

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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.

Moorhead Restorative Care Center January 21, 2022 Page 6 Sincerely,

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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

	-	& MEDICAID SERVICES				M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DA	TE SURVEY
		245052	B. WING _		1:	C 2/22/2021
	PROVIDER OR SUPPLIER	ARE CENTER		STREET ADDRESS, CITY, STATE, ZI 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
	compliance with Ap Preparedness Requision conducted during a survey. The facility The facility's plan or as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form.	/22/21, a survey for pendix Z, Emergency uirements, §483.73(b)(6) was standard recertification was NOT in compliance. f correction (POC) will serve f compliance upon the otance. Because you are rour signature is not required first page of the CMS-2567				
E 007 SS=C	onsite revisit of you validate substantial regulation has beer EP Program Patien CFR(s): 483.73(a)(	t Population 3)	E 00	)7		2/18/22
	§441.184(a)(3), §4 §483.73(a)(3), §483 §485.68(a)(3), §483 §485.920(a)(3), §485 [(a) Emergency Pla and maintain an em that must be review 2 years. The plan m (3) Address [patient but not limited to, p services the [facility an emergency; and	<ul> <li>16.54(a)(3), §418.113(a)(3),</li> <li>160.84(a)(3), §482.15(a)(3),</li> <li>3.475(a)(3), §484.102(a)(3),</li> <li>5.625(a)(3), §485.727(a)(3),</li> <li>91.12(a)(3), §494.62(a)(3).</li> <li>n. The [facility] must develop hergency preparedness plan wed, and updated at least every hust do the following:]</li> <li>t/client] population, including, ersons at-risk; the type of d) has the ability to provide in continuity of operations, has of authority and succession</li> </ul>				
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 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.

DEDARTMENT OF LIEALTH AND LUMANN SERVICES

		AND HUMAN SERVICES			FOI	RM APF	/14/2022 PROVED 38-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		( )	DATE SU COMPLET	
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NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
MOORHE	AD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) MPLETION DATE
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	Plan. The LTC facil an emergency prep reviewed, and upda plan must do all of t (3) Address resider limited to, persons a LTC facility has the emergency; and co including delegation plans. *NOTE: ["Persons a hospice, PACE, HH RHC/FQHC, or ESI This REQUIREMEN by: Based on interview facility failed to add Preparedness Plan including, but not lin had the potential to currently residing in Findings include: Review of the facilit Plan, revised 3/17/2 population, includin at-risk, the type of s ability to provide in of operations was m	at risk; the type of services the ability to provide in an ntinuity of operations, as of authority and succession at risk" does not apply to: ASC, IA, CORF, CMCH, RD facilities.] NT is not met as evidenced and document review, the ress in their Emergency the patient population mited to, persons at-risk. This effect all 24 residents the facility.			<ol> <li>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</li> <li>All residents have the ability to be affected by the lack of addressing the patient population, the type of services to 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.</li> <li>Education on updating the EPP has been provided to the Physical Plant Director (PPD).</li> </ol>	he	
	-				4. An audit will be done on the patient		

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		AND HUMAN SERVICES			F	ORM	02/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	(X3) DATE SU COMPLET	
		245052	B. WING				22/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	• == /	
MOORHE	EAD RESTORATIVE O	CARE CENTER			310 SECOND AVENUE NORTH IOORHEAD, MN 56560		
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E 007	Continued From pa	ige 2	E 0		population and the type of services th facility has the ability to provide in an emergency will be done weekly x 8 we then monthly for 4 months, until 100% compliance is achieved. These results be sent to QAPI for review	eeks	
	CFR(s): 483.73(e)	TC Emergency Power	E 04	41			2/18/22
	hospital must imple power systems bas forth in paragraph ( policies and proced	on for Participation: standby power systems. The ement emergency and standby sed on the emergency plan set (a) of this section and in the lures plan set forth in ) and (ii) of this section.					
	[LTC facility and the emergency and sta	25(e) standby power systems. The e CAH] must implement ndby power systems based on n set forth in paragraph (a) of					
	Emergency general must be located in requirements found Code (NFPA 99 and Amendments TIA 1 12-5, and TIA 12-6) and Tentative Interi 12-2, TIA 12-3, and	2-2, TIA 12-3, TIA 12-4, TIA ), Life Safety Code (NFPA 101 m Amendments TIA 12-1, TIA I TIA 12-4), and NFPA 110, Ire is built or when an existing					
		.73(e)(2), §485.625(e)(2) tor inspection and testing. The					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		TE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	CO	MPLETED	
		245052	B. WING		12	2/22/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
MOORH	EAD RESTORATIVE C	ARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
E 041	[hospital, CAH and the emergency pow and [maintenance] Health Care Faciliti Safety Code. 482.15(e)(3), §483. Emergency general LTC facilities] that r to power emergence for how it will keep operational during t evacuates. *[For hospitals at §4 and CAHs §485.62 The standards inco section are approver reference by the Di Federal Register in 552(a) and 1 CFR p material from the se inspect a copy at th Center, 7500 Secur or at the National A Administration (NAI availability of this m 202-741-6030, or g http://www.archives _federal_regulation If any changes in th incorporated by refe document in the Fe the changes.	LTC facility] must implement ver system inspection, testing, requirements found in the es Code, NFPA 110, and Life 73(e)(3), §485.625(e)(3) tor fuel. [Hospitals, CAHs and naintain an onsite fuel source by generators must have a plan emergency power systems the emergency, unless it 482.15(h), LTC at §483.73(g), 5(g):] rporated by reference in this ed for incorporation by rector of the Office of the accordance with 5 U.S.C. bart 51. You may obtain the burces listed below. You may be CMS Information Resource rity Boulevard, Baltimore, MD rchives and Records RA). For information on the naterial at NARA, call o to: s.gov/federal_register/code_of is/ibr_locations.html. his edition of the Code are erence, CMS will publish a deral Register to announce otection Association, 1	E 04	41			

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		AND HUMAN SERVICES				FORM	02/14/202 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	_ (X3) DATE S COMPL	
		245052	B. WING	;			_ 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD RESTORATIVE O	CARE CENTER			310 SECOND AVENUE NORTH IOORHEAD, MN 56560		
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	edition, issued Aug						
	<ul> <li>edition, issued August 11, 2011.</li> <li>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</li> <li>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</li> <li>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</li> <li>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</li> <li>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</li> <li>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</li> </ul>						
	(viii) TIA 12-1 to NF 2011.	PA 101, issued August 11,					
	2012.	PA 101, issued October 30, PA 101, issued October 22,					
	2013.	PA 101, issued October 22,					
	2013. (xiii) NFPA 110, Sta	indard for Emergency and stems, 2010 edition, including					
	TIAs to chapter 7, i This REQUIREME	ssued August 6, 2009 NT is not met as evidenced					
	interview, the facilit the emergency gen edition), The Life S				1. No specific residents were ide monthly test of the generator at 3 the generator kilowatt rating was 1/26/22.	0% of done on	
	Emergency and Sta 8.4.2. This deficier	0 edition), Standard for andby Power Systems, section at finding could have a on the 24 residents residing			2.All residents can be affected by of proper monthly generator testin 30% of the generator kilowatt ratii Generator testing has been comp protect all residents	ng at ng.	
	Findings include:				3.Education on proper monthly get testing has been provided to the F Plant Director (PPD).		
	review of available inspection docume	11:13 AM, it was revealed by a emergency generator test and ntation and an interview with Director (PPD), that the facility			4. An audit will be done to ensure proper documentation of monthly generator tests at 30% of the gen kilowatt rating will be done weekly	erator	

Facility ID: 00938

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COI	MPLETED
		245052	B. WING		12	C / <b>22/2021</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
MOORH	EAD RESTORATIVE (	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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	verifying that the er	r document information nergency generator had be 0 percent of the generator		weeks then monthly for 4 mo 100% compliance is achieve results will be sent to QAPI fo	d. These	
F 000	at the time of disco	,	F 000	)		
	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.					
	SUBSTANTIATED H5052149C (MN79 and F686 H5052157C (MN58 H5052162C (MN56	plaints were found to be 2264) with deficiencies at F677 3048) with deficiency at F686 3564) with deficiency at F677 3347) with deficiency at F686				
	AND The following comp SUBSTANTIATED H5052154C (MN74 H5052155C (MN62 H5052156C (MN55 H5052158C (MN55 H5052159C (MN55 H5052160C (MN55 H5052161C (MN55 H5052164C (MN55)	4674) 2868) 2623) 7537) 7152) 7071) 5989)				

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		AND HUMAN SERVICES				FORM	: 02/14/2022 APPROVED : 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	CON	E SURVEY IPLETED C	
		245052	B. WING				22/2021	
NAME OF I	PROVIDER OR SUPPLIER	1	<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE			
MOORHI	EAD RESTORATIVE O	CARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560					
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	implemented by the AND The following comp UNSUBSTANTIATE H5052150C (MN78 H5052151C (MN74 H5052153C (MN74 The facility's plan o as your allegation of Departments accep enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an onsite revisit of you validate that substa regulations has bee Notify of Changes ( CFR(s): 483.10(g)( §483.10(g)(14) Not (i) A facility must im consult with the res consistent with his of representative(s) w (A) An accident inverse mental, or psychos deterioration in heat	e facility prior to survey: plaints were found to be ED: 3262) 3159) 3974) 3902) f correction (POC) will serve of compliance upon the brance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ar facility may be conducted to antial compliance with the en attained. (Injury/Decline/Room, etc.) 14)(i)-(iv)(15) ification of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident then there is- olving the resident which I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or	F 04				2/18/22	

Facility ID: 00938

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED C	
		245052	B. WING				22/2021
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD RESTORATIVE C	CARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 7	F 5	580			
		treatment significantly (that is, ue an existing form of					
	<ul> <li>a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</li> <li>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</li> <li>(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.</li> <li>(iii) The facility must also promptly notify the resident and the resident representative, if any,</li> </ul>						
	as specified in §483 (B) A change in res	ident rights under Federal or					
	(iv) The facility mus update the address	State law or regulations as specified in paragraph e)(10) of this section. iv) The facility must record and periodically pdate the address (mailing and email) and hone number of the resident epresentative(s).					
	that is a composite §483.5) must disclo its physical configur locations that comp part, and must spec room changes betw under §483.15(c)(9	nposite distinct part. A facility distinct part (as defined in ose in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to veen its different locations ). NT is not met as evidenced					
	by: Based on interview facility failed to ens	/ and document review, the ure the physician was notified in condition for 1 of 2 residents			1. On 12/21/22 R8⊟s care plan wa reviewed and updated. On 12/22/2 primary physician was contacted to	2 R8⊟s	

		AND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVE
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	СОМ	E SURVEY PLETED
		245052	B. WING _			22/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
MOORH	EAD RESTORATIVE O	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	Findings include: R8's quarterly Minir 10/26/21, identified decision making an included cerebrova hemiparesis (weak (inability to speak of dependence. The M behavior concerns one staff for activiti cares. R8's care plan revis a substance abuse dependent as evide judgement and poor plan instructed staff associated with drin activities and monit beverages were no identified if staff sus staff were to contact monitoring and mer- care plan further in- acetaminophen, ga	age 8 notification of change. mum Data Set (MDS) dated R8 was independent with nd had diagnoses which scular accident (stroke), ness on one side), aphasia or find words) and alcohol MDS indicated R8 had no and required the assistance of es of daily living (ADL's). sed 5/27/21, identified R8 had disorder and was alcohol enced by history, with impaired or impulse control. The care if to educate R8 on the risk nking alcohol, encourage tor R8 to ensure alcoholic ot consumed. The care plan spected alcohol intoxication, ct the provider for increased dication hold parameters. The structed staff to hold aspirin, abapentin (pain medication), ure medication) and	F 58	<ul> <li>the orders of medications be Order was obtained and upd current order. Clarification al on time hold of medications glucose perimeters.</li> <li>2. This physician notification potential to affect all residen charts will be audited to ensu providers are notified if a cha condition has occurred.</li> <li>In addition, nursing staff wer beginning on 1/26/22 on notifications what constitutes a change in and when provider should be 3. Audits will be performed of notifications will be done wer weeks then monthly for 4 mo 100% compliance is achieved 4. Audits will be reviewed by or designee and then further will take place at next QAPI review and recommend any changes necessary.</li> <li>5. 02/18/22</li> </ul>	ated to reflect so received and blood has the ts. All resident ure that ange in e educated fication and condition e notified. on physician ekly x 8 onths, until ed. administrator discussion meeting to	
	intoxicated. The ca complete room che different times of th intervene if they ob R8's Order Summa signed by the provi included when R8 v	lepressant) when R8 was re plan identified staff were to ecks weekly for alcohol at ne week and staff were to served alcohol. ary Report dated 12/21/21, der identified current orders was intoxicated staff were to minophen, gabapentin, and				

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	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MI II T		ONSTRUCTION		<u>). 0938-039</u> TE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:			JNSTRUCTION		MPLETED	
			-				С	
		245052	B. WING			12/22/2021		
NAME OF I	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CO	DDE		
MOORHI	EAD RESTORATIVE (	CARE CENTER			SECOND AVENUE NORTH RHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	{	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 580	Continued From pa	age 9	F 58	80				
		eport instructed staff to monitor / hour when R8 was						
		parameters for the length of ation or to complete hourly s.						
	Review of R8's pro 12/21/21, revealed	gress notes from 9/8/21, to the following:						
	- 9/30/21, at 8:37 p.m. the nurse direct care staff R8 appeared int indicated a friend had provided h visiting. The note identified the n R8's vital signs which were within and noted R8 was alert and orien lacked evidence the provider had any medications had been held a had been monitored as ordered.	B appeared intoxicated and R8 had provided him a drink while dentified the nurse assessed ich were within normal limits alert and oriented. The note e provider had been updated, ad been held and blood sugars						
	8:00 p.m. R8 was r went to administer another resident's in a pop bottle. The and not oriented. R and the nurse adm	5 p.m. the note identified at not in his room when the nurse R8's insulin. R8 was found in room drinking drinks that were e note identified R8 to be weak R8 agreed to take his insulin inistered. The supervisor was notition as the room smelled of						
	alcohol. The nurse had been drinking drinks were taken t into the sink. Both the room with the li a bed so staff were able to assist R8 to	asked both residents if they and they both denied. The from both residents and poured residents shut themselves in ights off and door supported by a not able to enter. Staff were b bed after the nurse was able 88 had been noted to be						

