2.4, and NFPA 70,(2011 edition), National Electrical Code, sections 400-8, 590.3(D). 3. An audit to ensure that no multi-plug power taps or extension cords are being used will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is achieved. Results of the audit will be reported at QAPI for further oversight and review. 4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.	

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	00938	A. BUILDING: _____ B. WING _____	C 12/22/2021

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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 12/20/21, to 12/22/21, 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.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5052149C (MN79264) with licensing orders cited at 0900 and 0920 H5052157C (MN58048) with licensing orders cited at 0900 H5052162C (MN56564) with licensing orders cited at 0920 H5052163C (MN56347) with licensing orders cited at 0900 AND The following complaints were found to be SUBSTANTIATED: H5052154C (MN74674) H5052155C (MN62868) H5052156C (MN59623) H5052158C (MN57537) H5052159C (MN57152) H5052160C (MN57071) H5052161C (MN56989) H5052164C (MN57738), however NO licensing orders were cited due to actions implemented by the facility prior to survey: AND The following complaints were found to be UNSUBSTANTIATED: H5052150C (MN78262) H5052151C (MN75159) H5052152C (MN74974) H5052153C (MN74902) 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	2 000		

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2 000	Continued From page 2 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 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		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status	2 265		2/18/22

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2 265	Continued From page 3 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 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 interview and document review, the facility failed to ensure the physician was notified timely of a change in condition for 1 of 2 residents	2 265	Corrected	

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2 265	Continued From page 4 (R8) reviewed for notification of change. Findings include: R8's quarterly Minimum Data Set (MDS) dated 10/26/21, identified R8 was independent with decision making and had diagnoses which included cerebrovascular accident (stroke), hemiparesis (weakness on one side), aphasia (inability to speak or find words) and alcohol dependence. The MDS indicated R8 had no behavior concerns and required the assistance of one staff for activities of daily living (ADL's). cares. R8's care plan revised 5/27/21, identified R8 had a substance abuse disorder and was alcohol dependent as evidenced by history, with impaired judgement and poor impulse control. The care plan instructed staff to educate R8 on the risk associated with drinking alcohol, encourage activities and monitor R8 to ensure alcoholic beverages were not consumed. The care plan identified if staff suspected alcohol intoxication, staff were to contact the provider for increased monitoring and medication hold parameters. The care plan further instructed staff to hold aspirin, acetaminophen, gabapentin (pain medication), levetiracetam (seizure medication) and escitalopram (antidepressant) when R8 was intoxicated. The care plan identified staff were to complete room checks weekly for alcohol at different times of the week and staff were to intervene if they observed alcohol. R8's Order Summary Report dated 12/21/21, signed by the provider identified current orders included when R8 was intoxicated staff were to hold aspirin, acetaminophen, gabapentin, and escitilopram. The report instructed staff to monitor	2 265		

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2 265	Continued From page 5 blood sugars every hour when R8 was intoxicated. The orders lacked parameters for the length of time to hold medication or to complete hourly blood sugar checks. Review of R8's progress notes from 9/8/21, to 12/21/21, revealed the following: - 9/30/21, at 8:37 p.m. the nurse was informed by direct care staff R8 appeared intoxicated and R8 indicated a friend had provided him a drink while visiting. The note identified the nurse assessed R8's vital signs which were within normal limits and noted R8 was alert and oriented. The note lacked evidence the provider had been updated, any medications had been held and blood sugars had been monitored as ordered. - 11/24/21, at 11:25 p.m. the note identified at 8:00 p.m. R8 was not in his room when the nurse went to administer R8's insulin. R8 was found in another resident's room drinking drinks that were in a pop bottle. The note identified R8 to be weak and not oriented. R8 agreed to take his insulin and the nurse administered. The supervisor was notified of R8's condition as the room smelled of alcohol. The nurse asked both residents if they had been drinking and they both denied. The drinks were taken from both residents and poured into the sink. Both residents shut themselves in the room with the lights off and door supported by a bed so staff were not able to enter. Staff were able to assist R8 to bed after the nurse was able to open the door. R8 had been noted to be confused and incoherent. The note lacked evidence the provider had been updated, any medications had been held and blood sugars had been monitored hourly.	2 265		

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 12/22/2021

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
2 265	Continued From page 6 Review of R8's medication administration records from 9/1/21, to 12/21/21 revealed the following: -September 2021, identified on 9/30/21, no medication had been held or additional blood sugars had been checked. -November 2021, identified on 11/24/21, no medication had been held or additional blood sugars had been checked. During an interview on 12/21/21, at 10:37 a.m. licensed practical nurse (LPN)-A identified staff were expected to observe R8 for signs of alcohol impairment. LPN-A revealed if R8 had been suspected of drinking alcohol she would have completed an incident report and checked R8's vital signs. LPN-A stated she was unaware room checks were expected to be completed. LPN-A stated she had only been working in the facility for about two months and was not aware of any other interventions for R8. During an interview on 12/21/21, at 3:43 p.m. LPN-D indicated on 11/24/21, R8 appeared to be impaired and smelled of alcohol. LPN-D contacted the director of nursing (DON) and received instruction to remove the alcohol. LPN-D stated he was unsure how R8 received the alcohol as he had not left the facility nor had any visitors during his shift. LPN-D indicated R8 refused to leave the other residents room when he entered to check R8's blood sugar and administer his insulin. LPN-D confirmed the provider had not been contacted and no further assessments had been completed on R8. During an interview on 12/21/21, at 4:37 p.m. the DON indicated R8 had a history of alcohol abuse.	2 265		

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 12/22/2021

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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2 265	Continued From page 7 DON stated staff were expected to notify the provider, follow the orders to hold medications and to follow the care plan as outlined when R8 was suspected to be intoxicated. DON confirmed she had been notified of the incident on 11/24/21, and had instructed the nurse to notify the provider and monitor R8. DON stated staff should have notified the provider when R8 was noted to be intoxicated for further instruction. DON confirmed R8's order for holding medications and checking hourly blood sugars when R8 was suspected of being impaired had no length of time identified. During an interview on 12/22/21, at 11:08 a.m. nurse practitioner (NP) identified she was R8's primary provider and indicated she had discussed with R8 the risks associated with alcohol use. NP stated she expected staff to contact her for further direction when R8 was intoxicated. NP confirmed she had not been notified of the 11/24/21, incident. NP stated she was not aware the orders to hold R8's medications and check hourly blood sugars lacked a length of time. A policy on change of condition was requested and not provided. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		2/18/22

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 12/22/2021

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

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2 830	Continued From page 8 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. This MN Requirement is not met as evidenced by: FALLS Based on observation, interview, and document review, the facility failed to comprehensively reassess, for root cause analysis following falls, and failed to implement interventions prevent further falls for 1 of 2 resident (R13) who had a fall with a fracture and remained at risk for falls and of 1 of 2 residents (R20) who had a recent fall and who remained at risk for falls. R20's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 11/20/21, identified R20 had diagnoses which included diabetes, Osteoarthritis and peripheral vascular disease. The MDS identified R20 had intact cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and locomotion. The MDS identified R20 was unable to maintain his balance during transitions without physical assistance. The MDS identified R20 used a	2 830	Corrected	

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 12/22/2021

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2 830	Continued From page 9	2 830		

walker and wheelchair for mobility and occasionally ambulated with assistance of two staff. The MDS did not identify R20 had any falls since the last assessment.

R20's SCSA Care Area Assessment (CAA) dated 11/20/21, identified R20 required extensive assistance with ADL's which included bed mobility, transfers and had a decline in condition related to recent COVID-19 diagnosis, and other medical conditions such as heart failure, diabetes, values deformity (deformity of foot/ankle) and chronic pain. The CAA identified R20 was at risk for falls related to impaired mobility, medication use and wounds on his feet.

R20's current care plan revised 12/9/21, revealed R20 had poor memory, was recently diagnosed with dementia, and required extensive assistance of two staff with bed mobility, transfers and mobility. The care plan revealed R20 was at high risk for falls and used a full mechanical lift for all transfers. The care plan revealed the following fall interventions were to be implemented, call light within reach with prompt answering, wearing gripper socks when ambulating or in the wheelchair. The care plan lacked any information or updated interventions resulting from R20's fall in the facility.

R20's Visual/Bedside Kardex Report (nursing assistant care guide) dated 12/21/21, revealed R20 was dependent on two staff and the use of full body mechanical lift for all transfers, required extensive assistance with bed mobility and had the following safety interventions; reminders to use his call light, gripper socks on when walking or in wheelchair, clear path to his bathroom. R20's Kardex lacked any indication R20 had fallen in the facility, or any updated interventions

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 12/22/2021

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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2 830	Continued From page 10 following his fall. Review of R20's Resident Fall Risk Assessment dated 8/24/21, identified R20 was alert, had a history of one to two falls in the last three months, was ambulatory and continent. R20's risk assessment revealed medications he received and diagnosis which could potentially increase risk for falls. The assessment identified R20 fall risk score was a nine, however, the form did not identify what the fall risk score meant. Review of R20's facility incident report dated 11/4/21, identified at 5:00 p.m. R20 was found seated on the floor of his room between his wheelchair and his bed, faced the door to his room. The incident report identified R20's bed was too high and resident did not have gripper socks on, though had them on earlier in the morning. The incident report identified R20 had been transferring himself from his wheelchair to his bed, missed the bed and slipped down. The report revealed R20 had been educated on the positioning of his bed for a safe transfer. The incident report did not identify R20's needs for physical assistance with transfers and other mobility or any indication of R20's cognition/memory recall. Review of R20's Fall Assessment date 11/28/21, identified R20 was at moderate risk for fall based on the following information; R20 had a recent fall, used narcotic medication and had no memory recall within the last seven days prior to the assessment. The fall assessment identified R20 was frequently incontinent, had no behaviors, was confined to a chair, was unable to independently come to a standing position and a decrease in muscle coordination. The fall assessment lacked any fall interventions or a	2 830		

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	00938	A. BUILDING: _____ B. WING _____	C 12/22/2021

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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2 830	Continued From page 11 review of R20's prior falls. On 12/20/21, at 12:39 p.m. R20 was observed laying in bed, on his back, faced the television, his eyes were opened, he wore a white short sleeved shirt, had ACE wraps on and gripper socks. R20's bed was raised approximately 30 inches from the ground and he had a rolling over the bed table positioned to the left of his bed. On 12/20/21, at 4:45 p.m. during a telephone interview with R20's family member (FM)-A, indicated R20 was oftentimes disheveled when she came to visit. FM-A stated she felt R20 had declined both physically and cognitively since his arrival to the facility approximately four months prior. FM-A stated prior to R20's admission to the hospital and subsequent admission to the facility, he used to be very sharp mentally and took care with his appearance. FM-A stated R20 had recently fallen in the facility, though was unsure what the cause was or what the facility had implemented to prevent further falls. FM-A indicated she felt R20 was no longer able to retain information given to him consistently. FM-A indicated R20's bed was raised off the floor, so he could sit at the side of his bed with his feet on the floor, as R20 was over six feet, six inches tall. However, she indicated she was not sure if R20 was at risk for sliding off of his bed. On 12/21/21, at 10:15 a.m. R20 was observed laying in bed on his back, R20's bed was raised approximate 30 inches from the floor. (NA)-C stood next to R20's bed, proceeded to assist him with incontinence cares, and left his room. R20 remained laying in bed, bed was raised approximately 30 inches from the floor. - at 11:22 a.m. R20 was observed seated on on	2 830		

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 12/22/2021

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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2 830	Continued From page 12	2 830		

the side of his bed, with an over the bed table positioned in front of him, he held a sandwich with his right hand. R20's lower legs were covered with a white sheet, he wore gripper socks on both feet and his left foot was positioned on the floor with a bed sheet between his foot and the floor. R20's right foot dangled from the bed. R20 leaned on the rolling over the bed table, as he ate the sandwich and watched the television. R20's bed was elevated approximately 30 inches from the ground, his left foot touched fully on the ground.