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		E & MEDICAID SERVICES	1			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245052	B. WING _		12	C / <b>22/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	•	· [	STREET ADDRESS, CITY, STATE, ZIP CC	DE	
MOORHI	EAD RESTORATIVE	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	medications had be been monitored ho Review of R8's me from 9/1/21, to 12/2 -September 2021, i medication had be sugars had been c -November 2021, i medication had be sugars had been c During an interview licensed practical r were expected to c impairment. LPN-/ suspected of drink completed an incid vital signs. LPN-A checks were expect stated she had only about two months interventions for Ra During an interview LPN-D indicated on impaired and smel contacted the direct received instruction stated he was unst	een held and blood sugars had burly. dication administration records 21/21 revealed the following: identified on 9/30/21, no en held or additional blood hecked. dentified on 11/24/21, no en held or additional blood hecked. w on 12/21/21, at 10:37 a.m. hurse (LPN)-A identified staff observe R8 for signs of alcohol A revealed if R8 had been ing alcohol she would have lent report and checked R8's stated she was unaware room cted to be completed. LPN-A y been working in the facility for and was not aware of any other				

Facility ID: 00938

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			
		245052	B. WING			C 12/22/2021	
NAME OF	PROVIDER OR SUPPLIER						
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 11	F 5	80			
F 677 SS=D	DON indicated R8 H DON stated staff we provider, follow the ca was suspected to b she had been notifie and had instructed and monitor R8. DO notified the provider intoxicated for furth R8's order for holdin hourly blood sugars being impaired had During an interview nurse practitioner (H primary provider an with R8 the risks as stated she expected further direction wh confirmed she had 11/24/21, incident. the orders to hold F hourly blood sugars A policy on change and not provided. ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A res out activities of daily services to maintair personal and oral h	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and	F 6	77			2/18/22

Facility ID: 00938

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TATEMEN	OF DEFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	. ,		(X3) DAT	0938-039 E SURVEY PLETED
		245052	B. WING			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/.	22/2021
	EAD RESTORATIVE (			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 677	Based on observa review, the facility is assistance for 1 of dependent on facil Findings include: R20's Significant C (SCSA) Minimum I 11/20/21, identified included diabetes, vascular disease. intact cognition and with activities of da mobility, transfers, R20's SCSA Care A 11/20/21, identified assistance with AD mobility, transfers a related to recent C medical conditions diabetes, valgus de foot/ankle) and chr R20's current care R20 had poor men with dementia, and of two staff with be and grooming. R20 indication of R20's removal. R20's Visual/Bedsi assistant care guid R20 required exter bathing and persor	tion, interview and document failed to provide shaving 1 resident (R20) who was ity staff for grooming. Change of Status Assessment Data Set (MDS) dated I R20 had diagnoses which Osteoarthritis and peripheral The MDS identified R20 had d required extensive assistance aily living (ADL's) of bed toileting and personal hygiene. Area Assessment (CAA) dated I R20 required extensive DL's which included bed and had a decline in condition OVID-19 diagnosis, and other such as heart failure, eformity (deformity of	F 67	<ul> <li>1.R20 was identified as not having facial hair removed. Resident disters shortly after survey. Nursing staffed ucated on 01/26/2022 regarding resident cares.</li> <li>2.All residents have the potential affected in this area. This includes female and male residents. Nurse educated beginning on 1/26. Auce performed to ensure other residen not affected by this practice and or plans will be updated will residen preferences as interviews are constructed.</li> <li>3.Audits will be performed on groweekly x 8 weeks then monthly formonths, until 100% compliance is achieved.</li> <li>4.Audits will be reviewed by adm or designee and then further discowill take place at next QAPI meet review and recommend any nece changes necessary.</li> <li>5.02/18/2022</li> </ul>	charged were g to be s both es were its will be nts are care t nducted. oming or 4 s nistrator ussion ing to	

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		AND HUMAN SERVICES			F	NTED: 02/14/2022 ORM APPROVED B NO. 0938-0391
STATEMEN	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		(3) DATE SURVEY COMPLETED
		245052	B. WING _			C 12/22/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		
MOORH	EAD RESTORATIVE C	ARE CENTER		2810 SECOND AVENUE NOR MOORHEAD, MN 56560	8TH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE	
F 677	On 12/20/21, at 12: laying in bed, on his his eyes were open coarse facial hair a (5) millimeters (mm cheeks, chin, upper On 12/20/21, at 4:4 interview with R20's indicated R20 was she came to visit. F declined both physi arrival to the facility prior. FM-A stated p hospital and subset he used to be well g On 12/21/21, at 10: laying in bed on his upper lip, neck and covered with thick v mm long facial hair bed, proceeded to cares, and left his r assistance with fact - at 11:22 a.m. R20 the side of his bed, positioned in front of his right hand. R20' with a white sheet, feet. R20's cheeks, line continued to be coarse facial hair 3 - at 2:40 p.m. R20 v back in his bed, cov mid lower legs to his	<ul> <li>39 p.m. R20 was observed</li> <li>39 p.m. R20 was observed</li> <li>a back, faced the television,</li> <li>ed and he had thick white</li> <li>pproximately three (3) to five</li> <li>in length, which covered his</li> <li>r lip, jaw line and neck.</li> <li>5 p.m. during a telephone</li> <li>a family member (FM)-A,</li> <li>oftentimes disheveled when</li> <li>M-A stated she felt R20 had</li> <li>cally and cognitively since his</li> <li>approximately four months</li> <li>prior to R20's admission to the</li> <li>quent admission to the facility,</li> <li>groomed.</li> <li>15 a.m. R20 was observed</li> <li>back, R20's cheeks, chin,</li> <li>jaw line continued to be</li> <li>white coarse facial hair 3-5</li> <li>(NA)-C stood next to R20's</li> <li>assist him with incontinence</li> <li>oom without offering</li> </ul>	F 67	77		

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		AND HUMAN SERVICES				FORM	APPROVED
							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
					·		C
		245052	B. WING				22/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C			2	2810 SECOND AVENUE NORTH		
					MOORHEAD, MN 56560		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 677	• · · · · · · · · · · · · · · · · · · ·	•	F 6	77	·		
		white coarse facial hair 3-5					
	mm long facial hair						
	On 12/22/21, at 7:0	7 a.m. R20 was observed					
		n bed, covered with a sheet					
		nis torso. R20's cheeks, chin,					
		jaw line continued to be					
		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 re	equired extensive assistance					
		ressing, personal hygiene, and					
		to recall information. NA-C not aware of R20's shaving					
		not offer to assist him with					
	facial hair removal.						
		00 a.m. during an interview,					
		equired extensive assistance indicated R20's cognition					
		coarse of the day. LPN-A					
		aware of R20's preference for					
	facial hair removal.						
	0.40/04/04.444						
		40 a.m. during an interview, ) required extensive					
		mobility, transfers and					
		cated R20's cognition would					
		ourse of the day and his					
	needs should have	been anticipated.					
	On 12/21/21 at 12.	46 p.m. during a telephone					
		s family member (FM)-B					
		oncerns with R20's cares not					
		utinely and R20's recent					
		. He indicated R20 appeared					
		en and generally unclean <i>I</i> -B indicated R20 used to take					

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245052	B. WING				C <b>22/2021</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH NOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 15	F6	677			
	shaven on his head	oming, and used to be clean I and face. FM-B stated he felt I if he looked disheveled.					
	LPN-C stated R20 his cares and felt R	9 p.m. during an interview required assistance with all of 20 had a poor memory and ion would fluctuate over the					
	trained medication a required extensive except for eating, h TMA-B stated she f was not always able	8 p.m. during an interview a aid (TMA)-B stated R20 assistance with all cares e required set up assistance. felt R20 had memory loss and e to recall events or his needs. ne believed R20 was assisted aily.					
	NA-B stated R20 w ADL's and felt he has month, following his stated she felt R20 always able to reca indicated R20 used always able to reca needs were to be a preferred to be clear	4 a.m. during an interview as totally dependent for his ad declined within the past s COVID-19 illness. NA-B had memory loss and was not ll instructions or events. She his call light, but was not ll what he wanted and his nticipated. NA-B indicated R20 an shaven and should have facial hair removal daily.					
	(DON) indicated sh preference for facial stated R20's cognit overall declining sin COVID-19. The DC R20's shaving prefe	47 p.m. the director of nursing e was not aware of R20's al hair removal. The DON ion had been fluctuating and nee November when he had DN indicated she expected erence to be identified and asist with facial hair removal if					

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		AND HUMAN SERVICES			FORM	): 02/14/2022 1 APPROVED ): 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	TE SURVEY MPLETED C
		245052	B. WING			/22/2021
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY,		
MOORHI	EAD RESTORATIVE O	CARE CENTER		2810 SECOND AVENUE MOORHEAD, MN 56		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From pa he desired.	ige 16	F6	77		
	provided.	requested, one was not Prevent/Heal Pressure Ulcer 1)(i)(ii)	F6	86		2/18/22
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that if (ii) A resident with p necessary treatmen with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review the facility fa comprehensively as implement pressure of 1 resident (R20) worsening pressure caused actual harm three (3) pressure of unstagable ulcer, d pressure ulcer on th unstagable lateral r worsened in size.	sure ulcers. prehensive assessment of a must ensure that- res care, consistent with ards of practice, to prevent d does not develop pressure idividual's clinical condition they were unavoidable; and pressure ulcers receives int and services, consistent andards of practice, to revent infection and prevent		lacking measure subsequently dis shortly after surv 2.All residents ha develop skin imp reviewed. Nursin 01/26/2022 regat and wound meas education will con tests to determin on wound care w measurements of assessments are	charged from the facility	

Facility ID: 00938

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			0.00			0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED		
		245052	B. WING _			C <b>22/2021</b>		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP				
MOORHI	EAD RESTORATIVE	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 686	Continued From pa	age 17	F 68	6				
	present but does n loss. May include u	s not exposed. Slough may be ot obscure the depth of tissue undermining or tunneling		<ul> <li>weekly x 8 weeks then monomorphic months, until 100% complication</li> <li>achieved.</li> <li>4.Audits will be reviewed be or designee and then further</li> </ul>	ance is y administrator			
	Unstagable ulcer; wound bed cannot be visualized due to the presence of slough or eschar Slough; non-viable yellow, tan, gray, green or		will take place at next QAP review and recommend an changes necessary. 5.02/18/2022	I meeting to				
	brown tissue; usua and mucinous in te	Illy moist, can be soft, stringy exture. Slough may be adherent wound or present in clumps		0.02/10/2022				
	hard or soft in textu tan in color, and m tissue and eschar	d or devitalized tissue that is ure; usually black, brown, or ay appear scab like. Necrotic are usually firmly adherent to und and often the sides/edges						
	Findings include:							
	(SCSA) Minimum I 11/20/21, identified included diabetes, vascular disease. intact cognition and with activities of da	Change of Status Assessment Data Set (MDS) dated I R20 had diagnoses which osteoarthritis and peripheral The MDS identified R20 had d required extensive assistance hily living (ADL's) of bed toileting and personal hygiene.						
	The MDS identified developing pressur had the following p in place; pressure and application of	A R20 was at risk for re ulcers and identified R20 pressure relieving interventions relieving device for chair, bed, non-surgical dressings and ions to areas other than feet.						

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDI	NG			
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	810 SECOND AVENUE NORTH		
MOORH	EAD RESTORATIVE C	ARE CENTER		N	MOORHEAD, MN 56560		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	V	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RATE	DAIL
			1		/		
F 686	Continued From pa	ae 18	F 6	86			
		-					
		Area Assessment (CAA) dated					
		R20 required extensive					
		L's which included bed and R20 had a decline in					
		recent COVID-19 diagnosis,					
		conditions such as heart					
		arus deformity (deformity of					
		the lateral part of the foot					
		and chronic pain. The CAA					
		admitted to the facility with a					
		y to his left heel and right					
		received daily dressing					
		identified the following nterventions were in place;					
		ting device to bed, wheelchair					
		fer repositioning periodically					
		er, the CAA identified R20's					
		ked weekly by licensed staff.					
		y characteristics of R20's					
		ch as stage, tissue type,					
		l any signs of healing or					
	worsening.						
	P20's modical ross	rd lacked any further					
	comprehensive skir						
	R20's current core	plan revised 12/9/21, revealed					
		ory, was recently diagnosed					
		required extensive assistance					
		d mobility, transfers and					
		plan revealed R20 had a					
		re ulcer development, had					
	open wounds on his	s legs, and feet. R20's care					
		s the bilateral unstageable					
		s, use of a pressure					
		e to bed or wheelchair, or					
		lically with toileting or list any					
	pressure relieving in						

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	-	AND HUMAN SERVICES					FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIP	LE CONSTRUCTION	0		E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	l` í					PLETED
								C
		245052	B. WING					22/2021
NAME OF F	PROVIDER OR SUPPLIER		·	ę	STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
мооры	EAD RESTORATIVE C			2	2810 SECOND AVENUE NORTH			
	LAD RESIDRATIVE C	ARE CENTER		I	MOORHEAD, MN 56560			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF COR			(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A			COMPLETION DATE
		,			DEFICIENCY)			
			1					
F 686	Continued From pa	ge 19	F 6	86	3			
		de Kardex Report (nursing						
		e) dated 12/21/21, lacked any nterventions for staff to follow.						
	pressure relieving li							
	R20's current physi	cian orders signed 12/21/21,						
	revealed the followi							
		104 fee Desurtee basts						
		/21, for Prevalon boots re relieving boots) on right						
		to keep the Prevalon boot on						
		may remove to walk, one time						
	daily.	-						
	order dated 12/2/2	1 electron loss and fact with						
		21, cleanse legs and feet with iter. Apply Aquaphor (lotion) to						
		en wounds with Adaptic ( is a						
	•	esigned to help protect the						
		nting the dressing from						
		und.) Wrap entire leg (foot to						
		llowed by ace wrap in a figure ge daily and prn (as needed)						
	every day shift for u							
		41 a.m. R20 was interviewed,						
		a sore on his right foot that						
		nd indicated his left foot sore vas admitted to the facility.						
		changed subjects, talked						
	about many random	n topics and was unable to						
		stion or provide any more						
	information.							
	On 12/20/21 at 12.	39 p.m. R20 was observed						
		s back, faced the television.						
	Both of R20's feet r	ested directly on a regular						
		with ACE bandages and were						
		er socks. R20's left foot toes nst the footboard of his bed						
1	wore pressed again							

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY
/					3		C
		245052	B. WING	_		12/:	22/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD RESTORATIVE C				2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	and his right foot re lateral aspect of his On 12/21/21, at 10: laying in bed on his (NA)-C stood next t and proceeded to a cares. R20's bilater feet to his knees wi gripper socks on his cares, NA-C was of heels to help boost placed both heels of assisted NA-C to m head of his bed. R20 wrapped feet on the aspect of his right fo standard mattress. offer R20 pressure offer use of his Prev - at 10:45 a.m. R20 on his back, his bar his bed. R20's left h standard mattress a mattress, directly of At that time, license observed to cleanse proceeded to comp to his anterior left fo two ulcers on the la LPN-A donned clea R20's feet, was not R20's feet, R20's left his right foot rested mattress.	<ul> <li>asted on the mattress on the a foot.</li> <li>15 a.m. R20 was observed back, nursing assistant to R20's bed, on his left side assist R20 with incontinence al legs were wrapped from his th ACE bandages and he wore s feet. Following incontinence baserved to tell R20 to use his him up in bed. R20 then on the mattress of the bed, and nove himself up towards the 20 then rested both of his ACE e bed, his left heel and lateral oot rested directly on the NA-C was not observed to relief to his feet, nor did she valon boots.</li> <li>was observed laying in bed re legs and feet were visible on heel was laying directly on his and his right foot rested on the n the lateral aspect of his foot. As a spect of his right foot. In gripper socks to both of observed to elevate or offload of theel and lateral aspect of his right foot. In gripper socks to both of observed to elevate or offload of theel and lateral aspect of directly on the standard</li> </ul>	F 6				
	mattress. -at 11:22 a.m. R20	was observed seated on the an over the bed table					

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY IPLETED
		245052	B. WING				C <b>22/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	I		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,                                     </u>	
MOORHI	EAD RESTORATIVE O	CARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	positioned in front of on both feet, his rig lateral aspect of his floor. - at 2:40 p.m. R20 y back in his bed, com mid lower legs to his	of him, he wore gripper socks ht leg was inverted and his foot rested directly on the was observed lying on his vered with a sheet from his is upper torso. R20's left heel of his right foot rested directly	Fθ	86			
	NA-C stated R20 re with bed mobility, tr personal hygiene. N to help turn himself move him up in bee open ulcers on both would have drainag leave spots on R20 felt R20 had a poor would fluctuate over 12:08 p.m. during a indicated R20 wore he was in bed and	225 a.m. during an interview equired extensive assistance ransfers, dressing and NA-C indicated R20 was able and used his feet to help d. NA-C indicated R20 had n of his feet which oftentimes ge coming from them and d's sheets. NA-C indicated she memory and his cognition er the course of the day. At a follow up interview, NA-C e Prevalon boots at night when was not aware of any pressure ons in place such as elevating					
	LPN-A stated R20 m with his ADL's and fluctuated over the indicated R20 requ his bilateral foot uld since R20's admiss indicated she comp daily and felt the an drainage present of	00 a.m. during an interview, required extensive assistance indicated R20's cognition course of the day. She ired daily dressing changes to ærs, which had been present sion to the facility. LPN-A oleted R20's dressing changes eas were improving by less n his old dressings LPN-A complete R20's ulcer					

Facility ID: 00938

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C	ARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	measurements or a bilateral foot press a wound clinic and 12:10 p.m. during a stated R20 was sup when he was in bed LPN-A indicated shi foot ulcers were pre R20 had no pressur place. On 12/21/21 at 11:4 NA-A indicated R20 assistance with bed dressing. NA-A indi- dressings to his fee indicated she thoug boots but was not s able to move his ex of any pressure reliv On 12/21/21, at 12: interview with R20's indicated he had co- being completed ro decline in cognition chronic foot ulcers to deformity, though w foot ulcers to his lef recently notified by by a podiatrist for for had concerns R20 I and stated he had r boots or his feet off On 12/21/21, at 2:4 was reviewed with th had pressure ulcers	Assessments, believed R20's ure ulcers were monitored by R20's primary physician. At follow up interview, LPN-A oposed to wear Prevalon boots d, but refused to wear them. e did not feel R20's bilateral essure related and confirmed re relieving interventions in	Fθ	\$86			

If continuation sheet Page 23 of 75

	OF DEFICIENCIES						. 0938-039
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· /	TE SURVEY MPLETED
				<u> </u>			С
		245052	B. WING			12	/22/2021
NAME OF F	ROVIDER OR SUPPLIER	R		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	AD RESTORATIVE	CARE CENTER			0 SECOND AVENUE NORTH DORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIOI DATE
F 686	Continued From p	age 23	F 6	86			
		N stated she believed R20 was					
		cility with the lateral right foot					
		as not sure if R20's left heel upon his admission. The DON					
		expect R20's left heel and right					
		rs to be assessed weekly,					
		le measurements, wound					
		dications of healing, and current , the DON confirmed R20's					
		dentify any pressure relieving					
	interventions in pla	ace for R20's bilateral foot					
		t that time, a request was made	•				
	foot pressure ulce	ssess R20's left heel and right					
		rvation was conducted with					
		) was observed laying on his					
		ft heel and his right lateral were laying directly upon R20's					
		eft upper foot and toes were					
		e foot board of his bed. The					
		feet did not have any pressure					
		indicated she would need to ssist her to boost R20 up in bec	1				
		sure from his left foot. At 3:06	•				
		d R20's room, the DON stood					
		f R20's bed took hold of a lift					
		Inderneath R20's mid-body. the lift sheet on the left side of					
		I NA-E encouraged R20 to					
		he bed and push to assist to					
	•	20's left heel and right lateral pressed against the mattress as	2				
		up in bed. NA-E immediately					
	left R20's room. The	he DON proceeded to remove					
	R20's ACE wraps	and dressings for e following was observed;					
	mageuramente th	A TANAWING WAS ABSANIAD		1			1

Facility ID: 00938

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` ´			(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		245052	B. WING	i		C 12/22/2021	
NAME OF PROVIDER OR	SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHEAD RESTO	RATIVE	CARE CENTER			810 SECOND AVENUE NORTH NOORHEAD, MN 56560		
PREFIX (EACH D	DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
unstagable centimeter slough tiss 0.2 by 0.2 presented the pressu had opene foot pressu slough tiss - R20's left purulent dr pressure u and was co eschar tiss pressure u size and a visualized - R20's late drainage a ulcer which dark reddis DON confi had worse wound bec due to the The DON of ulcers had wear the P R20 had n interventio ulcers. On 12/22/2 laying on h	yellow/gr e pressur s (cm) by sue on the cm. with with epiti ire ulcer s ed. The D ure ulcer sue and h t heel, ha rainage a ulcer whice overed w sue. The ulcer had wound b due to th eral right ind revea h measur sh/brown rmed R2 ned by a d was no thick, da confirme worsene Prevalon I o current ns in place	reenish) and revealed an re ulcer which measured 3.0 y 2.0 cm and had an area of e wound bed that measured the remaining wound bed helial tissue. The DON stated started as a blood blister which OON confirmed R20's top left had worsened in size, had had purulent drainage. ad a minimal amount of and revealed an unstagable ch measured 1.3 cm by 1.2 cm <i>v</i> ith thick, hard, dark brown DON confirmed R20's left heel d worsened by an increase in bed was no longer able to be	F	586			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	(X2) MUI			<b>IB NO. 0938-0391</b> (X3) DATE SURVEY	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:					PLETED
			_			с	
		245052	B. WING			12/22/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	:	
моория	EAD RESTORATIVE C			2	810 SECOND AVENUE NORTH		
	AD RESTORATIVE C	ARE CENTER		N	MOORHEAD, MN 56560		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
		,			DEFICIENCY)		
F 686	Continued From pa	ge 25	F 6	86			
		s right foot rested directly on					
	the standard mattre	SS.					
	Review of R20's no	diatry progress notes from					
		1, revealed the following:					
		-					
	· · ·	d with an ulcerated right foot,					
		y, a stage 3 decubitus ulcer of					
		ormity (deformity of foot/ankle part of the foot faces					
		nt ankle and chronic					
		tion of the bone) involving					
	ankle and foot. The	e note revealed R20's right foot					
		and recommended an MRI					
		ce imaging) and a Prevalon					
		ot for the right foot to protect					
	from pressure.						
	- 10/5/21, seen for a	a follow up visit. The note					
	revealed R20 had s	swelling and redness of the					
		ecommended to prevent R20					
		ire on his feet. The note lacked					
		out R20's unstagable left heel op of left foot pressure ulcer.					
	pressure dicer or to	p of left loot pressure dicer.					
	- 12/16/21, seen for	r a follow up visit of his lateral					
	right foot. Note reve	ealed R20's lateral right foot					
		shallow and appeared					
		vious visit. The note revealed					
		phasized the need to get all					
		lateral foot. The note lacked out R20's unstagable left heel					
		op of left foot pressure ulcer.					
		s lacked any further					
		ne status or progress towards					
	ulcer.	of R20's left heel pressure					

If continuation sheet Page 26 of 75

CENTERS FOR MEDICARE & MEDICAD SERVICES     OME NO. 0938-0391       STATEMENT OF DEFICIENCIES     OVI) PROVIDERUPURENCULA     (22) MULTIPLE CONSTRUCTION     (23) DATE SUMMEY       AND PLAN OF CORRECTION     245052     STREET ADDRESS, CTY, STATE, 2P CODE     C       IMMOORHEAD RESTORATIVE CARE CENTER     STREET ADDRESS, CTY, STATE, 2P CODE     C     12/22/2021       MOORHEAD RESTORATIVE CARE CENTER     STREET ADDRESS, CTY, STATE, 2P CODE     C     C       TAG     SUMMARY STATEMENT OF DEFICIENCIES     D     PREFIX     CROSHENCE TO THE APPROPRIATE     COMENCI ON SHOULD BE       TAG     SUMMARY STATEMENT OF DEFICIENCIES     D     PREFIX     CROSHENCE TO THE APPROPRIATE     COMENCI ON SHOULD BE       TAG     SUMMARY STATEMENT OF DEFICIENCIES     D     PREFIX     CROSHENCE TO THE APPROPRIATE     COMENCI ON SHOULD BE       TAG     SUMMARY STATEMENT OF DEFICIENCIES     D     PREFIX     CROSHENCE TO THE APPROPRIATE     COMENCI ON SHOULD BE       TAG     SUMMARY STATEMENT OF DEFICIENCIES     D     PREFIX     CROSHENCE TO THE APPROPRIATE     COMENCI ON SHOULD BE       TAG     SUMMARY STATEMENT OR INFORMATION     PREFIX     CROSHENCE TO THE APPROPRIATE     COMENCION       F 686     Continued From page 26     R     F 686     Continue State, presence of this left heal undor indication of depth. The wound evaluation lacked any characteristics of R20's left heal undo			AND HUMAN SERVICES				FORM	APPROVED	
AND PLAN OF CORRECTION     DENTIFICATION NUMBER:     A BUILDING     COMPLETED       AND OF PROVIDER OR SUPPLIER     245052     B. WING     COMPLETED       MOORHEAD RESTORATIVE CARE CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE     2810 SECOND AVENUE NORTH       MOORHEAD RESTORATIVE CARE CENTER     SIMMENT STATEMENT OF DEFICIENCES     PREFIX     TAGE       PREFIX     SUMMANY STATEMENT OF DEFICIENCES     PREFIX     PREVIX OR USE CODE VENUE       F 686     Continued From page 26     PREVIX OR USE IDENTIFING INFORMATION)     F 686       Review of R20's facility Skin and Wound     Evaluation from 30121, to 10/12/21, revealed the following:     F 686       -8/31/21, indicated R20 had a diabetic ulcer of his left theel which measured 0.6 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 was healing or had worsened.       -3/31/21, 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 left heel ulcer swound bed, presence of pain, current treatment, and interventions. Further, R20's wound bed, presence of pain, current treatment, R20's left heel ulcer swound evaluation in adked any characteristics of R20's left heel ulcer was healing or had worsened.       -9/21/21, indicated R20 had a diabetic ulcer on the wound evaluation lacked any characteristics of R20's left heel ulcer was healing or had worsened.       -9/21/21, indicated R20 had a diabetic ulcer on his left heel which measured 0.6 cm by 0.4 cm and had n									
245052     B. WIND     C     C       MAUE OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2/P CODE     2310 SECOND AVENUE NORTH       MOORHEAD RESTORATIVE CARE CENTER     STREET ADDRESS, CITY, STATE, 2/P CODE     2310 SECOND AVENUE NORTH       PARTIN     ISUMMARY STATEMENT OF DEFICIENCIES     2010 SECOND AVENUE NORT CORRECTION     000       PREFIX     ISUMMARY STATEMENT OF DEFICIENCIES     000     000     000       IPACH DEFICIENCY ON USE TO EXPRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     010     000     000     000       F 686     Continued From page 26 Review of R20's facility Skin and Wound Evaluation from 8/31/21, to 10/12/21, revealed the following;     F 686     F 686     F     686       -9/31/21, indicated R20 had a diabetic ulcer of his left heel which measured 0.8 cm long by 0.5 cm wide an had no indication of depth. The wound evaluation lacked any characteristics of R20's left heel ulcer whether R20's left heel ulcer developed or whether 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 of 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 oright foot ulcer was healing or had worsened.     -9/21/21, indicated R20 had a diabetic ulcer of this left heel which measured 0.6 cm by 0.4 cm and had no indication of depth. The wound evaluation id not identify whether R20's wound evaluation of the ulcer's wound bed, presence of pain, current treatment, and interventions. Further, R20's wound evaluation id achet									
245052     B. WING     12/22/021       INME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY. STATE. JP CODE     2010       PARTINE OF RESTORATIVE CARE CENTER     STREET ADDRESS. CITY. STATE. JP CODE     2010       PARTINE RESTORATIVE CARE CENTER     STREET ADDRESS. CITY. STATE. JP CODE     2010       PARTINE RESTORATIVE CARE CENTER     STREET ADDRESS. CITY. STATE. JP CORE     COMPLETON       PREFIX     SUMMARY STREEMENT OF DEFICIENCIES     PREFIX     PREFIX     COMPLETON       PREFIX     REGULATORY OR LSC IDENTIFYMON INFORMATION)     TAG     PREFIX     COMPLETON       F 686     Continued From page 26     F     PREFIX     F     F     Construction from S12/21, to 10/12/21, revealed the following;     F     686       -8/31/21, indicated R20 had a diabetic ulcer of his left heel which measured 0.8 cm long by 0.5 cm wound evaluation indicked any characteristics of R20's left heel ulcer swonad evaluation indication of depth. The wound evaluation indicked any characteristics of 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 indicked any characteristics of R20's sight foot ulcer, such as a description of the ulcer's wound evaluation acked any characteristics of R20's origin to ulcer's wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventons. Further, R20's wound evaluation idd not identify whether R20's left heel ulcer was healing or had worsened.     -9/21/21, indi				_			С		
MME OF PROVIDER OR SUPPLIER         STREET ADDRESS. CITY, STATE, 2P CODE           MOORHEAD RESTORATIVE CARE CENTER         28105           (M1)D PRETX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         10 PREVEX PREVEX TAG         PROVIDER'S FLAN OF CORRECTIVE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         00 PREVEX PREVEX TAG         PROVIDER'S FLAN OF CORRECTIVE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         00 PREVEX PREVEX TAG         00 PREVEX PREVEX PROVIDER'S FLAN OF CORRECTIVE TAG         00 PREVEX PROVIDER'S FLAN OF CORRECTION (EACH ORRECTIVE ACTION NEARING IN IEACH ORRECTIVE ACTION NEARING IN IEACH ORRECTIVE ACTION NEARING IN IEACH ORRECTIVE ACTION INFORMATION)         00 PREVEX PREVEX TAG           F 686         Continued From page 26 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 the elucer such as a description of the ulcer's wound bed, presence of drainage, perl-wound condition, presence of drainage, perl-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound evaluation did not identify whether R20's dorsum right foot ulcer, such as a description of the ulcer's wound evaluation lacked any characteristics of R20's wound evaluation adid not identify whether R20's wound evaluation adid not identify whether R20's wound evaluation id and the 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 ulcer's wound bed, presence of pain, current treatment, and interventions. Further,			245052	B. WING					
MOORHEAD, RESTORATIVE CARE CENTER       MOORHEAD, MN 56560         (X4) [D] PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH BEFICIENCY MUST BE REACEDED BY FULL (EACH DEFICIENCY MUST BE REACEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PIERX TAG       PROVIDENTS ALL OF CORRECTION (EACH DEFICIENCY)       COMPLETO (EACH DEFICIENCY)         F 686       Continued From page 26 Review of R20's facility Skin and Wound Evaluation from 8/31/21, to 10/12/21, revealed the following;       F 686       F 686         -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, pert-wound condition, presence of pain, current treatment, and interventions. Further, R20's left heel ulcer developed or whether R20's left heel ulcer developed or bis inght foot ulcer, such as a description of the ulcer's wound bed, presence of drainage, pert-wound condition, presence of pain, current treatment, and interventions. Further, R20's wound valuation lacked any characteristics of 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 educter 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 R20's left heel ulcer such as a description of the ulcer's wound bed, presence of drainage, peri-wound condition,	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	-	
OWNER         Display in the interventions of the ulcer's wound bed, presence of drainage, peri-wound condition, presence of pain, current treatment, and interventions. Further, R20's left heel         Description         Description <thdescription< th="">         Description         Descri</thdescription<>	мооры				2	810 SECOND AVENUE NORTH			
Image: TAG       IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)       PREFX TAG       IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMBETION DATE         F 686       Continued From page 26 Review of R20's facility Skin and Wound Evaluation from 8/31/21, to 10/12/21, revealed the following;       F 686       F 686         -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 ulcers wound bed, presence of pain, current treatment, and interventions. Further, 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, dift foot ulcer, such as a description of the ulcer's wound bed, presence of drainage, peri-wound of identify whether R20's right foot whether R20's right foot whether R20's right foot ulcer, such as a description of the ulcer's wound bed, presence of drainage, peri-wound bed, presence of pain, current treatment, and interventions. Further, 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 idicated revisits of R20's left heel ulcer such as a description of the ulcer's wound bed, presence of drainage, peri-wound condition, presence of drainage, peri-wound condition, presence of drainage, peri-wound evaluation idic hot identify whether R20's right foot ulcer was healing or had worsened.		LAD RESIDRATIVE C	ARE CENTER		N	IOORHEAD, MN 56560			
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Facility ID: 00938