-at 12:01 p.m. R20 was observed to push off of his over the bed table with his left hand, the table moved slightly, he then moved his legs onto the bed, and laid on his back. R20's call light was on his left side, within his reach, was not observed to be be on. R20's bed remained elevated approximately 30 inches from the ground.

- at 2:40 p.m. R20 was observed laying on his back in his bed, covered with a sheet from his mid lower legs to his upper torso.

- at 5:00 p.m. R20 was observed laying in bed on his back, his eyes were closed, call light was within reach on his left side. R20's bed was raised approximately 40 inches off of the ground.

On 12/22/21, at 7:07 a.m. R20 was observed laying on his back in bed, covered with a sheet from his ankles to his torso. R20's bed was raised approximately 30 inches from the floor.

On 12/21/21, at 10:25 a.m. during an interview NA-C stated R20 required extensive assistance with bed mobility, dressing, personal hygiene, and felt he was not able to recall information. NA-C indicated R20's bed was kept raised due to R20's

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 12/22/2021

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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2 830	Continued From page 13	2 830		

height and wanting to sit at the side of his bed. She stated R20 required the use of a full mechanical lift for all transfers and was not supposed to bear weight on his feet. NA-C indicated R20 had no falls in the facility and was not sure if he was at risk for falls.

On 12/21/21, at 11:00 a.m. during an interview, LPN-A stated R20 required extensive assistance with his ADL's and indicated R20's cognition fluctuated over the coarse of the day. LPN-A stated R20 preferred to keep his bed elevated off of the floor due to his height and wanting to sit at the edge of his bed. She indicated R20 was non-weight bearing at that time due to his foot ulcers and used a full mechanical lift for all transfers. LPN-A indicated she was not aware of any falls and indicated she was not aware of any fall interventions in place for R20.

On 12/21/21 at 11:40 a.m. during an interview, NA-A indicated R20 required extensive assistance with bed mobility, transfers and dressing. NA-A indicated R20's cognition would fluctuate over the course of the day and his needs should be anticipated. NA-A stated she was not aware if R20 had any falls since his admission and indicated R20 was not weight bearing at that time and required the use of a full mechanical lift.

On 12/21/21, at 12:46 p.m. during a telephone interview with R20's family member (FM)-B indicated he had concerns with R20's cares not being completed routinely and R20's recent decline in cognition. He indicated R20 would appear disheveled, his room would be in disarray and he oftentimes would be either laying in bed or seated at the edge of the bed. FM-B indicated he was notified R20 had fallen in September, but

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 12/22/2021

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
2 830	Continued From page 14	2 830		

was not told what had happened and was not aware of any interventions in place to mitigate his risk for falls. FM-B indicated R20's bed was usually elevated approximately 30 inches from the floor, as he was so tall and he could easily sit at the edge of the bed. However, FM-B indicated with R20's changing cognition and decline in his self care, he felt R20 was at high risk for fall and for slipping out of his bed.

On 12/21/21, at 4:19 p.m. during an interview LPN-C stated R20 required assistance with all of his cares and felt R20 had a poor memory and indicated his cognition would fluctuate over the course of the day. LPN-C indicated she was not aware of R20 having any falls, nor was she aware of any fall prevention interventions in place.

On 12/21/21, at 4:58 p.m. during an interview a trained medication aid (TMA)-B stated R20 required extensive assistance with all cares except for eating, he required set up assistance. TMA-B stated she felt R20 had memory loss and was not always able to recall events or his needs. TMA-B indicated she was not aware of R20 having any falls since his admission, and indicated he should have gripper socks on for general safety.

On 12/22/21, at 8:44 a.m. during an interview NA-B stated R20 was totally dependent for his ADL's and felt he had declined within the past month, following his COVID-19 illness. NA-B stated she felt R20's had memory loss and was not always able to recall instructions or events. She indicated R20 used his call light, but was not always able to recall what he wanted and his needs were to be anticipated. NA-B indicated R20 had not fallen when she was working and was not aware if he had fallen since his admission. NA-B

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 12/22/2021

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
2 830	Continued From page 15	2 830		

indicated she R20 preferred his bed raised approximately 30 inches from the ground so he could sit at the edge of his bed with his feet on the floor. NA-B indicated she felt R20 was at risk for falls and made sure she routinely checked on him. NA-B indicated he had not observed R20 attempting to transfer himself.

R13

R13's admission Minimum Data Set (MDS) dated 11/17/21, identified R13 was cognitively intact and had diagnoses which included end stage renal disease, diabetes mellitus and dependence on renal dialysis. R13's MDS indicated he required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. The MDS identified R13 had one fall with no injury since admission.

R13's care plan revised 12/20/21, identified R13 required extensive assistance of one to two staff with most ADL's which included transfers, bed mobility, toileting and walking. The care plan indicated R13 was at moderate risk for falls due to gait/balance issues and had multiple falls since admission. The care plan instructed staff to anticipate and meet resident's needs, ensure R13's call light was within reach and staff were to encourage R13 to use his call light.

Review of R13's fall risk assessments from 11/11/21, to 12/20/21, revealed the following:

- 11/11/21, R13's fall risk assessment determined R13 to be high risk for falls due to a history of falls, hypoglycemic (used to treat Diabetes Mellitus) medication use, sometimes had memory impairment, exhibited loss of balance while

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 12/22/2021

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
2 830	Continued From page 16	2 830		

standing, required hands on assistance to move from place to place and decrease noted in muscle coordination.

- 12/20/21, R13's fall risk assessment determined R13 to be at moderate risk for falls due to history of falls, hypoglycemic medication use, sometimes had memory impairment and exhibited loss of balance while standing.

Review of R13's progress notes from 11/11/21, to 12/21/21, revealed the following:

- 11/15/21, at 5:16 a.m. R13 had an unwitnessed fall while in his room. R13 stated he was sitting on the bed when he fell. R13 was assisted back to bed, vital signs and neurological checks were completed and noted to be within normal limits (WNL).

- 11/23/21, at 2:27 p.m. post fall follow- up charting: R13 had a small skin tear which reopened on his left elbow and staff cleaned, dried and treated. R13's neurological checks and vital signs were WNL. The progress note lacked information when the fall occurred or how the fall happened.

- 12/20/21, at 3:10 a.m. R13 was found at 1:15 a.m. in the hallway a few steps from his door lying on the floor with his head against the wall and his feet faced the doorway to his room. R13's call light had been within reach and he had not used it. R13 stated he got up because he wanted to go smoke and he fell on the way. Three staff assisted R13 off the floor and it was noted R13 had a swollen right elbow. R13 complained of pain and rated his pain at a seven on a scale of one to ten. Tylenol 500 mg. was administered to R13. R13's vital signs and neurological signs

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 12/22/2021

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
2 830	Continued From page 17	2 830		

were checked and found to be WNL. R13 had been placed on oxygen due to sats had dropped to 88% . The nurse practitioner (NP) and director of nursing (DON) were notified of the fall.

- 12/20/21, at 3:22 p.m. R13 had been sent to the ortho clinic earlier that morning at 9:15 a.m. for assessment of his right arm due to swelling and pain noted. R13 returned to the facility with an order for surgery.

Review of the progress notes lacked evidence of a comprehensive assessment of R13's falls to determine a root cause of his multiple falls, and lacked documentation of appropriate interventions implemented to minimize his falls.

Review of facility incident reports from 11/15/21, to 12/21/21, revealed the following:

- 11/15/21, at 2:38 a.m. unwitnessed fall- staff went to answer R13's call light and found him on the floor. R13 stated he had been sitting on the bed and he fell out of bed. An abrasion was noted to the top of his scalp. R13 was assisted to bed with the use of a hoyer (total body) lift.

- 11/23/21, at 2:30 a.m. R13 was found sitting on the floor next to his bed with both legs stretched forward. R13 stated he rolled from the bed. R13 was transferred, assessment completed and R13 was noted to be bleeding from an old wound present on his left elbow. The wound was cleansed and treated.

No incident report had been provided for the fall which occurred on 12/20/21.

Review of the incident reports lacked evidence of a comprehensive assessment of R13's falls to

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 12/22/2021

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
2 830	Continued From page 18	2 830		

determine a root cause of his multiple falls, and lacked documentation of appropriate interventions implemented to minimize his falls.

On 12/21/21, at 2:57 p.m R13 returned from his ortho clinic appointment and was noted to have a splint covered with ace wrap to his right arm. Licensed Practical Nurse (LPN)-A applied the gait belt to R13's waist while he was in his wheelchair, assisted R13 to stand, pivoted R13 to his right side and assisted R13 to sit on the edge of his bed. LPN-A removed the gait belt from R13's waist and assisted him to lay in the bed. LPN-A ensured R13's call light was within reach and reminded R13 to call for assistance when needed. R13 verbalized understanding.

On 12/20/21, at 4:35 p.m. R13 stated he had fallen and broke his arm during the night. R13 indicated he had been at the clinic earlier that day and they had planned on surgery in the near future to repair his arm. R13 stated he had not used the call light prior to his fall the night before. R13 indicated he was aware he was expected to call staff for assistance however he did not want to bother the staff. R13 stated staff frequently reminded him to use his call light and he was aware he could have fallen without staff assistance.

On 12/21/21, at 2:54 p.m. nursing assistant (NA)-D stated R13 was alert and oriented and required assistance of one staff with transfers. NA-D indicated staff frequently reminded R13 to use his call light and R13 understood he should have called for assistance and yet he continued to self transfer despite the reminders. NA-D stated he had been informed of R13's fall on 12/20/21, and knew R13 had injured his right arm. NA-D indicated he ensured R13 had his call

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 12/22/2021

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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2 830	Continued From page 19 light within reach after providing cares to R13. On 12/21/21, at 3:18 p.m. trained medication aid (TMA)-B stated R13 was alert and oriented and required assistance from staff with all ADL's. TMA-B indicated she had been informed of R13's fall on 12/20/21, and was aware he had injured his right arm. TMA-B stated staff frequently reminded R13 to use his call light however he continued to self transfer. TMA-B indicated she had only been aware of R13's fall on 12/20/21, and had not heard of any other falls prior to that time. On 12/22/21, at 8:38 a.m. LPN-A stated R13 was at risk for falls and indicated R13 had fallen a couple of nights ago and had broken his right arm. LPN-A stated when a fall occurred, she assessed the resident, provided treatment as necessary and notified the family. LPN-A stated she was not sure what the facility expectations were after a resident fall occurred and confirmed the facility did not have a process in place to follow after a resident had a fall to determine root cause and add new interventions to prevent future falls. On 12/22/21, at 12:20 p.m. DON confirmed R13 was at risk for falls and stated R13 had four or five falls since admission to the facility. DON confirmed she had been unable to determine the exact number as the facility lacked a process for tracking or trending falls. DON confirmed the facility had not completed an incident report on R13's latest fall on 12/20/21. The DON stated her expectation was for staff to complete an assessment of R13 after a fall occurred which included checking vital signs and neurological checks, treat R13 if any injuries had occurred, notify the physician and DON. DON verified the	2 830		

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 12/22/2021

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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2 830	Continued From page 20 facility lacked a process to assess each fall for root cause and to implement new interventions to prevent future falls. On 12/22/21, at 12:47 p.m. the director of nursing (DON) confirmed R20's fall on 11/4/21, had not identified a potential root cause for his fall, and confirmed R20's medical record lacked a comprehensive assessment of R20's fall, his fall risk and failed to identify fall interventions. The DON stated R20's cognition had been fluctuating over the course of the day since he had COVID in November and indicated R20 would not be able to recall instructions given to him routinely. The DON stated R20 preferred to have his bed elevated from the ground in order to be able to sit on the edge of his bed. She indicated R20 was able to transfer himself upon admission, and felt he may not always recall he needs assistance with transfers due to decline in his strength. The DON indicated R20's current fall interventions included to keep his call light within reach, wear gripper socks when up and confirmed R20's care plan lacked fall interventions related to his fall in November. The DON stated due to R20's changing cognition she felt he was at high risk for falls and should have further fall interventions in place, such as gripper socks on in bed, assistance with sitting on the edge of bed, grab bars to aid in positioning. A policy for falls prevention was requested and was not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents with falls receive the necessary services to keep them safe. The director of nursing or designee, could	2 830		

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	00938	A. BUILDING: _____ B. WING _____	C 12/22/2021

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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2 830	Continued From page 21 conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. DIALYSIS Based on interview, and document review, the facility failed to ensure the dialysis access site was consistently monitored and assessed for 2 of 2 residents (R10 and R19) reviewed for dialysis. Findings include: R10's quarterly Minimum Data Set (MDS) dated 11/15/21, identified R10 had diagnoses which included debility (physical weakness) end stage renal disease, anemia, diabetes and heart failure. The MDS identified R10 was cognitively intact and received supervision with activities of daily living (ADL's) of transfers, dressing, and bed mobility. The MDS identified R10 received dialysis care during the seven day look back period. R10's admission MDS dated 8/16/21, identified R10 had diagnoses which included debility, end stage renal disease, hear failure, chronic respiratory disease and diabetes. The MDS identified R10 received extensive assistance with transfers, toileting, and required supervision with dressing, bed mobility and personal hygiene. The MDS identified R10 received dialysis care. R10's admission Care Area Assessment (CAA) dated 8/16/21, identified R10 was recently hospitalized with a pulmonary infection, received dialysis and was fatigued after dialysis sessions.	2 830		

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	00938	A. BUILDING: _____ B. WING _____	C 12/22/2021

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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2 830	Continued From page 22 The CAA revealed R10 received dialysis three times a week, fatigued easily, was alert and oriented though had some mild forgetfulness. The CAA lacked documentation of R10's fistula (intravenous access for dialysis) and required monitoring of thrill and bruit (an auditory method of check fistula patency). R10's current care plan revised 10/19/21, revealed R10 had end stage renal disease, received hemodialysis and had diabetes. The care plan lacked documentation of R10's fistula site, or any required monitoring of thrill and bruit or post dialysis assessment. R10's nursing assistant care guide printed 12/22/21, lacked any indication R10 received dialysis, or had a fistula. R10's physician orders, signed 11/30/21, identified R10 received dialysis three times a week. R10's care plan lacked any documentation of R10's fistula or direction for monitoring R10's access site for bleeding or for checking bruit and thrill. R10's medical record lacked any documentation R10's fistula bruit and thrill was routinely monitored. On 12/20/21, at 3:12 p.m. during an interview, R10 stated he received dialysis three times a week from at a dialysis clinic in a neighboring town. R10 stated he had a fistula site on her upper left arm, lifted the sleeve to his top and revealed a thick white bandage approximately four inches long and three inches wide on his upper left arm. He indicated the dialysis clinic monitored his fistula and stated the facility nursing staff had never looked at his dialysis site	2 830		

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 12/22/2021

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
2 830	Continued From page 23	2 830		

since his admission. R10 stated he had no episodes of profuse bleeding from the site, though had a low blood pressure on a couple of occasions which required medication from the dialysis center. R10 stated the facility was not currently monitoring his access site, nor were they checking his blood pressure upon return to the facility.

On 12/21/21 at 12:12 p.m. during an interview licensed practical nurse (LPN)-A stated R10 received dialysis three times a week. LPN-A indicated R10 took care of his own access site and stated she did not check his fistula upon return. LPN-A confirmed she did not check R10's fistula bruit and thrill for function, indicated no order was in place to do so. LPN-A indicated the dialysis center would call if R10 had any complications from his run and would let her know if he required further monitoring.

On 12/21/21, at 4:43 p.m. during an interview LPN-C stated he believed R10 had a fistula on his left upper arm and received dialysis three times a week. LPN-C indicated he would usually check R10's vital signs upon return from dialysis if needed. He indicated if there were complications, such as hemorrhaging or low blood pressure, during dialysis the center would call and notify them of needed monitoring. LPN-C confirmed he did not monitor R10's fistula site and had never checked R10's bruit and thrill.

On 12/21/21, at 5:08 p.m. during an interview, trained medication aid (TMA)-B stated R10 received dialysis three times a week and would bring back a red folder following his appointment. She indicated she would check R10's vital signs upon return when he had issues with low blood pressures. She stated she did not routinely check

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 12/22/2021

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
2 830	Continued From page 24 R10's vital signs upon return and stated licensed nursing staff would check R10's fistula site. On 12/22/21, at 7:24 a.m. during an interview, LPN-B stated the facility did not have a current practice in place for monitoring residents post dialysis prior to that day. LPN-B stated she felt residents who received dialysis should get a full set of vital signs upon return, should have their access site monitored for bleeding and their access site (fistula) should be checked daily for bruit and thrill. On 12/22/21, at 8:26 a.m. during a telephone interview with Sanford Dialysis registered nurse, charge nurse (RN)-A, confirmed R10 received dialysis three times a week at their clinic. RN-A stated she would expect R10's fistula to be monitored for bleeding upon his return to the facility along with his vital signs. She indicated R10 had a history of low blood pressure following his dialysis runs, and felt it was important R10's blood pressure was monitored upon his return. RN-A stated she usually contacted the facility if R10 had any complications during his session, but felt it was very important the facility routinely monitored him. RN-A stated it was a standard of practice to check R10's fistula's bruit and thrill and monitor his fistula due to risk for bleeding, low blood pressure, infection and death if complications were not identified in a timely manner. On 12/22/21, at 8:38 a.m. TMA-A confirmed R10 received daily three times a week and indicated there were no processes in place for monitoring R10's fistula or check his vitals signs post dialysis. R13	2 830		

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 12/22/2021

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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2 830	Continued From page 25 R13's admission Minimum Data Set (MDS) dated 11/17/21, identified R13 was cognitively intact and had diagnoses which included end stage renal disease, diabetes mellitus and dependence on renal dialysis. R13's MDS indicated he required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. The MDS identified R13 received dialysis. R13's care plan revised 12/20/21, identified R13 required dialysis related to renal failure. Interventions listed included: do not draw blood or take blood pressure in arm with graft, encourage resident to go to dialysis appointments, monitor labs and report to doctor as needed, monitor/document/report as needed any signs or symptoms of infection to access site: redness, swelling, warmth or drainage and wok with resident to relieve discomfort for side effects of the disease and treatment. The care plan lacked instruction to staff to monitor dialysis site for bleeding or any other adverse reactions. Review of R13's physician orders signed on 11/24/21, identified R13 was prescribed a Diabetic Diet. The orders lacked orders for dialysis treatments or monitoring parameters. Review of R13's progress notes from 11/17/21, to 12/21/21, revealed a lack of any post-dialysis assessments. Review of R13's dialysis post-observation records from 11/17/21, to 12/21/21, revealed the following: -11/26/21, at 12:50 p.m. R13's blood pressure	2 830		

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 12/22/2021

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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2 830	Continued From page 26	2 830		

(BP) was 173/66 and the dressing to his fistula (an access for dialysis) site to his left upper arm was clean, dry and intact. The record revealed the thrill (a rumbling sensation you can feel) and bruit (a rumbling sensation you can hear) were noted.

R13's electronic health record (EHR) lacked any further dialysis post-observation records.

On 12/20/21, at 4:35 p.m. R13 stated he received dialysis three times a week on Monday, Wednesday and Friday. R13 stated he attended dialysis on Sunday, Tuesday and Thursday of the current week due to the holiday coming up. R13 indicated the nursing staff checked his blood sugar and escorted him to the dining room once he returned from dialysis. R13 stated no other actions had been completed by the nursing staff such as checking his dialysis site for bleeding or checking his vital signs. R13 lifted his left arm and pointed to his dialysis site which was covered by a bandage and stated the bandage was still in place from the dialysis run the day before and nursing staff had not checked the site nor removed the bandage yet.

On 12/21/21, at 11:46 a.m. licensed practical nurse (LPN)-A entered R13's room after R13 returned from dialysis, checked R13's blood sugar and administered insulin to R13's right abdomen area. LPN-A picked up the folder which contained information about R13's dialysis run and placed it on the desk at the nurse's station.

On 12/21/21, at 11:50 a.m. LPN-A stated when R13 returned from dialysis she would check his blood sugar and scan the information from the dialysis center into R13's EHR. LPN-A indicated she was not aware of what the process was at

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 12/22/2021

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
2 830	Continued From page 27	2 830		

the facility for completing post- dialysis assessments. LPN-A confirmed she had not completed a post-dialysis assessment on R13 and further stated she had never completed one at the facility since she began her employment there.