If continuation sheet Page 27 of 75

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED		
		245052	B. WING			C 12/22/2021			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
MOODU			2810 SECOND AVENUE NORTH						
WOORN	EAD RESTORATIVE C	ARECENTER		N	IOORHEAD, 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 686	Continued From pa	ge 27	F 6	86					

Facility ID: 00938

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES					0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
-			A. BUILDI	ING	3		с	
		245052	B. WING				22/2021	
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	. <b>-</b>	_	
MOODUI				2	2810 SECOND AVENUE NORTH			
MOORHE	EAD RESTORATIVE C	ARECENTER		I	MOORHEAD, MN 56560			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	Х	(EACH CORRECTIVE ACTION SHOUL		COMPLETION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	27.112	
F 686	Continued From pa	ae 28	F 6	86				
	left foot and lateral	•	10	00	,			
		nght loot.						
	On 12/21/21, at 4:5	8 p.m. during an interview						
	trained medication	aid (TMA)-B stated R20						
	•	assistance with all cares						
		e required set up assistance.						
		elt R20 had memory loss and e to recall events or his needs.						
		had ACE wraps on daily for						
		nt and had ulcers on both of						
		ted she was unaware of any						
		nterventions in place for R20's						
		e ulcers of his left heel, top of						
	left foot and lateral	right foot.						
	On 12/22/21 at 7.5	5 a.m. during an interview,						
		and ACE wraps on daily for						
		nt and had ulcers on both of						
		t seen R20's unstagable						
		his feet. LPN-B stated she						
	was unaware of any							
		ce for R20's unstagable						
	lateral right foot.	his left heel, top of left foot and						
	lateral right loot.							
	On 12/22/21, at 8:4	4 a.m. during an interview,						
		as totally dependent for his						
		had memory loss and was						
		ecall instructions or events.						
		) was supposed to wear						
		en in bed for pressure ulcers efused to wear them. NA-B						
		aware of any pressure						
		ns in place for R20's						
		e ulcers of his left heel, lateral						
	right foot and top of							
		ogress notes were reviewed 4/21, revealed the following:						

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	FORM	02/14/2022 APPROVED							
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPL		MB NO. 0938-0391 (X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	` ´				PLETED		
		245052	B. WING				C		
	PROVIDER OR SUPPLIER	243032	D. WING	B. WING 12/22 STREET ADDRESS, CITY, STATE, ZIP CODE					
					810 SECOND AVENUE NORTH				
MOORH	EAD RESTORATIVE C	CARE CENTER		N	IOORHEAD, MN 56560				
(X4) ID			ID	.,	PROVIDER'S PLAN OF CORRECTIO		(X5)		
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE		
					DEFICIENCY)				
F 686	Continued From no	ao  20	<b>–</b>						
1 000	Continued From pa	ige za	F 6	080					
	-9/1/21, revealed R	20 was seen in the facility for							
		facility. The note revealed							
		er of right foot with necrosis to lacked any characteristic of							
		and lacked any direction or							
	recommendations.	The note lacked any							
		20's unstagable left heel							
	pressure ulcer.								
		20 was seen in the facility for							
		cellulitis right lower extremity,							
		y wound with Mepilex dressing on moderately exuding							
	wounds, leg and for	ot ulcers, pressure injuries,							
		, graft and donor sites and							
	consult.	and requested a wound care							
		R20 was seen in the facility							
		ted to fluid retention. The note chronic ulcers on his feet and							
		he note lacked any further							
		R20's chronic ulcers and							
	lacked any docume left heel pressure u	entation of R20's unstagable							
	leit neel pressure u								
		R20 was seen at the facility,							
		ed right foot and left heel skin							
		It layer exposed. The progress tion to continue dressing and							
		vound care clinic instructions.							
	-11/11/21 revealed	R20 was seen in the facility							
		xamination revealed skin							
	thickness deep righ	t foot ulcers, top of left foot							
		eft heel with fat layer exposed.							
		revealed direction to continue of legs and to follow up with							

If continuation sheet Page 30 of 75
		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245052	B. WING	i				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	E		
MOODU				28	310 SECOND AVENUE NORTH			
MOORH	EAD RESTORATIVE C	ARECENTER		М	OORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
F 686	Continued From pa wound care clinic.	-	F	686				
	for a routine visit, d and concerns with	R20 was seen in the facility iscussed dementia diagnosis worsening. The note did not or left foot pressure ulcers e time of the visit.						
	interview, R20's prind doctor (MD)-A state pressure ulcers of h and top of left foot. seen R20 at the fac not been able to vis she had not been to left heel pressure u ulcer or top of left for was routinely seen however, she would and monitor R20's p least weekly for any pressure on R20's for could certainly cause expect the facility to relieving intervention	5 p.m. during a telephone mary physician, medical ad she was aware R20 had his lateral right foot, left heel MD-A stated she had last ility on 12/21/21, though had ualize his feet. MD-A stated old of any changes to R20's lcer, lateral right foot pressure bot ulcer. She indicated R20 by a podiatrist for wound care, d expect the facility to assess pressure ulcers routinely, at changes. MD-A stated any eft heel or the lateral right foot se further injury and she would o routinely implement pressure ns to prevent worsening.						
	placed to R20's poor a return call. A return 12/23/21, at 9:28 a. confirmed he had la follow up managem pressure ulcer. The visualize R20 had a of his left heel and the and would have wa changes. The podia	7 a.m. a telephone call was diatrist, a message was left for in call was received on m. from R20's podiatrist. He ast seen R20 on 12/16/21, for ent of his lateral right foot podiatrist stated he did not in unstagable pressure ulcer foot during the last two visits inted to be notified of any attrist stated he had seen R20 eptember for management of						

Facility ID: 00938

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY IPLETED
		245052	B. WING			C 22/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH		
MOORHE	EAD RESTORATIVE C	ARE CENTER		MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE		
F 686 F 689 SS=D	R20's lateral right for had felt the wound I first saw it. He state aware of the increa- thick, hard dark tiss recent visit. He state assist R20 to keep right foot and had o worn when not up w he felt it was impera- prevent any pressur now expect R20's lateral right pressure to his feet pressure to his feet pressure ulcers and form. A policy was requese Free of Accident Ha CFR(s): 483.25(d) (1) §483.25(d) Accident The facility must en §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility far reassess, for root c and failed to implen further falls for 1 of	bot chronic pressure ulcer and ooked better than when he ed he had not been made se in size and did not see the ue at the time of R20's most ed he expected the facility to all pressure off of his lateral rdered Prevalon boots to be valking. The podiatrist stated ative to R20's healing to re on his right foot and would eft heel to be offloaded at all rist stated he felt any pressure at foot, left heel or any would worsen existing a could cause new ones to sted, one was not provided. azards/Supervision/Devices 1)(2)	F 68		lex f were	2/18/22

Facility ID: 00938

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED	
		245052	B. WING		C 12/22/2021		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MOORHI	EAD RESTORATIVE (	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROD DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 689	Continued From pa	age 32 ents (R20) who had a recent	F 689	initiated per below.			
	(SCSA) Minimum I 11/20/21, identified included diabetes, vascular disease. T intact cognition and with activities of da mobility, transfers, MDS identified R20 balance during tran assistance. The MI walker and wheelc occasionally ambu staff. The MDS did since the last asse R20's SCSA Care a 11/20/21, identified assistance with AD mobility, transfers a related to recent C medical conditions diabetes, values de foot/ankle) and chr R20 was at risk for mobility, medicatio R20's current care R20 had poor men with dementia, and of two staff with be	Change of Status Assessment Data Set (MDS) dated I R20 had diagnoses which Osteoarthritis and peripheral The MDS identified R20 had d required extensive assistance aily living (ADL's) of bed toileting and locomotion. The 0 was unable to maintain his nsitions without physical DS identified R20 used a hair for mobility and lated with assistance of two I not identify R20 had any falls		<ul> <li>2. This has the potential to affect a residents that reside inside MRHO prevention policies has been revie and updated as necessary. Nursir were educated on 01/26/22 regard prevention, fall history, fall assess and care planning. As well as interventions to prevent falls.</li> <li>3. DON or designee will perform a falls weekly x 8 weeks then month months, until 100% compliance is achieved.</li> <li>4. Audits will be reviewed by admit or designee and then further discuwill take place at next QAPI meetir review and recommend any neceschanges.</li> <li>5.02/18/2022</li> </ul>	CC. Fall ewed ng staff ding fall ments, udits on nly for 4 histrator ussion ng to		

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	;	
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
					-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 33	F6	89			
	gripper socks when wheelchair. The car	a ambulating or in the re plan lacked any information tions resulting from R20's fall					
	assistant care guide R20 was dependen full body mechanica extensive assistant the following safety use his call light, gr or in wheelchair, cle R20's Kardex lacke	de Kardex Report (nursing e) dated 12/21/21, revealed it on two staff and the use of al lift for all transfers, required ce with bed mobility and had interventions; reminders to ipper socks on when walking ear path to his bathroom. ed any indication R20 had or any updated interventions					
	dated 8/24/21, iden history of one to two was ambulatory and assessment reveal and diagnosis which risk for falls. The as	esident Fall Risk Assessment tified R20 was alert, had a o falls in the last three months, d continent. R20's risk ed medications he received h could potentially increase assessment identified R20 fall he, however, the form did not I risk score meant.					
	11/4/21, identified a seated on the floor wheelchair and his room. The incident was too high and re socks on, though ha morning. The incide been transferring hi his bed, missed the report revealed R20	cility incident report dated at 5:00 p.m. R20 was found of his room between his bed, faced the door to his report identified R20's bed esident did not have gripper ad them on earlier in the ent report identified R20 had imself from his wheelchair to a bed and slipped down. The 0 had been educated on the ed for a safe transfer. The					

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY IPLETED
		245052	B. WING				C <b>22/2021</b>
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	incident report did r physical assistance mobility or any indic cognition/memory r Review of R20's Fa identified R20 was on the following info fall, used narcotic n memory recall withit the assessment. Th R20 was frequently behaviors, was con- independently com- decrease in muscle assessment lacked review of R20's prior On 12/20/21, at 12: laying in bed, on his his eyes were open sleeved shirt, had A socks. R20's bed w inches from the gro the bed table position On 12/20/21, at 4:4 interview with R20's indicated R20 was she came to visit. F declined both physia arrival to the facility prior. FM-A stated p hospital and subset he used to be very with his appearance recently fallen in the what the cause was	not identify R20's needs for e with transfers and other cation of R20's recall. All Assessment date 11/28/21, at moderate risk for fall based ormation; R20 had a recent nedication and had no in the last seven days prior to ne fall assessment identified r incontinent, had no fined to a chair, was unable to e to a standing position and a e coordination. The fall I any fall interventions or a	F	589			

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		AND HUMAN SERVICES			FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·		(X3) DATE COM	E SURVEY PLETED
		245052	B. WING			C 22/2021
NAME OF	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOORH	EAD RESTORATIVE C	ARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	indicated she felt R retain information g indicated R20's bec he could sit at the s the floor, as R20 wa However, she indica was at risk for slidin On 12/21/21, at 10: laying in bed on his approximate 30 inc stood next to R20's with incontinence c remained laying in H approximately 30 in - at 11:22 a.m. R20 the side of his bed, positioned in front of his right hand. R20' with a white sheet, feet and his left foo with a bed sheet be R20's right foot dan leaned on the rolling the sandwich and w bed was elevated a the ground, his left ground. -at 12:01 p.m. R20 his over the bed tak moved slightly, he t bed, and laid on his his left side, within H be be on. R20's bed approximately 30 in	20 was no longer able to jiven to him consistently. FM-A d was raised off the floor, so side of his bed with his feet on as over six feet, six inches tall. ated she was not sure if R20	F 689			