On 12/21/21, at 3:18 p.m. trained medication aid (TMA)-B stated when R13 returned from dialysis she gave the folder from the dialysis center to the nurse and the nurse checked R13's blood sugar. TMA-B indicated she had not observed a nurse complete any other tasks such as checking R13's vital signs or checking his dialysis site and further stated the facility had no dialysis post-assessment process in place. TMA-B stated the nurses typically left the bandage on R13's left arm for a couple of days.

On 12/22/21, at 12:20 p.m. director of nursing (DON) confirmed the facility did not complete post- dialysis assessments which included monitoring of R13's access site and vital signs when R13 returned from dialysis. DON stated the facility received the dialysis run information from the dialysis center and scanned it into R13's EHR.

On 12/22/21, at 1:06 p.m. the director of nursing (DON) stated the facility had no current policy or procedure in place for post dialysis assessments, fistula/site monitoring and was currently in the process of educating staff and implementing post dialysis assessments. The DON confirmed it was a professional standard of practice for residents who received hemodialysis to be monitored for complications such as bleeding, low blood pressure post dialysis and their access site should be checked daily. The DON confirmed R10's care plan lacked any information of R10's

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 12/22/2021

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
2 830	Continued From page 28 access site or post dialysis needs. Review of a facility policy titled, Dialysis Care, adopted 2/12/20, revealed it was the policy of the facility each resident who received the care and provisions of dialysis were consistent with the professional standards of practice. The policy identified it was the facility's responsibility to assess and monitor residents who received dialysis for any complications by checking vital signs, medication management and monitoring residents dialysis access sites. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents that receive the hemodialysis to keep them safe. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. 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	2 900		2/18/22

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 12/22/2021

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
2 900	Continued From page 29 B. a resident who has pressure sores 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 accurately and comprehensively assess, monitor, develop and implement pressure relieving interventions for 1 of 1 resident (R20) reviewed for current, worsening pressure ulcers. This deficient practice caused actual harm when R20's left heel stage three (3) pressure ulcer worsened to an unstagable ulcer, development of an unstagable pressure ulcer on the top left foot and an unstagable lateral right foot pressure ulcer which worsened in size. Stage 3 pressure ulcer; full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling Unstagable ulcer; wound bed cannot be visualized due to the presence of slough or eschar Slough; non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Eschar tissue; dead or devitalized tissue that is hard or soft in texture; usually black, brown, or	2 900	Corrected	

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 12/22/2021

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
2 900	Continued From page 30	2 900		

tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

Findings include:

R20's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 11/20/21, identified R20 had diagnoses which included diabetes, osteoarthritis and peripheral vascular disease. The MDS identified R20 had intact cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and personal hygiene. The MDS identified R20 was at risk for developing pressure ulcers and identified R20 had the following pressure relieving interventions in place; pressure relieving device for chair, bed, and application of non-surgical dressings and ointments/medications to areas other than feet. The MDS incorrectly identified R20 had no unhealed pressure ulcers or other open areas.

R20's SCSA Care Area Assessment (CAA) dated 11/20/21, identified R20 required extensive assistance with ADL's which included bed mobility, transfers and R20 had a decline in condition related to recent COVID-19 diagnosis, and other medical conditions such as heart failure, diabetes, varus deformity (deformity of foot/ankle in which the lateral part of the foot faces downwards) and chronic pain. The CAA identified R20 was admitted to the facility with a pressure ulcer/injury to his left heel and right bottom of foot that received daily dressing changes. The CAA identified the following pressure relieving interventions were in place; pressure redistributing device to bed, wheelchair and staff were to offer repositioning periodically

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 12/22/2021

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
2 900	Continued From page 31	2 900		

with toileting. Further, the CAA identified R20's skin would be checked weekly by licensed staff. The CAA lacked any characteristics of R20's pressure ulcers such as stage, tissue type, measurements and any signs of healing or worsening.

R20's medical record lacked any further comprehensive skin assessments.

R20's current care plan revised 12/9/21, revealed R20 had poor memory, was recently diagnosed with dementia, and required extensive assistance of two staff with bed mobility, transfers and dressing. The care plan revealed R20 had a potential for pressure ulcer development, had open wounds on his legs, and feet. R20's care plan did not address the bilateral unstageable foot pressure ulcers, use of a pressure redistributing device to bed or wheelchair, or repositioning periodically with toileting or list any pressure relieving interventions.

R20's Visual/Bedside Kardex Report (nursing assistant care guide) dated 12/21/21, lacked any pressure relieving interventions for staff to follow.

R20's current physician orders signed 12/21/21, revealed the following;

- order dated 12/18/21, for Prevalon boots (specialized pressure relieving boots) on right foot, very important to keep the Prevalon boot on to protect the foot, may remove to walk, one time daily.

- order dated 12/2/21, cleanse legs and feet with gentle soap and water. Apply Aquaphor (lotion) to entire leg, cover open wounds with Adaptic (is a primary dressing designed to help protect the

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 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 900	Continued From page 32	2 900		

wound while preventing the dressing from adhering to the wound.) Wrap entire leg (foot to knee) with Kerlix followed by ace wrap in a figure eight fashion. Change daily and prn (as needed) every day shift for ulcer.

On 12/20/21, at 11:41 a.m. R20 was interviewed, he indicated he had a sore on his right foot that he had long term and indicated his left foot sore was new since he was admitted to the facility. R20 then, abruptly changed subjects, talked about many random topics and was unable to answer further question or provide any more information.

On 12/20/21, at 12:39 p.m. R20 was observed laying in bed, on his back, faced the television. Both of R20's feet rested directly on a regular mattress, wrapped with ACE bandages and were covered with gripper socks. R20's left foot toes were pressed against the footboard of his bed and his right foot rested on the mattress on the lateral aspect of his foot.

On 12/21/21, at 10:15 a.m. R20 was observed laying in bed on his back, nursing assistant (NA)-C stood next to R20's bed, on his left side and proceeded to assist R20 with incontinence cares. R20's bilateral legs were wrapped from his feet to his knees with ACE bandages and he wore gripper socks on his feet. Following incontinence cares, NA-C was observed to tell R20 to use his heels to help boost him up in bed. R20 then placed both heels on the mattress of the bed, and assisted NA-C to move himself up towards the head of his bed. R20 then rested both of his ACE wrapped feet on the bed, his left heel and lateral aspect of his right foot rested directly on the standard mattress. NA-C was not observed to offer R20 pressure relief to his feet, nor did she

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 12/22/2021

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
2 900	Continued From page 33 offer use of his Prevalon boots. - at 10:45 a.m. R20 was observed laying in bed on his back, his bare legs and feet were visible on his bed. R20's left heel was laying directly on his standard mattress and his right foot rested on the mattress, directly on the lateral aspect of his foot. At that time, licensed practical nurse (LPN)-A was observed to cleanse R20's legs and feet, and proceeded to complete R20's dressing changes to his anterior left foot ulcer, left heel ulcer and two ulcers on the lateral aspect of his right foot. LPN-A donned clean gripper socks to both of R20's feet, was not observed to elevate or offload R20's feet, R20's left heel and lateral aspect of his right foot rested directly on the standard mattress. -at 11:22 a.m. R20 was observed seated on the side of his bed, with an over the bed table positioned in front of him, he wore gripper socks on both feet, his right leg was inverted and his lateral aspect of his foot rested directly on the floor. - at 2:40 p.m. R20 was observed lying on his back in his bed, covered with a sheet from his mid lower legs to his upper torso. R20's left heel and lateral aspect of his right foot rested directly on the standard mattress. On 12/21/21, at 10:25 a.m. during an interview NA-C stated R20 required extensive assistance with bed mobility, transfers, dressing and personal hygiene. NA-C indicated R20 was able to help turn himself and used his feet to help move him up in bed. NA-C indicated R20 had open ulcers on both of his feet which oftentimes would have drainage coming from them and leave spots on R20's sheets. NA-C indicated she	2 900		

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	00938	A. BUILDING: _____ B. WING _____	C 12/22/2021

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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2 900	Continued From page 34	2 900		

felt R20 had a poor memory and his cognition would fluctuate over the course of the day. At 12:08 p.m. during a follow up interview, NA-C indicated R20 wore Prevalon boots at night when he was in bed and was not aware of any pressure relieving interventions in place such as elevating his feet in bed.

On 12/21/21, at 11:00 a.m. during an interview, LPN-A stated R20 required extensive assistance with his ADL's and indicated R20's cognition fluctuated over the course of the day. She indicated R20 required daily dressing changes to his bilateral foot ulcers, which had been present since R20's admission to the facility. LPN-A indicated she completed R20's dressing changes daily and felt the areas were improving by less drainage present on his old dressings LPN-A stated she did not complete R20's ulcer measurements or assessments, believed R20's bilateral foot pressure ulcers were monitored by a wound clinic and R20's primary physician. At 12:10 p.m. during a follow up interview, LPN-A stated R20 was supposed to wear Prevalon boots when he was in bed, but refused to wear them. LPN-A indicated she did not feel R20's bilateral foot ulcers were pressure related and confirmed R20 had no pressure relieving interventions in place.

On 12/21/21 at 11:40 a.m. during an interview, NA-A indicated R20 required extensive assistance with bed mobility, transfers and dressing. NA-A indicated R20 required daily dressings to his feet and legs due to ulcers and indicated she thought R20 might have special boots but was not sure. She indicated R20 was able to move his extremities and was not aware of any pressure relieving interventions for his feet.