		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245052	B. WING				C <b>22/2021</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	back in his bed, cowmid lower legs to hi - at 5:00 p.m. R20 whis back, his eyes within reach on his approximately 40 in On 12/22/21, at 7:0 laying on his back in from his ankles to happroximately 30 in On 12/21/21, at 10: NA-C stated R20 rewith bed mobility, difelt he was not able indicated R20's beck height and wanting She stated R20 rewind indicated R20's beck height and wanting She stated R20 rewindicated R20 had rewindicated R20's beck height and wanting She stated R20 rewindicated R20 had	vered with a sheet from his is upper torso. was observed laying in bed on vere closed, call light was left side. R20's bed was raised inches off of the ground. 7 a.m. R20 was observed in bed, covered with a sheet his torso. R20's bed was raised inches from the floor. 25 a.m. during an interview equired extensive assistance ressing, personal hygiene, and to recall information. NA-C d was kept raised due to R20's to sit at the side of his bed. Juired the use of a full all transfers and was not weight on his feet. NA-C no falls in the facility and was at risk for falls. 00 a.m. during an interview, required extensive assistance indicated R20's cognition coarse of the day. LPN-A ed to keep his bed elevated off his height and wanting to sit at . She indicated R20 was at that time due to his foot ull mechanical lift for all dicated she was not aware of ted she was not aware of any	Fé	89			

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TATEMENT	OF DEFICIENCIES	KANNERSPICES     KANNERSPICES     KANNERSPICE     KANNERSPICE     KANNERSPICE     KANNERSPICE     KANNERSPICE	l` í	TIPLE CONSTRUCTION	(X3) D.	O. 0938-039 ATE SURVEY OMPLETED
		245052	B. WING			C
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	•	2/22/2021
	EAD RESTORATIVE (			2810 SECOND AVENUE NOR MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	assistance with be dressing. NA-A ind fluctuate over the o needs should be a was not aware if R admission and indi bearing at that time mechanical lift. On 12/21/21, at 12 interview with R20' indicated he had co being completed ro decline in cognition appear disheveled and he oftentimes seated at the edge was notified R20 h was not told what h aware of any interv risk for falls. FM-B usually elevated ap the floor, as he wa at the edge of the h with R20's changin self care, he felt R2 for slipping out of h On 12/21/21, at 4: LPN-C stated R20 his cares and felt F indicated his cogni course of the day. aware of R20 havin of any fall preventio	0 required extensive d mobility, transfers and licated R20's cognition would course of the day and his nticipated. NA-A stated she 20 had any falls since his icated R20 was not weight e and required the use of a full 2:46 p.m. during a telephone 's family member (FM)-B oncerns with R20's cares not outinely and R20's recent n. He indicated R20 would , his room would be in disarray would be either laying in bed or e of the bed. FM-B indicated he ad fallen in September, but had happened and was not ventions in place to mitigate his indicated R20's bed was oproximately 30 inches from s so tall and he could easily sit bed. However, FM-B indicated ng cognition and decline in his 20 was at high risk for fall and	F 64	89		

Facility ID: 00938

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	except for eating, h TMA-B stated she f was not always able TMA-B indicated sh having any falls sind indicated he should general safety. On 12/22/21, at 8:4 NA-B stated R20 w ADL's and felt he ha month, following his stated she felt R20' not always able to reca needs were to be a had not fallen when aware if he had falle indicated she R20 p approximately 30 in could sit at the edge the floor. NA-B indicated attempting to transf	assistance with all cares e required set up assistance. felt R20 had memory loss and e to recall events or his needs. he was not aware of R20 ce his admission, and I have gripper socks on for 4 a.m. during an interview ras totally dependent for his ad declined within the past s COVID-19 illness. NA-B 's had memory loss and was recall instructions or events. used his call light, but was not ill what he wanted and his nticipated. NA-B indicated R20 n she was working and was not en since his admission. NA-B preferred his bed raised nches from the ground so he e of his bed with his feet on cated she felt R20 was at risk sure she routinely checked on d he had not observed R20	Fδ	589			
	R13						
	11/17/21, identified	inimum Data Set (MDS) dated R13 was cognitively intact and ch included end stage renal					

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	-	AND HUMAN SERVICES			FOR	D: 02/14/2022 MAPPROVED D. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DA	NTE SURVEY
		245052	B. WING _		1;	C 2/22/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
MOORH	EAD RESTORATIVE C	ARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 689	disease, diabetes n renal dialysis. R13's extensive assistance living (ADL's) which transfers, locomotic hygiene and bathing one fall with no inju R13's care plan rev required extensive a with most ADL's wh mobility, toileting ar indicated R13 was to gait/balance issu admission. The car anticipate and mee R13's call light was encourage R13 to u Review of R13's fal 11/11/21, R13's fal 11/11/21, R13's fal R13 to be high risk falls, hypoglycemic Mellitus) medication impairment, exhibits standing, required h from place to place muscle coordination - 12/20/21, R13's fal R13 to be at moder of falls, hypoglycem had memory impair balance while stand	nellitus and dependence on s MDS indicated he required ce with most activities of daily on included bed mobility, on, dressing, toileting, personal g. The MDS identified R13 had ry since admission. Tised 12/20/21, identified R13 assistance of one to two staff itch included transfers, bed nd walking. The care plan at moderate risk for falls due es and had multiple falls since e plan instructed staff to t resident's needs, ensure within reach and staff were to use his call light. I risk assessments from 21, revealed the following: Il risk assessment determined for falls due to a history of ( used to treat Diabetes n use, sometimes had memory ed loss of balance while nands on assistance to move and decrease noted in n. all risk assessment determined rate risk for falls due to history nic medication use, sometimes rment and exhibited loss of ding.	F 68	39		

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	FUCINECTICA	DENTRICATION NONDER.	A. BUILDI	ING			C
		245052	B. WING				22/2021
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	_	
MOORHI	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 40	F 6	389			
	<ul> <li>11/15/21, at 5:16 a fall while in his room on the bed when he to bed, vital signs a completed and note (WNL).</li> <li>11/23/21, at 2:27 p charting: R13 had a reopened on his lef dried and treated. F vital signs were WN information when th happened.</li> <li>12/20/21, at 3:10 a a.m. in the hallway on the floor with his feet faced the doorn light had been withi it. R13 stated he go smoke and he fell of assisted R13 off the had a swollen right pain and rated his p one to ten. Tylenol 8 R13. R13's vital sig were checked and 1 been placed on oxy to 88%. The nurse of nursing (DON) w</li> <li>12/20/21, at 3:22 p ortho clinic earlier th assessment of his r</li> </ul>	a.m. R13 had an unwitnessed n. R13 stated he was sitting e fell. R13 was assisted back and neurological checks were ed to be within normal limits o.m. post fall follow- up a small skin tear which t elbow and staff cleaned, R13's neurological checks and NL. The progress note lacked he fall occurred or how the fall a.m. R13 was found at 1:15 a few steps from his door lying shead against the wall and his way to his room. R13's call n reach and he had not used of up because he wanted to go on the way. Three staff e floor and it was noted R13 elbow. R13 complained of bain at a seven on a scale of 500 mg. was administered to ns and neurological signs found to be WNL. R13 had /gen due to sats had dropped practitioner (NP) and director /ere notified of the fall. p.m. R13 had been sent to the hat morning at 9:15 a.m. for right arm due to swelling and urned to the facility with an					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPI	LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD RESTORATIVE C	ARE CENTER			2810 SECOND AVENUE NORTH		
				Γ	MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ae 11	F 6	00			
1 000		ress notes lacked evidence of	ΓŬ	09			
	a comprehensive a	ssessment of R13's falls to					
		use of his multiple falls, and					
	lacked documentati interventions impler	mented to minimize his falls.					
	Review of facility in to 12/21/21, revealed	ncident reports from 11/15/21,					
	10 12/21/21, 1000000	d the following.					
		a.m. unwitnessed fall- staff					
		3's call light and found him on d he had been sitting on the					
	bed and he fell out	of bed. An abrasion was noted					
		alp. R13 was assisted to bed					
	with the use of a ho	yer (lotal body) int.					
		a.m. R13 was found sitting on					
		bed with both legs stretched the rolled from the bed. R13					
		sessment completed and R13					
		eding from an old wound					
	cleansed and treate	elbow. The wound was ed					
	No incident report h which occurred on	nad been provided for the fall 12/20/21.					
	Review of the incide	ent reports lacked evidence of					
		ssessment of R13's falls to					
	lacked documentati	use of his multiple falls, and ion of appropriate					
		mented to minimize his falls.					
	On 12/21/21 at 2:5	7 p.m R13 returned from his					
	ortho clinic appointr	ment and was noted to have a					
		ace wrap to his right arm.					
		Nurse (LPN)-A applied the gait while he was in his wheelchair,					
		nd, pivoted R13 to his right					

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI 1	TIP	U DE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` '		B		PLETED
						(	C
		245052	B. WING			12/:	22/2021
NAME OF F	PROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD RESTORATIVE C	ARE CENTER			2810 SECOND AVENUE NORTH		
					MOORHEAD, MN 56560		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFI>	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	~	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
			r.		DEFICIENCE)		
F 689	Continued From no	ao 40	БО				
F 009	-	•	F 6	89	3		
		13 to sit on the edge of his d the gait belt from R13's					
		him to lay in the bed. LPN-A					
		light was within reach and					
	-	all for assistance when					
	needed. R13 verba	lized understanding.					
	On 12/20/21, at 4:3	5 p.m. R13 stated he had					
	fallen and broke his	arm during the night. R13					
		en at the clinic earlier that day					
		ed on surgery in the near arm. R13 stated he had not					
		rior to his fall the night before.					
	R13 indicated he wa	as aware he was expected to					
		nce however he did not want					
		R13 stated staff frequently e his call light and he was					
		e fallen without staff					
	assistance.						
		4 p.m. nursing assistant					
		was alert and oriented and of one staff with transfers.					
		f frequently reminded R13 to					
	use his call light and	d R13 understood he should					
		stance and yet he continued					
	-	bite the reminders. NA-D informed of R13's fall on					
		R13 had injured his right					
		d he ensured R13 had his call					
	light within reach af	ter providing cares to R13.					
	On 12/21/21 at 2.1	9 nm trained medication aid					
		8 p.m. trained medication aid 3 was alert and oriented and					
		from staff with all ADL's.					
	TMA-B indicated sh	he had been informed of R13's					
		d was aware he had injured					
		B stated staff frequently se his call light however he					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF I	PROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C	ARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	continued to self tra had only been awar and had not heard of time. On 12/22/21, at 8:3 at risk for falls and it couple of nights age arm. LPN-A stated assessed the reside necessary and notif she was not sure w were after a resider the facility did not h follow after a reside cause and add new future falls. On 12/22/21, at 12: was at risk for falls five falls since admit confirmed she had exact number as th tracking or trending facility had not com R13's latest fall on expectation was for assessment of R13 included checking w checks, treat R13 if notify the physician facility lacked a pro- root cause and to ir prevent future falls. On 12/22/21, at 12: (DON) confirmed R identified a potentia	ansfer. TMA-B indicated she re of R13's fall on 12/20/21, of any other falls prior to that 8 a.m. LPN-A stated R13 was indicated R13 had fallen a b and had broken his right when a fall occurred, she ent, provided treatment as fied the family. LPN-A stated hat the facility expectations of fall occurred and confirmed ave a process in place to ent had a fall to determine root v interventions to prevent 20 p.m. DON confirmed R13 and stated R13 had four or ission to the facility. DON been unable to determine the e facility lacked a process for falls. DON confirmed the pleted an incident report on 12/20/21. The DON stated her staff to complete an after a fall occurred which vital signs and neurological any injuries had occurred, and DON. DON verified the cess to assess each fall for nplement new interventions to	F	589			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,	LE CONSTRUCTION	· /	E SURVEY
NND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i		pleted C
		245052	B. WING			_ 22/2021
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOORH	EAD RESTORATIVE O	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 689	risk and failed to ide DON stated R20's of over the course of the November and indi- to recall instructions DON stated R20 pre- elevated from the group of his the able to transfer him he may not always with transfers due the DON indicated R20 included to keep his gripper socks where plan lacked fall inter November. The DOC changing cognition falls and should have place, such as gripper	sessment of R20's fall, his fall entify fall interventions. The cognition had been fluctuating the day since he had COVID in cated R20 would not be able s given to him routinely. The referred to have his bed ground in order to be able to sit bed. She indicated R20 was uself upon admission, and felt recall he needs assistance o decline in his strength. The b's current fall interventions s call light within reach, wear of up and confirmed R20's care reventions related to his fall in DN stated due to R20's she felt he was at high risk for ve further fall interventions in per socks on in bed, ing on the edge of bed, grab	F 689			
F 698 SS=D	was not provided. Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must en require dialysis reco with professional st	nsure that residents who eive such services, consistent andards of practice, the	F 698			2/18/22
	comprehensive per the residents' goals This REQUIREMEN by: Based on interview	son-centered care plan, and		1.The two residents identified were and R13. R10 has subsequently	e R10	

Facility ID: 00938

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		AND HUMAN SERVICES			F	ORM A	02/14/202 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			COMP	SURVEY PLETED
		245052	B. WING			C 12/2	, 2/2021
NAME OF F	PROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD RESTORATIVE O	ARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIO DATE
F 698	Continued From pa	ge 45	F6	98			
		onitored and assessed for 2 of ad R19) reviewed for dialysis.			discharged. R13 s care plan updated reflect current interventions including monitoring post dialysis treatments	d to	
	Findings include:	imum Data Set (MDS) dated			Nursing staff were educated on 01/26/ 2.Resident's receiving outpatient dialy		
	11/15/21, identified included debility (pl	R10 had diagnoses which hysical weakness) end stage			practice. 4 residents have been identif as being affected by this practice. Car	re	
	The MDS identified	nia, diabetes and heart failure. R10 was cognitively intact vision with activities of daily			plans will be updated and residents will go for outpatient dialysis will have a po dialysis assessment completed. Nursi	ost	
	mobility. The MDS	nsfers, dressing, and bed identified R10 received the seven day look back			staff educated on 1/26/21. 3. DON or designee will perform audit post dialysis assessments will be done weekly x 8 weeks then monthly for 4 months, until 100% compliance is		
	R10 had diagnoses stage renal disease	DS dated 8/16/21, identified which included debility, end , hear failure, chronic and diabetes. The MDS			achieved. 4.Audits will be reviewed by administra or designee and then further discussio will take place at next QAPI meeting to	on	
	transfers, toileting, dressing, bed mobi	ived extensive assistance with and required supervision with lity and personal hygiene. The preceived dialysis care.	ES       OM         LA       (X2) MULTIPLE CONSTRUCTION         R:       A. BUILDING         B. WING	ry			
	dated 8/16/21, iden hospitalized with a dialysis and was fai The CAA revealed	are Area Assessment (CAA) tified R10 was recently pulmonary infection, received tigued after dialysis sessions. R10 received dialysis three ued easily, was alert and					
	oriented though had CAA lacked docum (intravenous acces	d some mild forgetfulness. The entation of R10's fistula s for dialysis) and required and bruit (an auditory method					
		plan revised 10/19/21, and stage renal disease,					

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT OF DEFIC AND PLAN OF CORRE	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245052	B. WING			12/2	22/2021
NAME OF PROVIDEF	R OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHEAD RE	STORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH NOORHEAD, MN 56560		
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
receive care pl site, or or post R10's 12/22/2 dialysis R10's identifi week. of R10 access thrill. R10's R10	lan lacked do r any required t dialysis assis 21, lacked ar s, or had a fis physician ord ed R10 recei R10's care p d's fistula or d s site for blee medical reco fistula bruit a ored. /20/21, at 3:1 ated he rece from at a dialy R10 stated he left arm, lifted ed a thick wh ches long an left arm. He i ored his fistula g staff had ne his admission les of profuse n had a low bl ons which re s center. R10 tly monitoring hecking his b	vsis and had diabetes. The ocumentation of R10's fistula d monitoring of thrill and bruit essment. stant care guide printed by indication R10 received	F	398			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY
		245052	B. WING				C 22/2021
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MOODU				2	2810 SECOND AVENUE NORTH		
MOORH	EAD RESTORATIVE C	ARE CENTER		Ν	MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	On 12/21/21 at 12:1 licensed practical n received dialysis the indicated R10 took and stated she did return. LPN-A confit fistula bruit and thrit order was in place to dialysis center would complications from know if he required On 12/21/21, at 4:4 LPN-C stated he be his left upper arm a times a week. LPN- check R10's vital sig if needed. He indica complications, such blood pressure, dur call and notify them confirmed he did no and had never check On 12/21/21, at 5:0 trained medication a received dialysis the bring back a red fol She indicated she w upon return when h pressures. She state R10's vital signs up nursing staff would On 12/22/21, at 7:2 LPN-B stated the fa practice in place for dialysis prior to that	12 p.m. during an interview urse (LPN)-A stated R10 ree times a week. LPN-A care of his own access site not check his fistula upon rmed she did not check R10's Il for function, indicated no to do so. LPN-A indicated the Id call if R10 had any his run and would let her further monitoring. -3 p.m. during an interview elieved R10 had a fistula on and received dialysis three -C indicated he would usually gns upon return from dialysis	F 6	98			

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	0		E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	<u> </u>			PLETED
		245052	B. WING					C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, Z			
MOORHE	EAD RESTORATIVE C		2810 SECOND AVENUE NORTH					
					MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPF	BE	(X5) COMPLETION DATE
F 698	Continued From pa set of vital signs up access site monitor access site (fistula) bruit and thrill. On 12/22/21, at 8:2 interview with Sanfo charge nurse (RN)- dialysis three times stated she would ex monitored for bleed facility along with hi R10 had a history o his dialysis runs, an blood pressure was RN-A stated she us R10 had any compl but felt it was very in monitored him. RN- practice to check R and monitor his fistr low blood pressure, complications were manner. On 12/22/21, at 8:3 received daily three there were no proce		F 6	\$98 \$		2Y)		
	11/17/21, identified	inimum Data Set (MDS) dated R13 was cognitively intact and ch included end stage renal						

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
мооры	EAD RESTORATIVE C			2	810 SECOND AVENUE NORTH		
	EAD RESTORATIVE C	ARE CENTER		N	IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	disease, diabetes m renal dialysis. R13's extensive assistance living (ADL's) which transfers, locomotic hygiene and bathing received dialysis. R13's care plan rev required dialysis rel Interventions listed take blood pressure resident to go to dia labs and report to d monitor/document/r symptoms of infecti swelling, warmth or resident to relieve d the disease and tree instruction to staff to bleeding or any othe Review of R13's ph 11/24/21, identified Diabetic Diet. The of dialysis treatments Review of R13's pro 12/21/21, revealed assessments. Review of R13's dia from 11/17/21, to 12 following: -11/26/21, at 12:50 (BP) was 173/66 an (an access for dialy	nellitus and dependence on s MDS indicated he required ce with most activities of daily n included bed mobility, on, dressing, toileting, personal g. The MDS identified R13 rised 12/20/21, identified R13 lated to renal failure. included: do not draw blood or e in arm with graft, encourage alysis appointments, monitor	F 6	98			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				Сом	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD RESTORATIVE C	ARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	v	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG	х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
F 698	Continued From pa	ae 50	F 6	98			
	-	g sensation you can feel) and	10	.00			
		insation you can hear) were					
		alth record (EHR) lacked any -observation records.					
	dialysis three times Wednesday and Fri dialysis on Sunday, current week due to indicated the nursin	5 p.m. R13 stated he received a week on Monday, iday. R13 stated he attended Tuesday and Thursday of the o the holiday coming up. R13 ng staff checked his blood					
	he returned from dia actions had been co such as checking h checking his vital si and pointed to his d by a bandage and s place from the dialy nursing staff had no	him to the dining room once alysis. R13 stated no other ompleted by the nursing staff is dialysis site for bleeding or gns. R13 lifted his left arm dialysis site which was covered stated the bandage was still in <i>y</i> sis run the day before and ot checked the site nor					
	nurse (LPN)-A enter returned from dialys sugar and administer abdomen area. LPN contained information	46 a.m. licensed practical red R13's room after R13 sis, checked R13's blood ered insulin to R13's right N-A picked up the folder which on about R13's dialysis run e desk at the nurse's station.					
	R13 returned from o blood sugar and sca dialysis center into she was not aware the facility for comp	50 a.m. LPN-A stated when dialysis she would check his an the information from the R13's EHR. LPN-A indicated of what the process was at leting post- dialysis -A confirmed she had not					

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245052	B. WING	i			C 22/2021
NAME OF I	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 698	completed a post-d and further stated s at the facility since there. On 12/21/21, at 3:1 (TMA)-B stated who she gave the folder nurse and the nurse TMA-B indicated sh complete any other vital signs or check stated the facility ha post-assessment p the nurses typically arm for a couple of On 12/22/21, at 12:	<ul> <li>alialysis assessment on R13</li> <li>be had never completed one she began her employment</li> <li>8 p.m. trained medication aid en R13 returned from dialysis</li> <li>from the dialysis center to the e checked R13's blood sugar. The had not observed a nurse</li> <li>tasks such as checking R13's ing his dialysis site and further ad no dialysis</li> <li>rocess in place. TMA-B stated the further bandage on R13's left</li> </ul>	F	598			
	post- dialysis asses monitoring of R13's when R13 returned facility received the the dialysis center a EHR. On 12/22/21, at 1:0 (DON) stated the fa procedure in place fistula/site monitorin process of educatin dialysis assessment a professional stand who received hemo complications such pressure post dialysis should be checked	ssments which included a access site and vital signs from dialysis. DON stated the dialysis run information from and scanned it into R13's 6 p.m. the director of nursing acility had no current policy or for post dialysis assessments, ng and was currently in the ng staff and implementing post tts. The DON confirmed it was dard of practice for residents obialysis to be monitored for as bleeding, low blood sis and their access site daily. The DON confirmed tked any information of R10's					

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		AND HUMAN SERVICES				FORM	: 02/14/2022 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			`´CO№	E SURVEY IPLETED C
		245052	B. WING				22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C	CARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 698	Continued From pa	ge 52	F 6	698			
	adopted 2/12/20, ref facility each resider provisions of dialys professional standa identified it was the assess and monitor dialysis for any com- signs, medication monitor (statistical dialysis and statistical dialysis and diversion of the resident's med- divide the section for (ii) Any irregularities during this review monitor attending physician director and director minimum, the resid- and the irregularity (iii) The attending physician director and director minimum, the resid- and the irregularity (iii) The attending physician	iew, Report Irregular, Act On 1)(2)(4)(5) egimen Review. drug regimen of each resident at least once a month by a st. review must include a review	F 7	<b>7</b> 56			2/18/22

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	-	I AND HUMAN SERVICES	1			RM APPF 10. 093	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SUR	
		245052	B. WING			C 12/22/20	)21
NAME OF F	PROVIDER OR SUPPLIER		· [	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE (	CARE CENTER			810 SECOND AVENUE NORTH NOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COM	(X5) IPLETIOI DATE
F 756	Continued From pa	age 53	F 7	756			
	action has been tal be no change in the	en reviewed and what, if any, ken to address it. If there is to e medication, the attending ocument his or her rationale in ical record.					
	maintain policies a drug regimen revie limited to, time fran the process and ste when he or she ide requires urgent act	facility must develop and nd procedures for the monthly w that include, but are not nes for the different steps in eps the pharmacist must take entifies an irregularity that ion to protect the resident. NT is not met as evidenced					
	facility failed to ens recommendations manner for 4 of 5 r	v and document review the sure pharmacy were addressed in a timely esidents (R20, R15, R9 and unnecessary medications.			1.The following residents were identifie as being affected by this practice R20, R15, R9, R12. R20 R20 subsequently discharged from the facility. Resident R saw Psychiatric NP on 01/26/2021. Hgb A1C drawn and resulted on 12/27/2021	9	
	Findings include:	the second of Ode the Assessment			R15 pharmacy recommendations sent t primary physician to physician on	Ö	
	(SCSA) Minimum I 11/20/21, identified included diabetes, vascular disease. T intact cognition and with activities of da mobility, transfers,	change of Status Assessment Data Set (MDS) dated R20 had diagnoses which Osteoarthritis and peripheral The MDS identified R20 had d required extensive assistance ily living (ADL's) of bed toileting and personal hygiene.			12/17/2021 to be addressed returned of 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 of 12/17/2021. All December pharmacy		
	anticoagulant, diure seven of seven day	I R20 received antidepressant, etic, and opioid medications ys during the look back period.			reviews were returned. Pharmacy medication review policy updated on 01/21/2022. DON and ADON were educated on 1/21/22		
	11/20/21, identified assistance with AD	Area Assessment (CAA) dated R20 required extensive L's which included bed and had a decline in condition			2.This has the potential to affect all residents. All pharmacy recommendation will be reviewed within 7 days. Audits with be completed monthly to ensure that		

Facility ID: 00938

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
			/				С
		245052	B. WING			12/2	22/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE (	CARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 756	•	-	F 75	56			
	medical conditions diabetes, valgus de foot/ankle) and chr R20 received seve	OVID-19 diagnosis, and other such as heart failure, eformity (deformity of onic pain. The CAA's identified ral different medications which essant, anticoagulant, diuretic, ions.			<ul> <li>residents are receiving appropriate medication. Staff involved educate 01/21/2022.</li> <li>3.Audits will be performed on phan recommendations and response, r x 6 months, until 100% compliance achieved.</li> <li>4.Audits will be reviewed by admin</li> </ul>	d on macy nonthly e is	
		onsultant Pharmacist from 8/26/21, to 11/29/21, ing:	armacist or designee and then further discu	ssion ıg to			
	a recommendation	the pharmacy consultant had for separation of calcium and onse was documented.			5.02/18/22		
	- 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 you sugar (glucose) level, electrolyte and fluid balance, and kidney function. Glucose is a type 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.	o's practioner address the use e current dose, (which was too goxin level (medication used tion, lab helps determine and requested a basic blood test that measures your rel, electrolyte and fluid y function. Glucose is a type of ses for energy. Electrolytes uids in balance.) The lacked documentation R20's addressed the					
	pharmacist medica revealed the facility requested R20's pr recommendations forms revealed R20 recommendations	ovember 2021, consultant tion review, dated 11/29/21, y pharmacy consultant actioner address made in September. The D's practioner addressed the on 12/6/21, decreased R20's a Digoxin level and indicated					

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		AND HUMAN SERVICES				FORM	): 02/14/2022 // APPROVED ). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		LE CONSTRUCTION		TE SURVEY MPLETED
		245052	B. WING			12	2/22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP COD		
MOORH	EAD RESTORATIVE	CARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 756	Continued From pa	age 55	F 7	<b>'</b> 56			
	R20 had a basic m 11/15/21.	etabolic panel drawn on					
		edical record lacked harmacy review was ober, 2021.					
	R15						
	11/19/21, identified impairment and ha Parkinson's Diseas Mellitus. The MDS antipsychotic medi assessment refere	nimum Data Set (MDS) dated R15 had moderate cognitive d diagnoses which included se, Heart Failure and Diabetes indicated R15 received cation each day during the nce period. The MDS lacked a drug regimen review.					
		physician orders signed R15 received the following					
		te (medication used to prevent grams (mg.) one time daily.					
		medication used to treat 1000 mg. twice a day.					
	used to treat schize	pine Fumerate) (medication ophrenia, bipolar and major rr)25 mg. twice daily.					
		onsultant Pharmacist's (CPMR) forms from 6/28/21, ed the following:					
		endation was made to clarify dication administration record					

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	245052	B. WING	i			C 22/2021
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MOORHEAD RESTORATIVE C			-	10 SECOND AVENUE NORTH		
	ARE GENTER		M	OORHEAD, MN 56560		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
<ul> <li>extended release (I and confirmed the of Recommendation in scheduling of Metfor administered at meta acknowledged and 6/30/21.</li> <li>- 7/19/21, the facilit 2021.</li> <li>- 8/26/21, recommet physician to clarify the ER formulation response or signature - 9/22/21, recommeta physician to re-eval due to antipsychotic medicines used to mental and emotion potential for a direct who has Parkinson any response or signature - 10/29/21, recommeta face, trunk, and ext treated with antipsy assessment completa lacked any response physician.</li> <li>- 10/29/21, recommeta physician to clarify the ER formulation</li> </ul>	er Isosorbide Dinitrate 30 mg. ER). Physician acknowledged	F 7	756			

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		245052	B. WING_				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		-
MOORHI	EAD RESTORATIVE C	ARE CENTER			310 SECOND AVENUE NORTH OORHEAD, MN 56560		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 756	Continued From pa	ge 57	F 7	56			
	- 11/29/21, the facili November 2021.	ity lacked the form for					
	physician to re-eval due to antipsychotic potential for a direc who has Parkinson	nendation was made for the luate prescribing Quetiapine c medications have the t drug interaction for someone 's Disease. The form lacked gnature from the physician.					
	physician to clarify i should be the ER fo	nendation was made for the if Isosorbide mono 60 mg. ormulation or not. The form se or signature from the					
		rm titled Patient Summary 2/22/21, revealed the					
	- 6/28/21, irregularit	ties identified- see report.					
	- 7/19/21, irregularit	ties identified- see report.					
	-	ties identified- see report.					
		ties identified- see report.					
	-	rities identified- see report.					
	- 11/29/21, no irregi	ularities identified.					
	- 12/17/21, irregular	rities identified- see report.					
	R9						