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 12/22/2021

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
2 900	Continued From page 35 On 12/21/21, at 12:46 p.m. during a telephone interview with R20's family member (FM)-B indicated he had concerns with R20's cares not being completed routinely and R20's recent decline in cognition. FM-B indicated R20 had chronic foot ulcers to his right foot due R20's foot deformity, though was not aware of any history of foot ulcers to his left foot. FM-B indicated he was recently notified by the facility R20 would be seen by a podiatrist for foot care. FM-B indicated he had concerns R20 had not received routine cares and stated he had not observed R20's Prevalon boots or his feet off loaded during his visits. On 12/21/21, at 2:45 p.m. R20's medical record was reviewed with the DON, she confirmed R20 had pressure ulcers of his left heel, lateral right foot and were last measured in the facility on 10/12/21. The DON stated she believed R20 was admitted to the facility with the lateral right foot ulcer, however, was not sure if R20's left heel ulcer was present upon his admission. The DON stated she would expect R20's left heel and right foot pressure ulcers to be assessed weekly, which would include measurements, wound characteristics, indications of healing, and current treatment. Further, the DON confirmed R20's care plan did not identify any pressure relieving interventions in place for R20's bilateral foot pressure ulcers. At that time, a request was made to measure and assess R20's left heel and right foot pressure ulcers. -at 2:59 p.m. observation was conducted with DON present. R20 was observed laying on his back in bed, his left heel and his right lateral aspect of his foot were laying directly upon R20's mattress and his left upper foot and toes were pressed against the foot board of his bed. The DON stated R20's feet did not have any pressure	2 900		

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 12/22/2021

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
2 900	Continued From page 36	2 900		

relief in place and indicated she would need to find someone to assist her to boost R20 up in bed to relieve the pressure from his left foot. At 3:06 p.m. NA- E entered R20's room, the DON stood on the right side of R20's bed took hold of a lift sheet which was underneath R20's mid-body. NA-E took hold of the lift sheet on the left side of R20, the DON and NA-E encouraged R20 to place his feet on the bed and push to assist to move up in bed. R20's left heel and right lateral aspect of his foot pressed against the mattress as R20 was boosted up in bed. NA-E immediately left R20's room. The DON proceeded to remove R20's ACE wraps and dressings for measurements, the following was observed;

- R20's top left foot, had moderate purulent drainage (yellow/greenish) and revealed an unstagable pressure ulcer which measured 3.0 centimeters (cm) by 2.0 cm and had an area of slough tissue on the wound bed that measured 0.2 by 0.2 cm. with the remaining wound bed presented with epithelial tissue. The DON stated the pressure ulcer started as a blood blister which had opened. The DON confirmed R20's top left foot pressure ulcer had worsened in size, had slough tissue and had purulent drainage.

- R20's left heel, had a minimal amount of purulent drainage and revealed an unstagable pressure ulcer which measured 1.3 cm by 1.2 cm and was covered with thick, hard, dark brown eschar tissue. The DON confirmed R20's left heel pressure ulcer had worsened by an increase in size and a wound bed was no longer able to be visualized due to the eschar.

- R20's lateral right foot lower pressure ulcer, no drainage and revealed an unstagable pressure ulcer which measured 2.3 cm by 1.2 cm, thick,

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 12/22/2021

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
2 900	Continued From page 37	2 900		

dark reddish/brown tissue on the wound bed. The DON confirmed R20's right lateral pressure ulcer had worsened by an increase in size and a wound bed was no longer able to be visualized due to the thick, dark reddish brown tissue.

The DON confirmed all three of R20's pressure ulcers had worsened and stated R20 refused to wear the Prevalon boots. The DON confirmed R20 had no current pressure relieving interventions in place for his unstagable pressure ulcers.

On 12/22/21, at 7:07 a.m. R20 was observed laying on his back in bed, covered with a sheet from his ankles to his torso. R20's left heel and lateral aspect of his right foot rested directly on the standard mattress.

Review of R20's podiatry progress notes from 9/28/21, to 12/16/21, revealed the following:

- 9/28/21, presented with an ulcerated right foot, unspecified severity, a stage 3 decubitus ulcer of left heel, varus deformity (deformity of foot/ankle in which the lateral part of the foot faces downwards) of right ankle and chronic osteomyelitis (infection of the bone) involving ankle and foot. The note revealed R20's right foot ulcer was debrided and recommended an MRI (magnetic resonance imaging) and a Prevalon boot or Heel Lift boot for the right foot to protect from pressure.

- 10/5/21, seen for a follow up visit. The note revealed R20 had swelling and redness of the right leg and foot, recommended to prevent R20 from putting pressure on his feet. The note lacked any information about R20's unstagable left heel pressure ulcer or top of left foot pressure ulcer.

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 12/22/2021

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
2 900	Continued From page 38 - 12/16/21, seen for a follow up visit of his lateral right foot. Note revealed R20's lateral right foot pressure ulcer was shallow and appeared improved from previous visit. The note revealed R20's podiatrist emphasized the need to get all pressure off of the lateral foot. The note lacked any information about R20's unstagable left heel pressure ulcer or top of left foot pressure ulcer. R20's podiatry notes lacked any further documentation of the status or progress towards healing/worsening of R20's left heel pressure ulcer. Review of R20's facility Skin and Wound Evaluation from 8/31/21, to 10/12/21, revealed the following; -8/31/21, indicated R20 had a diabetic ulcer of his left heel which measured 0.8 cm long by 0.5 cm wide and had no indication of depth. The wound evaluation lacked any characteristics of R20's left heel ulcer such as a description of the ulcer's wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify when R20's left heel ulcer developed or whether R20's left heel ulcer was healing or had worsened. -8/31/21, indicated R20 had a diabetic ulcer on the sole of his right foot which measured 2.4 cm by 1.8 cm and had no indication of depth. The wound evaluation lacked any characteristics of R20's dorsum right foot ulcer, such as a description of the ulcer's wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify whether	2 900		

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 12/22/2021

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
2 900	Continued From page 39 R20's right foot ulcer was healing or had worsened. - 9/21/21, indicated R20 had a diabetic ulcer of his left heel which measured 0.6 cm by 0.4 cm and had no indication of depth. The wound evaluation lacked any characteristics of R20's left heel ulcer such as a description of the ulcers wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify when R20's left heel ulcer developed or whether R20's left heel ulcer was healing or had worsened. - 10/12/21, indicated R20 had a diabetic ulcer of his left heel which measured 1.4 cm by 0.8 cm and had no indication of depth. The wound evaluation lacked any characteristics of R20's left heel ulcer such as a description of the ulcers wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify whether R20's left heel ulcer was healing or had worsened. -10/12/21, indicated R20's dorsum right foot (part of foot facing upwards) had an unidentified area which measured 0.8 cm by 0.6 cm and had no indication of depth. The wound evaluation lacked any characteristics of R20's dorsum right foot ulcer, such as a description of the ulcers wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify whether R20's right foot ulcer was healing or had worsened. R20's medical record lacked any further ongoing evaluation of R20's left heel pressure ulcer. In	2 900		

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 12/22/2021

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
2 900	Continued From page 40	2 900		

addition, R20's medical record did not identify the presence or assessment of R20's lower left anterior foot pressure ulcer (top left foot.)

On 12/21/21, at 4:19 p.m. during an interview LPN-C indicated she felt R20 had a poor memory and indicated his cognition would fluctuate over the course of the day. LPN-C indicated R20 received daily dressing changes to both of his feet and ACE wraps for edema management. LPN-C stated he was not aware of any pressure relieving interventions in place for R20's unstagable pressure ulcers of his left heel, top of left foot and lateral right foot.

On 12/21/21, at 4:58 p.m. during an interview trained medication aid (TMA)-B stated R20 required extensive assistance with all cares except for eating, he required set up assistance. TMA-B stated she felt R20 had memory loss and was not always able to recall events or his needs. TMA-B stated R20 had ACE wraps on daily for edema management and had ulcers on both of his feet. TMA-B stated she was unaware of any pressure relieving interventions in place for R20's unstagable pressure ulcers of his left heel, top of left foot and lateral right foot.

On 12/22/21, at 7:55 a.m. during an interview, LPN-B stated R20 had ACE wraps on daily for edema management and had ulcers on both of his feet, but had not seen R20's unstagable pressure ulcers on his feet. LPN-B stated she was unaware of any pressure relieving interventions in place for R20's unstagable pressure ulcers of his left heel, top of left foot and lateral right foot.

On 12/22/21, at 8:44 a.m. during an interview, NA-B stated R20 was totally dependent for his

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 12/22/2021

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
2 900	Continued From page 41 ADL's and felt R20 had memory loss and was not always able to recall instructions or events. NA-B indicated R20 was supposed to wear Prevalon boots when in bed for pressure ulcers on his feet, but he refused to wear them. NA-B stated she was not aware of any pressure relieving interventions in place for R20's unstagable pressure ulcers of his left heel, lateral right foot and top of left foot. R20's practioner progress notes were reviewed from 9/1/21, to 11/24/21, revealed the following: -9/1/21, revealed R20 was seen in the facility for an initial visit at the facility. The note revealed R20 had a skin ulcer of right foot with necrosis to the bone. The note lacked any characteristic of his right foot ulcer and lacked any direction or recommendations. The note lacked any documentation of R20's unstagable left heel pressure ulcer. -9/2/21, revealed R20 was seen in the facility for a routine visit, had cellulitis right lower extremity, right lower extremity wound with Mepilex dressing (is indicated for use on moderately exuding wounds, leg and foot ulcers, pressure injuries, under compression, graft and donor sites and traumatic wounds) and requested a wound care consult. -10/13/21, revealed R20 was seen in the facility for weight gain related to fluid retention. The note revealed R20 had chronic ulcers on his feet and required an MRI. The note lacked any further direction regarding R20's chronic ulcers and lacked any documentation of R20's unstagable left heel pressure ulcer. -10/27/21, revealed R20 was seen at the facility,	2 900		

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 12/22/2021

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
2 900	Continued From page 42 examination revealed right foot and left heel skin deep ulcers, with fat layer exposed. The progress note revealed direction to continue dressing and wrapping legs per wound care clinic instructions. -11/11/21, revealed R20 was seen in the facility for a routine visit, examination revealed skin thickness deep right foot ulcers, top of left foot ulcer and ulcer of left heel with fat layer exposed. The progress note revealed direction to continue dressing, wrapping of legs and to follow up with wound care clinic. -11/24/21, revealed R20 was seen in the facility for a routine visit, discussed dementia diagnosis and concerns with worsening. The note did not identify R20's right or left foot pressure ulcers were reviewed at the time of the visit. On 12/22/21, at 3:45 p.m. during a telephone interview, R20's primary physician, medical doctor (MD)-A stated she was aware R20 had pressure ulcers of his lateral right foot, left heel and top of left foot. MD-A stated she had last seen R20 at the facility on 12/21/21, though had not been able to visualize his feet. MD-A stated she had not been told of any changes to R20's left heel pressure ulcer, lateral right foot pressure ulcer or top of left foot ulcer. She indicated R20 was routinely seen by a podiatrist for wound care, however, she would expect the facility to assess and monitor R20's pressure ulcers routinely, at least weekly for any changes. MD-A stated any pressure on R20's left heel or the lateral right foot could certainly cause further injury and she would expect the facility to routinely implement pressure relieving interventions to prevent worsening. On 12/22/21, at 7:37 a.m. a telephone call was placed to R20's podiatrist, a message was left for	2 900		

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 12/22/2021

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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2 900	Continued From page 43	2 900		

a return call. A return call was received on 12/23/21, at 9:28 a.m. from R20's podiatrist. He confirmed he had last seen R20 on 12/16/21, for follow up management of his lateral right foot pressure ulcer. The podiatrist stated he did not visualize R20 had an unstagable pressure ulcer of his left heel and foot during the last two visits and would have wanted to be notified of any changes. The podiatrist stated he had seen R20 three times since September for management of R20's lateral right foot chronic pressure ulcer and had felt the wound looked better than when he first saw it. He stated he had not been made aware of the increase in size and did not see the thick, hard dark tissue at the time of R20's most recent visit. He stated he expected the facility to assist R20 to keep all pressure off of his lateral right foot and had ordered Prevalon boots to be worn when not up walking. The podiatrist stated he felt it was imperative to R20's healing to prevent any pressure on his right foot and would now expect R20's left heel to be offloaded at all times. R20's podiatrist stated he felt any pressure on R20's lateral right foot, left heel or any pressure to his feet would worsen existing pressure ulcers and could cause new ones to form.