Facility ID: 00938

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			PLETED
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
MOORHI	EAD RESTORATIVE C				810 SECOND AVENUE NORTH		
				N	NOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From pa	ge 58	F 7	56			
	identified R9 had co included hypertensi (DM), renal insuffici MDS identified R9 r dressing and had u transfers and walkin received antianxiety antidepressants sev assessment referer Review of R9's curr 12/22/21, revealed medications: -Nystatin Suspensio to fight infections ca unit/milliliter (ml) giv for thrush. -Bupropion Hydroch tablet extended rele milligrams (mg) by depressive disorder 5/25/21. -Buspirone (Buspar to treat imbalance of tablet 15 mg tablet	ven of seven days during the					
	used to treat imbala HCL ER capsule 24	or) (antidepressant medication ance of chemicals in the brain) 4 hour 75 mg give 1 capsule by ng for depression. Revision					

CENTERS FOR MEDICARE &	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL			E SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING		Сом	PLETED
	245052	B. WING				C 22/2021
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHEAD RESTORATIVE CA			2	810 SECOND AVENUE NORTH		
			Ν	IOORHEAD, MN 56560		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
depressive disorders Release Sprinkle 125 mouth three times a depression/skin erup -Metformin (decrease levels) HCL tablet 50 times a day for DM. R9's Consultant Phan Reviews from 6/2021 the following: -6/28/21, No irregular -7/19/2021, No irregular -7/19/2021, No irregular -8/26/21, No irregular -9/22/21, and again of PRN. Identified the m frequency of use on the record (MAR). Staff w provider and update of frequency as soon as 30 days. -10/29/21, No irregular -11/29/21, No irregular	te) (used to treat manic s) Sodium Capsule Delayed 5 mg give 2 capsule by day for major bition. Revision date 5/25/21. ed blood glucose/sugar 00 mg give my mouth two rmacist's (CP) Medication 1 through 12/2021, identified rities identified. ularities identified. ularities identified. inties identified. on 12/17/21, Nystatin 5 ml nedication did not include the the medication administration were directed to contact the the MAR with the intended s possible but no later than arities identified. h, Effexor, Depakote, and n reduced recently. ist (CP)-A suggested a	F 7	756			

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH NOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 756	mouth twice a day. (hemoglobin is a pr the lungs to the cell attached to it) had b directed to repeat th similar value consic need for the metfor R9's lab review ider last Hemoglobin Ald of 6.1 percent. Facility primary phy 1:50 p.m. identified work and a hemogle R9's medical record primary physician w the CP recommend R12 R12's significant ch identified R12 had of extensive assitance walking, dressing, t The MDS indicated coronary heart dise pneumonia, arthritis post traumatic strees MDS identified R12's cu 12/28/21, revealed: -Metoprolol Tartrate	R9's most recent AIC rotein that carries oxygen form ls of the body that has sugar been 6.1 percent. Staff were he A1C at next lab draw and if der re-assessing the ongoing min. ntified 6/9/20, had been the C that was drawn with results vsician visit dated 12/22/21, at R9 had been in need of blood obin A1C was then ordered. d lacked documentation R9's vas updated or followed up on dations. nange MDS dated 11/13/21, cognition intact and required e needed with bed mobility, toileting, and personal hygiene. I R12's diagnoses included ease (CAD), HTN, DM, s, anxiety, depression, and ss syndrome (PTSD). The 2 received insulin and ven of seven days during the urrent physician orders signed	F 7	756			

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		AND HUMAN SERVICES				FORM	APPROVED
							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
			A. DOILDI			(	C
		245052	B. WING				22/2021
NAME OF F	PROVIDER OR SUPPLIER		· [	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
MOORHE	EAD RESTORATIVE C			2	810 SECOND AVENUE NORTH		
				N	NOORHEAD, MN 56560		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
			1				
F 756		-	F 7	56			
		let 25 mg give 0.5 mg by					
	mouth two times a o artery.	day for stented coronary					
	Zalnidam Tartrata	(and the used to treat					
		(sedative used to treat ated for short term use only)					
		0 mg by mouth as needed at					
	bedtime for primary						
	-Nitroglycerin (used	I to treat chest pain to increase					
		eart) tablet sublingual give 0.4					
		ery 5 minutes as needed for					
	check pain.						
		on Reviews from 6/2021					
	through 12/2021, Id	lentified the following:					
		on 10/29/21, Nitroglycerin 0.4					
		directed. CP recommended					
		ses/episode should be dicaion administration record					
	(MAR) no later than						
	(						
		lol Tartrate 25 mg tablets are					
		and should be ideally					
		neals or directly after meals to					
		ption. CP recommended Id have been added to the					
	actions.	In have been added to the					
		n 10 mg every bedtime (HS)					
		a psychological condition and					
		uated within the first 14 days of					
		mended in order to continue e-evaluation date to reassess					
		added, medication continued,					
	and then re-evaluat						
	-11/29/21, No irregu						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL			E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .			PLETED
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/2	22/2021
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH		
				N	100RHEAD, MN 56560		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI)	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
			1				
F 756	Continued From pa	ge 62	F 7	56			
	40/47/04 Nie ime m						
	-12/17/21, No irregu	Jiarities Identified.					
	2	s for June, July, and August ed and not provided.					
	R12's medical reco	rd lacked documentation					
		ician had been updated or					
	followed up on the (	CP recommendations.					
	On 12/22/21, at 10:	56 a.m. during a telephone					
		y pharmacy consultant,					
		the past it had been a acceleration acceleration acceleration and the physicians					
	address her pharma	acy recommendations in a					
		indicated she had thought					
		ompleted in August with no and October she made					
	recommendations t	o address her comments from					
		armacy consultant indicated harmacy recommendations to					
		oon as possible, but no later					
	than 60 day.						
	On 12/22/21. at 12:	35 p.m. director of nursing					
	(DON) stated she s	tarted reviewing the pharmacy					
		n November 2021, and not aware who reviewed them					
		ON confirmed the facility had					
	not followed up on t	the recommendations from					
		ber 2021, October 2021, and dverified there had been					
		ndations 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	e would expect residents					
		eviewed monthly and would ecommendations to be					

If continuation sheet Page 63 of 75

		AND HUMAN SERVICES			FORM	02/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CON	E SURVEY IPLETED
		245052	B. WING _			C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD RESTORATIVE O	ARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 756	Continued From pa	ge 63	F 75	56		
		ely manner. The DON / had identified issues with				
	reviews and their r addressed timely a confirmed R20's re September had not December.	nts completing monthly ecommendations being couple of months ago. She commendations from been not addressed until				
	Review, reviewed 4 facility's policy to ha review residents me to ensure all medic discontinued and m the facility would en address pharmacy manner.	d, Pharmacy Medication /3/18, identified it was the ave the consultant pharmacist edications for dose reductions ations were properly ordered, nonitored. The policy revealed usure the provider would recommendations in a timely rescribed by Physician 1)(2)	F 80	08		2/18/22
	§483.60(e) Therape	eutic Diets apeutic diets must be				
	delegate to a regist task of prescribing therapeutic diet, to law. This REQUIREMEN	attending physician may ered or licensed dietitian the a resident's diet, including a the extent allowed by State NT is not met as evidenced				
	review the facility fa as prescribed by th	tion, interview, and document hiled to provide therapeutic diet e physician for 1 of 2 (R1) for therapeutic diet.		1.Resident R1 was identified as an incorrect diet order. On 12/3 order obtained for clarification for Order changed from surgical so regular diet, regular texture, reg consistency, small bite size, no	1/2021 MD or R1. ft to ular/thin	

Facility ID: 00938

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	СОМ	E SURVEY PLETED
		245052	B. WING			C 22/2021
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
IOORHE	EAD RESTORATIVE C	ARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 808	Continued From pa	ge 64	F 808	3		
	identified R1 had be 6/11/21, with the dia neuropathy unspect cataract, glaucoma rectal prolapsed, ar (prostate enlargem R1's quarterly Minin 9/16/21, identified F required one staff a and required super indicated R1 had ne or symptoms of a s identified R1 had ne The MDS section the left blank.	uarterly Minimum Data Set (MDS) dated 1, identified R1's cognition was intact and ed one staff assistance for grooming cares quired supervision for eating. The MDS ed R1 had no swallowing disorder or signs ptoms of a swallowing disorder. The MDS ed R1 had no known weight loss or gain. DS section that identified dental had been		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		
	dated 6/24/21, iden	re Area Assessment (CAA) tified R1 was missing most ining teeth were notably				
	a nutritional problem or por to risk of choking and weig chewing, fear and resistan risk for dehydration due to age and decreased mobilit instructed staff to assist R explain what was on his plan method when the meal wa plan indicated staff were to	ssist R1 with meal set up and n his plate utilizing the clock neal was delivered. The care were to provide and serve the gular diet with regular textures				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 02/14/2022 1APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	CON	TE SURVEY MPLETED C
		245052	B. WING				/22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD RESTORATIVE O	CARE CENTER			2810 SECOND AVENUE NORTH		
				Ν	MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 808	Continued From pa	age 65	F٤	308			
	order for R1 was a	soft/surgical diet.					
		ated 12/17/21, identified R1's Jlar, cut up meat for resident, p assistance.					
	Review of R1's Nut to 12/17/21, reveal	trition Data forms from 8/28/21, ed the following:					
		rition Data (Admission) form /ed a diet of regular with ktures.					
		itrition Data (Quarterly) form ing on a regular mechanical ar consistencies.					
	R1 was observed of	tion on 12/20/21, at 12:12 p.m. during the noon meal with a to wedges, and coleslaw.					
	R1 was observed to mashed potatoes, i and a slice of ham was observed to fe and pick up his slic was observed to he	tion on 12/20/21, at 5:25 p.m. o have a divided plate, with mixed vegetables, cucumbers, which had not been cut up. R1 el around his plate for his food e of ham and take a bite. R1 old the slice of ham in his hand ork on consuming it slowly.					
	R1 was served a tu	tion on 12/21/21, at 12:41 p.m., Ina fish sandwich, cucumber ices, and green grapes.					
		tion on 12/21/21, at 5:40 p.m., Intry fried steak, mashed and green grapes.					
	During an interview	/ on 12/20/21, at 3:31 p.m. R1					

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		). 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` '	G	· · ·	MPLETED
						С
		245052	B. WING		•	/22/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
MOORHE	EAD RESTORATIVE (	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 808	-	-	F 80	8		
	surgically removed months ago. R1 ind jaw bone was too w was why he did not received an Americ his meat ground up often that happene hard for him to eat needed to keep "m became small enot trouble swallowing.	ave any teeth as they had been down to the roots several dicated he had been told his weak to handle dentures which t have any. R1 stated he can diet and occasionally had o however was unsure how d. R1 indicated at times it was the meat. R1 stated he unching things" until they ugh or he would have had				
	nursing assistant ( R1 know where his	NA)-H stated staff were to let s food and drinks were on the ck method. NA-H stated R1				
	dietary manager (E nutritional assessment the information to t with each resident are staff document reported to him if a noted. DM indicate facility weekly and residents' nutritional not currently on an regular diet. DM de consisted of cutting should have indica further review, DM lacked information	y on 12/21/21, at 11:19 a.m. DM) identified he completed the nents and the dietician added he dietary slip which went out meal. DM indicated the direct red the residents' intakes and ny changes or concerns were d the dietician came to the together they reviewed al status. DM stated R1 was altered diet and R1 received a escribed a mechanical soft diet g up food and each dietary slip ted what size to cut it to. After confirmed R1's dietary slip R1 was on a mechanical soft tified he was on a regular diet				

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	-	AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOORHI	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 808	facility had no spec resident who had b soft diet. During an interview registered dietician mechanical soft die meats were to be c in a ground texture. grapes and cucum served to someone stated the diets wh food for each reside their dietary slip for a resident had beer included a mechan there would be an i During an interview stated the chicken i tough around the er eat the softer meat attempted to eat the too hard for him. During an interview the director of nursi staff completed a c identified each resid sent to dietary staff staff would follow o prescribed diets we had the potential fo the prescribed diet	I soft diet. DM stated the ial menus to follow for a een prescribed a mechanical on 12/21/21, at 3:55 p.m. (RD) confirmed R1 was on a st. RD stated she expected all ut up unless they were already RD confirmed foods such as bers should not have been on a mechanical soft diet. RD ich included the texture of the ent should have been listed on staff to follow. RD confirmed if n served the wrong diet which ical soft diet or pureed diet ncreased risk for choking. on 12/21/21, at 6:43 p.m. R1 he ate at his evening meal was dges however he was able to inside. R1 indicated he e grapes however the skin was of 012/22/21, at 10:35 a.m. ing (DON) stated the nursing ommunication form which dent's diet and the forms were . DON indicated she expected rders to ensure correctly are followed. DON confirmed chanical soft and stated R1 r choking or aspiration when had not been followed.	F				2/18/22
F 880 SS=E	Infection Prevention CFR(s): 483.80(a)(		F 8	80			2/18/22

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER.	A. BUILDII	NG _			C
		245052	B. WING				22/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD RESTORATIVE C	ARE CENTER			310 SECOND AVENUE NORTH OORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ige 68	F 88	80			
	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection	stablish and maintain an and control program a safe, sanitary and nment and to help prevent the ransmission of communicable					
		stablish an infection prevention n (IPCP) that must include, at owing elements:					
	reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based	d upon the facility assessment ng to §483.70(e) and following					
	procedures for the j but are not limited to (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pro-	reillance designed to identify cable diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ransmission-based precautions event spread of infections; isolation should be used for a					

Facility ID: 00938

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		AND HUMAN SERVICES			FORM	02/14/2022 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245052	B. WING_			22/2021	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 880	<ul> <li>(A) The type and dudepending upon the involved, and</li> <li>(B) A requirement t least restrictive post circumstances.</li> <li>(v) The circumstance must prohibit emploid disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in §483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must had transport linens so infection.</li> <li>§483.80(f) Annual r The facility will conditioned under the facility will conditioned in the facility will conditioned under the facility factors and update the facility factors and whore followed where and the facility factors and whore followed where followed</li></ul>	a infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct the disease; and ne procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility. ndle, store, process, and as to prevent the spread of review. duct an annual review of its neir program, as necessary. NT is not met as evidenced tion, interview, and document ailed to ensure appropriate equipment (PPE) practices n entering an isolation room for 326) who had been on isolation nile providing meal service to 5 , R2, R14, R16, R30) in the leficient practice had the II 24 residents currently	F 8	30 1.Resident R326 had isolation unvaccinated status. Staff were on proper donning of PPE prior a resident □s room when an isol is present. Residents R1, R2, R R30 were exposed to potential i related to improper donning of PPE on 1/26/2. This has the potential to affec residents that reside in MRHCC	educated to entering ation cart 14, R16, Ilness nask. All ocess of 22. t all		