A policy was requested, one was not provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could 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, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for

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 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 900	Continued From page 44 pressure ulcer development. TIME PERIOD FOR CORRECTION: fourteen (14) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide shaving assistance for 1 of 1 resident (R20) who was dependent on facility staff for grooming. Findings include: R20's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 11/20/21, identified R20 had diagnoses which included diabetes, Osteoarthritis and peripheral vascular disease. The MDS identified R20 had intact cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and personal hygiene. R20's SCSA Care Area Assessment (CAA) dated 11/20/21, identified R20 required extensive assistance with ADL's which included bed mobility, transfers and had a decline in condition related to recent COVID-19 diagnosis, and other	2 920	Corrected	2/18/22

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 12/22/2021

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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2 920	Continued From page 45 medical conditions such as heart failure, diabetes, valgus deformity (deformity of foot/ankle) and chronic pain. R20's current care plan revised 12/9/21, revealed R20 had poor memory, was recently diagnosed with dementia, and required extensive assistance of two staff with bed mobility, dressing, bathing and grooming. R20's care plan lacked any indication of R20's preference for facial hair removal. R20's Visual/Bedside Kardex Report (nursing assistant care guide) dated 12/21/21, revealed R20 required extensive assistance with dressing, bathing and personal hygiene. R20's care guide lacked direction for facial hair removal. On 12/20/21, at 12:39 p.m. R20 was observed laying in bed, on his back, faced the television, his eyes were opened and he had thick white coarse facial hair approximately three (3) to five (5) millimeters (mm) in length, which covered his cheeks, chin, upper lip, jaw line and neck. On 12/20/21, at 4:45 p.m. during a telephone interview with R20's family member (FM)-A, indicated R20 was oftentimes disheveled when she came to visit. FM-A stated she felt R20 had declined both physically and cognitively since his arrival to the facility approximately four months prior. FM-A stated prior to R20's admission to the hospital and subsequent admission to the facility, he used to be well groomed. On 12/21/21, at 10:15 a.m. R20 was observed laying in bed on his back, R20's cheeks, chin, upper lip, neck and jaw line continued to be covered with thick white coarse facial hair 3-5 mm long facial hair. (NA)-C stood next to R20's	2 920		

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	00938	A. BUILDING: _____ B. WING _____	C 12/22/2021

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
2 920	Continued From page 46	2 920		

bed, proceeded to assist him with incontinence cares, and left his room without offering assistance with facial hair removal.

- at 11:22 a.m. R20 was observed seated on on the side of his bed, with an over the bed table positioned in front of him, he held a sandwich with his right hand. R20's lower legs were covered with a white sheet, he wore gripper socks on both feet. R20's cheeks, chin, upper lip, neck and jaw line continued to be covered with thick white coarse facial hair 3-5 mm long facial hair.

- at 2:40 p.m. R20 was observed lying on his back in his bed, covered with a sheet from his mid lower legs to his upper torso. R20's cheeks, chin, upper lip, neck and jaw line continued to be covered with thick white coarse facial hair 3-5 mm long facial hair.

On 12/22/21, at 7:07 a.m. R20 was observed laying on his back in bed, covered with a sheet from his ankles to his torso. R20's cheeks, chin, upper lip, neck and jaw line continued to be covered with thick white coarse facial hair 3-5 mm long facial hair.

On 12/21/21, at 10:25 a.m. during an interview NA-C stated R20 required extensive assistance with bed mobility, dressing, personal hygiene, and felt he was not able to recall information. NA-C indicated she was not aware of R20's shaving preference and did not offer to assist him with facial hair removal.

On 12/21/21, at 11:00 a.m. during an interview, LPN-A stated R20 required extensive assistance with his ADL's and indicated R20's cognition fluctuated over the coarse of the day. LPN-A stated she was not aware of R20's preference for

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 12/22/2021

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
2 920	Continued From page 47 facial hair removal. On 12/21/21 at 11:40 a.m. during an interview, NA-A indicated R20 required extensive assistance with bed mobility, transfers and dressing. NA-A indicated R20's cognition would fluctuate over the course of the day and his needs should have been anticipated. On 12/21/21, at 12:46 p.m. during a telephone interview with R20's family member (FM)-B indicated he had concerns with R20's cares not being completed routinely and R20's recent decline in cognition. He indicated R20 appeared disheveled, unshaven and generally unclean when he visited. FM-B indicated R20 used to take great care with grooming, and used to be clean shaven on his head and face. FM-B stated he felt it would bother R20 if he looked disheveled. On 12/21/21, at 4:19 p.m. during an interview LPN-C stated R20 required assistance with all of his cares and felt R20 had a poor memory and indicated his cognition would fluctuate over the course of the day. On 12/21/21, at 4:58 p.m. during an interview a trained medication aid (TMA)-B stated R20 required extensive assistance with all cares except for eating, he required set up assistance. TMA-B stated she felt R20 had memory loss and was not always able to recall events or his needs. TMA-B indicated she believed R20 was assisted to shave his face daily. On 12/22/21, at 8:44 a.m. during an interview NA-B stated R20 was totally dependent for his ADL's and felt he had declined within the past month, following his COVID-19 illness. NA-B stated she felt R20 had memory loss and was not	2 920		

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	00938	A. BUILDING: _____ B. WING _____	C 12/22/2021

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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2 920	Continued From page 48 always able to recall instructions or events. She indicated R20 used his call light, but was not always able to recall what he wanted and his needs were to be anticipated. NA-B indicated R20 preferred to be clean shaven and should have been assisted with facial hair removal daily. On 12/22/21, at 12:47 p.m. the director of nursing (DON) indicated she was not aware of R20's preference for facial hair removal. The DON stated R20's cognition had been fluctuating and overall declining since November when he had COVID-19. The DON indicated she expected R20's shaving preference to be identified and expected staff to assist with facial hair removal if he desired. A facility policy was requested, one was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to activities of daily living. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing assistance with activities of daily living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident	2 965		2/18/22

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 12/22/2021

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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2 965	Continued From page 49 assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide therapeutic diet as prescribed by the physician for 1 of 2 (R1) residents reviewed for therapeutic diet. Findings include: R1's Admission Record printed 12/22/21, identified R1 had been admitted to the facility on 6/11/21, with the diagnoses of visual loss, neuropathy unspecified (disease of the nerves), cataract, glaucoma, dysfunction of the bladder, rectal prolapsed, and benign prostatic hyperplasia (prostate enlargement). R1's quarterly Minimum Data Set (MDS) dated 9/16/21, identified R1's cognition was intact and required one staff assistance for grooming cares and required supervision for eating. The MDS indicated R1 had no swallowing disorder or signs or symptoms of a swallowing disorder. The MDS identified R1 had no known weight loss or gain. The MDS section that identified dental had been left blank. R1's admission Care Area Assessment (CAA) dated 6/24/21, identified R1 was missing most teeth and the remaining teeth were notably broken. R1's care plan revised 6/11/21, identified R1 had	2 965	Corrected	

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	00938	A. BUILDING: _____ B. WING _____	C 12/22/2021

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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2 965	Continued From page 50	2 965		

a nutritional problem or potential for one related to risk of choking and weight loss due to difficulty chewing, fear and resistance to weight gain, and risk for dehydration due to laxative use, advanced age and decreased mobility. The care plan instructed staff to assist R1 with meal set up and explain what was on his plate utilizing the clock method when the meal was delivered. The care plan indicated staff were to provide and serve the diet as ordered; regular diet with regular textures and regular consistencies.

R1's current physician Order Summary Report dated 12/21/21, identified the prescribed diet order for R1 was a soft/surgical diet.

R1's dietary card dated 12/17/21, identified R1's diet as regular/regular, cut up meat for resident, divided plate, set up assistance.

Review of R1's Nutrition Data forms from 8/28/21, to 12/17/21, revealed the following:

- 8/28/21, R1's Nutrition Data (Admission) form identified R1 received a diet of regular with mechanical soft textures.

- 12/17/21, R1's Nutrition Data (Quarterly) form identified R1 as being on a regular mechanical soft diet with regular consistencies.

During an observation on 12/20/21, at 12:12 p.m. R1 was observed during the noon meal with a fish sandwich, potato wedges, and coleslaw.

During an observation on 12/20/21, at 5:25 p.m. R1 was observed to have a divided plate, with mashed potatoes, mixed vegetables, cucumbers, and a slice of ham which had not been cut up. R1 was observed to feel around his plate for his food

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 12/22/2021

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

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2 965	Continued From page 51	2 965		

and pick up his slice of ham and take a bite. R1 was observed to hold the slice of ham in his hand and continued to work on consuming it slowly.

During an observation on 12/21/21, at 12:41 p.m., R1 was served a tuna fish sandwich, cucumber slices, tomatoes slices, and green grapes.

During an observation on 12/21/21, at 5:40 p.m., R1 was served country fried steak, mashed potatoes, carrots, and green grapes.

During an interview on 12/20/21, at 3:31 p.m. R1 stated he did not have any teeth as they had been surgically removed down to the roots several months ago. R1 indicated he had been told his jaw bone was too weak to handle dentures which was why he did not have any. R1 stated he received an American diet and occasionally had his meat ground up however was unsure how often that happened. R1 indicated at times it was hard for him to eat the meat. R1 stated he needed to keep "munching things" until they became small enough or he would have had trouble swallowing.

During an interview on 12/20/21, at 4:35 p.m. nursing assistant (NA)-H stated staff were to let R1 know where his food and drinks were on the plate using the clock method. NA-H stated R1 was on a regular diet.

During an interview on 12/21/21, at 11:19 a.m. dietary manager (DM) identified he completed the nutritional assessments and the dietician added the information to the dietary slip which went out with each resident meal. DM indicated the direct are staff documented the residents' intakes and reported to him if any changes or concerns were noted. DM indicated the dietician came to the

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 12/22/2021

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
2 965	Continued From page 52	2 965		

facility weekly and together they reviewed residents' nutritional status. DM stated R1 was not currently on an altered diet and R1 received a regular diet. DM described a mechanical soft diet consisted of cutting up food and each dietary slip should have indicated what size to cut it to. After further review, DM confirmed R1's dietary slip lacked information R1 was on a mechanical soft and the sheet identified he was on a regular diet with meats to be cut up. DM confirmed R1 had been receiving the regular diet since he started working a couple months ago instead of the ordered mechanical soft diet. DM stated the facility had no special menus to follow for a resident who had been prescribed a mechanical soft diet.

During an interview on 12/21/21, at 3:55 p.m. registered dietician (RD) confirmed R1 was on a mechanical soft diet. RD stated she expected all meats were to be cut up unless they were already in a ground texture. RD confirmed foods such as grapes and cucumbers should not have been served to someone on a mechanical soft diet. RD stated the diets which included the texture of the food for each resident should have been listed on their dietary slip for staff to follow. RD confirmed if a resident had been served the wrong diet which included a mechanical soft diet or pureed diet there would be an increased risk for choking.

During an interview on 12/21/21, at 6:43 p.m. R1 stated the chicken he ate at his evening meal was tough around the edges however he was able to eat the softer meat inside. R1 indicated he attempted to eat the grapes however the skin was too hard for him.

During an interview on 12/22/21, at 10:35 a.m. the director of nursing (DON) stated the nursing

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 12/22/2021

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
2 965	Continued From page 53 staff completed a communication form which identified each resident's diet and the forms were sent to dietary staff. DON indicated she expected staff would follow orders to ensure correctly prescribed diets were followed. DON confirmed R1's diet was a mechanical soft and stated R1 had the potential for choking or aspiration when the prescribed diet had not been followed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures to ensure the correct diet order was served. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure residents are provided food of similar nutritive value. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 965		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in	21390		2/18/22

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 12/22/2021

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
21390	Continued From page 54 the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate personal protective equipment (PPE) practices were followed when entering an isolation room for 1 of 1 residents (R326) who had been on isolation precautions and while providing meal service to 5 of 10 residents (R1, R2, R14, R16, R30) in the dining room. This deficient practice had the potential to affect all 24 residents currently residing in the facility. Findings include: R326's Admission Record dated 12/21/21, identified R326 had been admitted to the facility on 12/17/21, with the diagnoses of diabetes mellitus (primary), history of COVID-19 (secondary), schizoaffective disorder, blood clot of lower extremity, anemia, and chronic constipation. R326's progress note dated 12/17/21, identified R326 had been admitted to the facility with history of COVID-19 pneumonia and deep vein	21390	Corrected	

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 12/22/2021

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
21390	Continued From page 55	21390		

thrombosis (blood clot). R326 had been placed on isolation with all services being provided in R326's room.

During an observation and interview on 12/20/21, at 12:40 p.m. nursing assistant (NA)-D obtained the noon meal from the enclosed cart located in hallway outside of R326's room. NA-D with the meal tray in his hand used his other hand to moved a housekeeping cart that had been parked in front of the door to R326's room. NA-D entered R326's room holding the meal tray without donning a gown or gloves, walked passed the housekeeper who was in the room in full PPE and set the meal tray down on the bedside table. NA-D moved a dirty glass from the bedside table to the nightstand. NA-D set up the meal tray and positioned the bedside table in front of R326 who was in bed with the head of bed elevated. Observed on the door to R326's room were 2 signs one which read "STOP, see charge nurse" and the other which read "Isolation PPE, staff to don gloves, goggles, mask, and gown, then doff gloves, goggles, gown, and mask". NA-D exited R326's room and sanitized his hands. NA-D confirmed he had not been wearing PPE and stated he should have worn all the PPE when entering R326's room. NA-D indicated it was the facility protocol staff were to wear all PPE any time there was a sign on the resident's door identifying isolation.

Review of the facility policy titled Personal Protective Equipment Using Protective Eyewear, Using Gloves, and Using Gowns, undated identified the objective was to prevent the spread of infections.

Review of the facility policy titled Contact Precautions dated 3/23/21, identified contact

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 12/22/2021

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
21390	Continued From page 56	21390		

precautions included the use of gloves and gowns when entering the isolation room. Staff were to don gloves prior to contact with the resident or the residents environment, wear a gown if substantial contact with the resident or environment was anticipated. Staff were to remove gloves and gown prior to leaving the resident room. Disease was more likely to be transmitted and occur between a health care worker and a resident.

MASKS

On 12/20/21, from 11:50 a.m. to 1:00 p.m. during the noon meal service in the main dining room the following was observed:

-at 11:50 a.m. the dietary assistant (DA)-A stood by the the steam table cart with goggles on, hair covered, and a mask worn loosely which hung below her nose. The DA-A grabbed a glass of juice (uncovered) from the cart, walked over to a table and placed it on the table in front of R1. DA-A stood next to R1 who was unmasked, conversed briefly and walked back to the cart.

-at 11:55 a.m. DA-A grabbed a glass of juice (uncovered), stood next to R16 and placed it on the table. DA-A grabbed the bottle of hand sanitizer and walked over to R14. DA-A stood next to R14 who was unmasked, bent over with mask which remained loosely placed and hung below her nose and asked R14 if he wanted to sanitize his hands. DA-A verbally instructed him to rub his hands together.

-at 12:00 p.m. DA-A walked over to R2 with her mask in the same position worn loosely, stood next to R2 who was unmasked, bent over, and asked her what she would like to drink. DA-A

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 12/22/2021

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
21390	Continued From page 57	21390		

stood next to R2, placed a glass of juice on the table, and conversed with her for approximately two minutes.

-at 12:05 p.m. DA-A stood next to R30 who was unmasked, placed a glass of juice (uncovered) on table in front of him, bent over, and asked if he wanted anything else to drink. R30 requested a cup of coffee. DA-A delivered a cup of coffee to R30. DA-A stood next to R30, visited with him while she opened two coffee creamers and placed them in his coffee cup. DA's mask remained in the same position.

- at 12:10 p.m. DA-A stood at the steam table in dining room and continued to wear mask remained loosely which hung below her nose. Nursing Assistant (NA)-C wore a properly positioned face mask which covered the nose, stood next to DA-A, and handed her a breakfast tray. NA-C was not observed to provide education to DA-A to cover the nose with the mask.

-at 12:15 p.m. to 12:50 p.m. DA-A transferred plates of food onto the food cart. The dietary manager (DM) wore a properly positioned face mask which covered the nose and stood on the other side of the steam table during the entire observation. DM was not observed to provide education to DA-A to cover the nose with the mask.

-at 12:30 p.m. DA-A reached up and pulled up her mask over her nose, however the mask remained loose, and after she sanitized her hands the mask slid back down below her nose.

-at 12:45 p.m. business office manager (BOM) entered the dining room, wore a properly positioned face mask which covered the nose,

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 12/22/2021

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
21390	Continued From page 58	21390		

stood next to DA-A, and asked if R30 had eaten his meal. DA-A's mask remained positioned loosely, which hung below her nose responded no. BOM was not observed to provide education to DA-A to cover the nose with the mask.

-at 1:00 p.m. DA-A remained in the dining room and her mask continued in the same position. Five residents remained in the dining room while DA-A cleaned off the dirty dishes from the dining room tables.

During an interview on 12/21/21, at 12:02 p.m. NA-A stated staff expected to wear a mask that covered our mouth and nose while they worked; especially when present were around residents and staff. NA-A stated wearing a mask helped prevent the spread of any germs such as COVID-19.

During an interview/observation on 12/21/21, at 12:37 p.m. DA-A stated the mask had been hard to keep over her nose. DA indicated staff were expected to keep our mask over the nose especially when close to residents, visiting, and bringing them food to help prevent the spread of infection. During the interview DA-A's mask remained positioned loosely, which hung below her nose then DA-A re-positioned the face mask to cover the nose and walked away

During an interview on 12/21/21, at 12:54 p.m. the facility cook (C)-A stated staff were expected to wear a mask over the mouth and nose especially when present around the residents and during meal service to help prevent the spread of infection.

During an interview on 12/22/21, at 7:52 a.m. DM stated all dietary staff were expected to wear a

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 12/22/2021

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
21390	Continued From page 59 mask which covered the mouth and nose and goggles or a face shield when meals were served and when out among residents. DM identified this practice helped prevent infection. Review of an undated facility policy titled Personal Protective Equipment - Using Face Masks identified the purpose was to guide the use of masks to prevent transmission of infectious agents through the air. Staff were to apply the face mask so that it covered the nose and mouth while they preformed treatment or services for the resident. 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. The DON or designee could educate staff and perform audits to ensure the infection control program is being implemented, tracked and trended. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992.	21530		2/18/22

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 12/22/2021

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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21530	Continued From page 60 This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure pharmacy recommendations were addressed in a timely manner for 4 of 5 residents (R20, R15, R9 and R12) reviewed for unnecessary medications. Findings include:	21530	Corrected	

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 12/22/2021

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
21530	Continued From page 61 R20's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 11/20/21, identified R20 had diagnoses which included diabetes, Osteoarthritis and peripheral vascular disease. The MDS identified R20 had intact cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and personal hygiene. The MDS identified R20 received antidepressant, anticoagulant, diuretic, and opioid medications seven of seven days during the look back period. R20's SCSA Care Area Assessment (CAA) dated 11/20/21, identified R20 required extensive assistance with ADL's which included bed mobility, transfers and had a decline in condition related to recent COVID-19 diagnosis, and other medical conditions such as heart failure, diabetes, valgus deformity (deformity of foot/ankle) and chronic pain. The CAA's identified R20 received several different medications which included, antidepressant, anticoagulant, diuretic, and opioid medications. Review of R20's Consultant Pharmacist Medication Review from 8/26/21, to 11/29/21, revealed the following: - 8/26/21, revealed the pharmacy consultant had a recommendation for separation of calcium and vitamin C, no response was documented. - 9/13/21, revealed the pharmacy consultant recommended R20's practioner address the use of Cinnamon at the current dose, (which was too high,) requested Digoxin level (medication used to treat atrial fibrillation, lab helps determine therapeutic level) and requested a basic metabolic panel (a blood test that measures your	21530		

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 12/22/2021

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
21530	Continued From page 62	21530		

sugar (glucose) level, electrolyte and fluid balance, and kidney function. Glucose is a type of sugar your body uses for energy. Electrolytes keep your body's fluids in balance.) The recommendations lacked documentation R20's primary practioner addressed the recommendations.

Review of R20's November 2021, consultant pharmacist medication review, dated 11/29/21, revealed the facility pharmacy consultant requested R20's practioner address recommendations made in September. The forms revealed R20's practioner addressed the recommendations on 12/6/21, decreased R20's cinnamon, ordered a Digoxin level and indicated R20 had a basic metabolic panel drawn on 11/15/21.

Review of R20's medical record lacked documentation a pharmacy review was conducted for October, 2021.

R15

R15's quarterly Minimum Data Set (MDS) dated 11/19/21, identified R15 had moderate cognitive impairment and had diagnoses which included Parkinson's Disease, Heart Failure and Diabetes Mellitus. The MDS indicated R15 received antipsychotic medication each day during the assessment reference period. The MDS lacked documentation of a drug regimen review.

Review of current physician orders signed 10/28/21, revealed R15 received the following medications:

- Isosorbide Dinitrate (medication used to prevent chest pain) 60 milligrams (mg.) one time daily.

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 12/22/2021

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
21530	Continued From page 63 - Metformin HCL (medication used to treat Diabetes Mellitus) 1000 mg. twice a day. - Seroquel (Quetiapine Fumerate) (medication used to treat schizophrenia, bipolar and major depressive disorder)25 mg. twice daily. Review of R15's Consultant Pharmacist's Medication Review (CPMR) forms from 6/28/21, to 12/17/21, revealed the following: - 6/27/21, recommendation was made to clarify and update the medication administration record (MAR) to administer Isosorbide Dinitrate 30 mg. extended release (ER). Physician acknowledged and confirmed the order on 6/30/21. Recommendation made for direction on the scheduling of Metformin 1000 mg. times to be administered at meal times. The physician acknowledged and confirmed the order on 6/30/21. - 7/19/21, the facility lacked the form for July 2021. - 8/26/21, recommendation was made for the physician to clarify if Isosorbide 60 mg. should be the ER formulation or not. The form lacked any response or signature from the physician. - 9/22/21, recommendation was made for the physician to re-evaluate prescribing Quetiapine due to antipsychotic medications (are a class of medicines used to treat psychosis and other mental and emotional conditions) have the potential for a direct drug interaction for someone who has Parkinson's Disease. The form lacked any response or signature from the physician.	21530		

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 12/22/2021

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
21530	Continued From page 64 - 10/29/21, recommendation was made to have a Tardive Dyskinesia (Tardive dyskinesias (TDs) are involuntary movements of the tongue, lips, face, trunk, and extremities that occur in patients treated with antipsychotic medications) assessment completed as necessary. The form lacked any response or signature from the physician. - 10/29/21, recommendation was made for the physician to clarify if Isosorbide 60 mg. should be the ER formulation or not. The form lacked any response or signature from the physician. - 11/29/21, the facility lacked the form for November 2021. - 12/17/21, recommendation was made for the physician to re-evaluate prescribing Quetiapine due to antipsychotic medications have the potential for a direct drug interaction for someone who has Parkinson's Disease. The form lacked any response or signature from the physician. - 12/17/21, recommendation was made for the physician to clarify if Isosorbide mono 60 mg. should be the ER formulation or not. The form lacked any response or signature from the physician. Review of facility form titled Patient Summary Report printed on 12/22/21, revealed the following: - 6/28/21, irregularities identified- see report. - 7/19/21, irregularities identified- see report. - 8/26/21, irregularities identified- see report.	21530		

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 12/22/2021

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
21530	Continued From page 65 - 9/22/21, irregularities identified- see report. - 10/29/21, irregularities identified- see report. - 11/29/21, no irregularities identified. - 12/17/21, irregularities identified- see report. R9 R9's quarterly Minimum Data Set dated 10/27/21, identified R9 had cognition intact and diagnoses included hypertension (HTN), diabetes mellitus (DM), renal insufficiency, and depression. The MDS identified R9 required supervision with dressing and had unstable balance during transfers and walking. The MDS indicated R9 received antianxiety medication and antidepressants seven of seven days during the assessment reference period. Review of R9's current physician orders signed 12/22/21, revealed R9 received the following medications: -Nystatin Suspension (antifungal medication used to fight infections caused by fungus) 100,000 unit/milliliter (ml) give 5 ml by as needed (PRN) for thrush. -Bupropion Hydrochloride (HCL) (antidepressant) tablet extended release (ER) 24 hour give 150 milligrams (mg) by mouth at bedtime for depressive disorder single episode. Revision date 5/25/21. -Buspirone (Buspar) (antianxiety medication used to treat imbalance of chemicals in the brain) HCL tablet 15 mg tablet give 15 mg by mouth three times a day for depressive major single episode.	21530		

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 12/22/2021

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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21530	Continued From page 66 Revision date 5/25/21. -Venlafaxine (Effexor) (antidepressant medication used to treat imbalance of chemicals in the brain) HCL ER capsule 24 hour 75 mg give 1 capsule by mouth in the morning for depression. Revision date 5/25/21. -Divalproex (Depakote) (used to treat manic depressive disorders) Sodium Capsule Delayed Release Sprinkle 125 mg give 2 capsule by mouth three times a day for major depression/skin eruption. Revision date 5/25/21. -Metformin (decreased blood glucose/sugar levels) HCL tablet 500 mg give my mouth two times a day for DM. R9's Consultant Pharmacist's (CP) Medication Reviews from 6/2021 through 12/2021, identified the following: -6/28/21, No irregularities identified. -7/19/2021, No irregularities identified. -8/26/21, No irregularities identified. -9/22/21, and again on 12/17/21, Nystatin 5 ml PRN. Identified the medication did not include the frequency of use on the medication administration record (MAR). Staff were directed to contact the provider and update the MAR with the intended frequency as soon as possible but no later than 30 days. -10/29/21, No irregularities identified. -11/29/21, Bupropion, Effexor, Depakote, and Buspar had not been reduced recently.	21530		

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 12/22/2021

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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21530	Continued From page 67 Consulting pharmacist (CP)-A suggested a psychiatric nurse practioner should have addressed these medications and if not she could have as soon as possible but no later than 60 days. -12/6/21, Metformin 500 mg tablet take 1 tab by mouth twice a day. R9's most recent AIC (hemoglobin is a protein that carries oxygen form the lungs to the cells of the body that has sugar attached to it) had been 6.1 percent. Staff were directed to repeat the A1C at next lab draw and if similar value consider re-assessing the ongoing need for the metformin. R9's lab review identified 6/9/20, had been the last Hemoglobin AIC that was drawn with results of 6.1 percent. Facility primary physician visit dated 12/22/21, at 1:50 p.m. identified R9 had been in need of blood work and a hemoglobin A1C was then ordered. R9's medical record lacked documentation R9's primary physician was updated or followed up on the CP recommendations. R12 R12's significant change MDS dated 11/13/21, identified R12 had cognition intact and required extensive assitance needed with bed mobility, walking, dressing, toileting, and personal hygiene. The MDS indicated R12's diagnoses included coronary heart disease (CAD), HTN, DM, pneumonia, arthritis, anxiety, depression, and post traumatic stress syndrome (PTSD). The MDS identified R12 received insulin and antidepressants seven of seven days during the look back period.	21530		

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 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21530	Continued From page 68 Review of R12's current physician orders signed 12/28/21, revealed: -Metoprolol Tartrate (used to relax blood vessels, slow heart rate to improve blood flow to decrease blood pressure) tablet 25 mg give 0.5 mg by mouth two times a day for stented coronary artery. -Zolpidem Tartrate (sedative used to treat insomnia and indicated for short term use only) tablet 10 mg give 10 mg by mouth as needed at bedtime for primary insomnia. -Nitroglycerin (used to treat chest pain to increase blood flow to the heart) tablet sublingual give 0.4 mg sublingually every 5 minutes as needed for check pain. R12's CP Medication Reviews from 6/2021 through 12/2021, identified the following: -9/22/21, and again on 10/29/21, Nitroglycerin 0.4 mg SL tab PRN as directed. CP recommended the maximum 3 doses/episode should be included on the medicaion administration record (MAR) no later than 30 days. -10/29/21, Metoprolol Tartrate 25 mg tablets are immediate release and should be ideally administered with meals or directly after meals to increase oral absorption. CP recommended "include food" should have been added to the actions. -10/29/21, Zolpidem 10 mg every bedtime (HS) PRN was used for a psychological condition and needed to be revaluated within the first 14 days of starting. CP recommended in order to continue	21530		

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	00938	A. BUILDING: _____ B. WING _____	C 12/22/2021

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21530	Continued From page 69	21530		

this medication a re-evaluation date to reassess should have been added, medication continued, and then re-evaluate again in 60 days.

-11/29/21, No irregularities identified.

-12/17/21, No irregularities identified.

Monthly CP reviews for June, July, and August 2021, were requested and not provided.

R12's medical record lacked documentation R12's primary physician had been updated or followed up on the CP recommendations.

On 12/22/21, at 10:56 a.m. during a telephone interview, the facility pharmacy consultant, indicated she felt in the past it had been a struggle to get the facility to have the physicians address her pharmacy recommendations in a timely manner. She indicated she had thought R20 had a review completed in August with no recommendations and October she made recommendations to address her comments from September. The pharmacy consultant indicated she expected her pharmacy recommendations to be addressed as soon as possible, but no later than 60 day.

On 12/22/21, at 12:35 p.m. director of nursing (DON) stated she started reviewing the pharmacy recommendations in November 2021, and indicated she was not aware who reviewed them prior to that time. DON confirmed the facility had not followed up on the recommendations from July 2021, September 2021, October 2021, and December 2021 and verified there had been repeated recommendations due to the facility's lack of follow-up.

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21530	Continued From page 70 On 12/22/21, at 12:47 p.m. the director of nursing (DON) indicated she would expect residents medications to be reviewed monthly and would expect pharmacy recommendations to be addressed in a timely manner. The DON indicated the facility had identified issues with pharmacy consultants completing monthly reviews and their recommendations being addressed timely a couple of months ago. She confirmed R20's recommendations from September had not been not addressed until December. A facility policy titled, Pharmacy Medication Review, reviewed 4/3/18, identified it was the facility's policy to have the consultant pharmacist review residents medications for dose reductions to ensure all medications were properly ordered, discontinued and monitored. The policy revealed the facility would ensure the provider would address pharmacy recommendations in a timely manner. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights	21915		2/18/22

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21915	Continued From page 71 Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to organize a family council at least annually. This had the potential to affect all 24 residents in the facility. Findings include: On 12/22/21, at 10:10 a.m. the director of social services, identified the facility did not have a family council group. The director of social services stated prior to 12/20/21, families and residents had not been notified or information regarding a family council group. A family council policy and procedure was requested but was not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could utilize several avenues of communication in attempt to promote a family council. This could include mailing, posting, and verbally requesting family members to consider forming a council. Results could be	21915	1. No single resident was identified in this deficiency. During the week of 12/20/2021 messages were sent to family members for the residents in the facility to give family members a choice to participate in family council. 2.This has the potential to affect all residents that reside at the facility. Audits will ensure that all current and future residents of MRHCC and families will be provided the opportunity to participate in family council every 12 months. Staff were educated on 12/22/21. 3.Audits will be completed by the director of social work or designee every six months for one year until 100% compliance is achieved. 4.Audits will be reviewed by administrator or designee and then further discussion will take place at the next QAPI meeting to review and recommend any necessary changes. 5.02/18/2022	

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21915	Continued From page 72 compiled, and further information provided to persons expressing interest. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21915		