Facility ID: 00938

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G		C
		245052	B. WING		•	22/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
MOORHI	EAD RESTORATIVE (	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 880	Continued From pa	age 70	F 88	0		
	Findings include:			were reviewed. Staff were e		
				01/26/2021 on appropriate I		
		Record dated 12/21/21, d been admitted to the facility		entering rooms with isolatio were also educated on prop		
	on 12/17/21, with the	he diagnoses of diabetes		of mask, so that it covers be	oth mouth and	
( ( (		history of COVID-19		nose when they are within 6	feet of	
		baffective disorder, blood clot anemia, and chronic		resident. 3.Audits will be performed o	on infection	
	constipation.			control related specifically to		
				placement. These will be do		
		ote dated 12/17/21, identified mitted to the facility with history		weeks then monthly for 4 m 100% compliance is achieved		
		monia and deep vein		4.Audits will be reviewed by		
	thrombosis (blood	clot). R326 had been placed		or designee and then furthe	r discussion	
	on isolation with all R326's room.	services being provided in		will take place at next QAPI		
	K320 S 100III.			review and recommend any changes.	Thecessary	
		tion and interview on 12/20/21,		5.02/18/22		
		ng assistant (NA)-D obtained n the enclosed cart located in				
		R326's room. NA-D with the				
		nd used his other hand to				
		eping cart that had been parked				
		to R326's room. NA-D entered ng the meal tray without				
		gloves, walked passed the				
		was in the room in full PPE and				
		own on the bedside table. y glass from the bedside table				
		NA-D set up the meal tray and				
	•	side table in front of R326 who				
		e head of bed elevated. oor to R326's room were 2				
		ad "STOP, see charge nurse"				
	and the other which	h read "Isolation PPE, staff to				
		es, mask, and gown, then doff				
		own, and mask". NA-D exited anitized his hands. NA-D				
		not been wearing PPE and				

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		AND HUMAN SERVICES				FORM	02/14/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	entering R326's roo facility protocol staft time there was a sig identifying isolation. Review of the facilit Protective Equipme Using Gloves, and identified the object of infections. Review of the facilit Precautions dated 3 precautions include gowns when enterin were to don gloves resident or the resid gown if substantial environment was an remove gloves and resident room. Dise transmitted and occ worker and a reside MASKS On 12/20/21, from the noon meal serv the following was of -at 11:50 a.m. the d	<ul> <li>ave worn all the PPE when om. NA-D indicated it was the f were to wear all PPE any gn on the resident's door</li> <li>ty policy titled Personal ent Using Protective Eyewear, Using Gowns, undated tive was to prevent the spread</li> <li>ty policy titled Contact 3/23/21, identified contact ed the use of gloves and ng the isolation room. Staff prior to contact with the dents environment, wear a contact with the resident or nticipated. Staff were to gown prior to leaving the ease was more likely to be cur between a health care ent.</li> <li>11:50 a.m. to 1:00 p.m. during fice in the main dining room bserved:</li> </ul>	F	380			
	covered, and a mas	ble cart with goggles on, hair sk worn loosely which hung e DA-A grabbed a glass of					

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		AND HUMAN SERVICES			F		APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	Сом	E SURVEY PLETED
		245052	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD RESTORATIVE C				2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
F 880	Continued From pa	ge 72	F 8	80			
	juice (uncovered) fr	om the cart, walked over to a on the table in front of R1.					
	DA-A stood next to	R1 who was unmasked, nd walked back to the cart.					
	(uncovered), stood	grabbed a glass of juice next to R16 and placed it on					
	sanitizer and walke next to R14 who wa	abbed the bottle of hand d over to R14. DA-A stood as unmasked, bent over with					
	below her nose and	ed loosely placed and hung I asked R14 if he wanted to DA-A verbally instructed him gether.					
	mask in the same p next to R2 who was asked her what she stood next to R2, pl	A walked over to R2 with her position worn loosely, stood a unmasked, bent over, and a would like to drink. DA-A laced a glass of juice on the ad with her for approximately					
	unmasked, placed a table in front of him wanted anything els cup of coffee. DA-A R30. DA-A stood ne while she opened to	A stood next to R30 who was a glass of juice (uncovered) on , bent over, and asked if he se to drink. R30 requested a delivered a cup of coffee to ext to R30, visited with him wo coffee creamers and coffee cup. DA's mask me position.					
	dining room and co remained loosely w Nursing Assistant (I positioned face mas	A stood at the steam table in ntinued to wear mask hich hung below her nose. NA)-C wore a properly sk which covered the nose, , and handed her a breakfast					

Facility ID: 00938

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	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES				1	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´				E SURVEY PLETED
			A. BUILDII	NG	·		C
		245052	B. WING				22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
моорци	EAD RESTORATIVE C			2	2810 SECOND AVENUE NORTH		
	EAD RESTORATIVE C	ARE CENTER		N	MOORHEAD, MN 56560		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
IAG			170		DEFICIENCY)	() () <u></u>	
			1				
F 880	Continued From pa	ge 73	F 88	80			
	· ·	observed to provide education					
		e nose with the mask.					
		2:50 p.m. DA-A transferred					
		the food cart. The dietary e a properly positioned face					
		d the nose and stood on the					
		eam table during the entire					
		as not observed to provide					
		o cover the nose with the					
	mask.						
	-at 12·30 n m □A-4	A reached up and pulled up her					
		e, however the mask remained					
		e sanitized her hands the					
	mask slid back dow	n below her nose.					
		ness office manager (BOM)					
		oom, wore a properly sk which covered the nose,					
		, and asked if R30 had eaten					
		ask remained positioned					
		below her nose responded					
		bserved to provide education					
	to DA-A to cover the	e nose with the mask.					
	-at 1:00 n m DA-A	remained in the dining room					
		nued in the same position.					
		ained in the dining room while					
		e dirty dishes from the dining					
	room tables.						
	During on interview	on 12/21/21, at 12:02 p.m.					
		xpected to wear a mask that					
		and nose while they worked;					
		esent were around residents					
	and staff. NA-A sta	ted wearing a mask helped					
		of any germs such as					
	COVID-19.						

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
AND FLAN C	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	ING .			C
		245052	B. WING				22/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH		
MOORH	EAD RESTORATIVE C	ARE CENTER			NOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 74	F 8	80			
	During an interview 12:37 p.m. DA-A sta to keep over her no expected to keep o especially when clo delivered food to he infection. During the remained positione her nose then DA-A to cover the nose a During an interview the facility cook (C) to wear a mask ove especially when pre- during meal service infection. During an interview stated all dietary sta mask which covere goggles or a face s and when out amor practice helped pre- Review of an undat Protective Equipme identified the purpo masks to prevent tr agents through the face mask so that if	/observation on 12/21/21, at ated the mask had been hard se. DA indicated staff were ur mask over the nose se to residents, visiting, and elp prevent the spread of e interview DA-A's mask d loosely, which hung below a re-positioned the face mask nd walked away on 12/21/21, at 12:54 p.m. -A stated staff were expected er the mouth and nose esent around the residents and to help prevent the spread of on 12/22/21, at 7:52 a.m. DM aff were expected to wear a d the mouth and nose and hield when meals were served ag residents. DM identified this					

Facility ID: 00938

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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 <u>only a suggestion</u> 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>. 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.

## Moorhead Restorative Care Center January 21, 2022 Page 2 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

		AND HUMAN SERVICES & MEDICAID SERVICES	F50	052	2034	FORM	: 02/17/2022 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245052	B. WING			12/	22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MOORH	EAD RESTORATIVE O			2	810 SECOND AVENUE NORTH		
WOORT				N	IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 00	00			
	FIRE SAFETY						
	Minnesota Departm Marshal Division or this survey, Moorhe not in compliance w participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Code (LSC), Chapt	Survey was conducted by the nent of Public Safety, Fire 12/22/2021. At the time of ead Rehab & HCC was found with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety er 19 Existing Health Care n of NFPA 99, The Health e.					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
		E AN EPOC, A PAPER COPY CORRECTION IS NOT					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

		AND HUMAN SERVICES				FORM	02/17/2022 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0938-0391 E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	01 - MAIN BUILDING 01	COM	PLETED
		245052	B. WING			12/:	22/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH NOORHEAD, MN 56560		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
K 000	Continued From pa	ge 1	К 0	00			
	HEALTH CARE FIF STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 5510	SHAL DIVISION STREET, SUITE 145					
	By e-mail to: FM.HC.Inspections	@state.mn.us					
		RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION:					
		ption of the corrective action correct the deficiency.					
		sures that will be put in place ency does not reoccur.					
		facility plans to monitor future solutions are sustained.					
	4. Identify who is re actions and monitor	sponsible for the corrective ring of compliance.					
	5. The actual or pro the remedy.	posed date for completion of					
	three stages. In 196 was constructed with determined to be Ty 1998 a 1-story addii northeast of the east and was determined construction. In 200	ive Care Center was built in 63 the original 1-story building thout a basement and was ype II (111) construction. In tion was constructed to the st wing of the original building d to be Type V (111) 09 a dayroom addition was northeast corner of the original					

Facility ID: 00938

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM	02/17/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION (X3 01 - MAIN BUILDING 01		E SURVEY PLETED
		245052	B. WING	i		12/2	22/2021
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD RESTORATIVE C	ARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	building and a dinin southeast of the ori constructed. These 1-story without a bar The building is fully fire alarm system w and smoke detection corridors. The fire a automatic fire depa The facility has a car census of 23 at the The requirements a are NOT MET: Means of Egress - 0 CFR(s): NFPA 101 Means of Egress - 0 Aisles, passageway exit locations, and a with Chapter 7, and continuously mainta full use in case of e 18/19.2.2 through 1 18.2.1, 19.2.1, 7.1.7 This REQUIREMEN by: Based on observat facility failed to prov the means of egress 101 (2012 edition), 19.2, 7.1.10.1., 7.1.	g room addition to the ginal dining room was additions are Type II (000), asement. sprinkler protected and has a with corridor smoke detection on in spaces open to the alarm system is monitored for rtment notification. apacity of 78 beds and had a time of the survey. at 42 CFR, Subpart 483.70(a) General General (s, corridors, exit discharges, accesses are in accordance I the means of egress is ained free of all obstructions to mergency, unless modified by 8/19.2.11. 10.1 NT is not met as evidenced tion and staff interview, the vide unobstructed access to as as required by the NFPA Life Safety Code sections, 10.2.1, & 7.1.6.4 These ould have a patterned impact		211		ng i are n oved.	3/10/22

Facility ID: 00938

If continuation sheet Page 3 of 22

		AND HUMAN SERVICES			F	ORM	02/17/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245052	B. WING			12/2	22/2021
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C	CARE CENTER			310 SECOND AVENUE NORTH OORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 211	Findings include: 1. On 12/22/2021, revealed there is a chairs located in the obstructing exit acc from the dining root 2. On 12/22/2021, revealed that the ex- main dining room h that are covering the making the panic b event of an emerged 3. On 12/22/2021,	at 1:05 PM, observations vending machine, table, and e main dining room that are cess of the means of egress m. at 1:05 PM, observations kit door that is located in the has blinds attached to the door he egress panic bar hardware ar not readily visible in the	К 2	211	<ul> <li>2.All residents have the potential to be affected by this deficiency. Physical P Director and maintenance assistant h been educated on NFPA 101 Life Saf Code sections 19.2, 7.1.10.1, 7.1.10.3, 7.1.6.4, rules pertaining to means of egress.</li> <li>3. An audit to ensure that means of egress are free from obstructions will performed Daily for 1 week, weekly for month, then monthly x 11 months. Refor the audit will be reported at QAPI for further oversight and review.</li> <li>4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.</li> </ul>	Plant have fety 2.1 & be or 1 esults or	
K 291 SS=F	removed in two sec sidewalk located ou station number 2. An interview with the verified these defice discovery. Emergency Lighting CFR(s): NFPA 101 Emergency Lighting is provided automa 18.2.9.1, 19.2.9.1 This REQUIREMENT by: Based on a review and staff interview, battery-operated er	ctions of the egress discharge utside the exit by nursing ne Maintenance Supervisor ient findings at the time of g	К 2	91	1. There are no specific residents identified. The annual 90-minute annu test/inspection was done on the battery-operated emergency lights. Th	ual	3/10/22

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		AND HUMAN SERVICES			FORM	: 02/17/202 APPROVE . 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION IG <b>01 - MAIN BUILDING 01</b>		E SURVEY IPLETED
		245052	B. WING _		12/22/2021	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MOORHE	EAD RESTORATIVE O	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 291	- 1	ige 4 dings could have a widespread	K 29	battery-operated emergency light	s have	
		ents within the facility.		been counted, labeled with the nu 1, 2, 3, 4. 2.All residents have the potential	umbers,	
	Findings include:	at 11:43 AM a review of		affected. Physical Plant Director maintenance assistant have been educated on NFPA 101 (2012 ed	and า	
	available battery-op testing documentat Maintenance Supe	ble battery-operated emergency lighting g documentation and interview with the enance Supervisor it was observed that the 3. An audit to ensure	Safety Code section 7.9.3.1.1, ru pertaining to emergency lighting. 3. An audit to ensure emergency	les <sup>′</sup> lighting		
	documentation the test/inspection for a			testing will be done weekly x 8 we monthly for 4 months, until 100% compliance is achieved. well as proper labeling of lighting	]	
	available battery-op	at 11:43 AM, a review of perated emergency lighting		equipment will be done . Results audit will be reported at QAPI for oversight and review.		
	Maintenance Super facility's emergency	ion and interview with the rvisor it was observed that the y lighting testing t was provided for the last 6		<ol> <li>Maintenance Director will be responsible for corrective actions monitoring of compliance.</li> </ol>	and	
	months since their information for devi Two of the six docu listed which conflict that listed four devi	last survey had conflicting ices located within the facility. Iments had only three devices ted with the other documents ces. The documentation also e names being used to identify				
	the facility's emerge					
	verified these deficient discovery.	e Maintenance Supervisor ient findings at the time of				
	Hazardous Areas - CFR(s): NFPA 101	Enclosure	K 32	1		3/10/22
	Hazardous Areas - Hazardous areas a	Enclosure re protected by a fire barrier				

Facility ID: 00938

If continuation sheet Page 5 of 22

		AND HUMAN SERVICES			F	TED: 02/17/20 ORM APPROVE NO. 0938-03	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED 12/22/2021	
		245052	B. WING	i			
NAME OF I	PROVIDER OR SUPPLIER	L	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C	ARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE	
K 321	fire rated doors) or system in accordan When the approved system option is us separated from oth partitions and doors Doors shall be self- and permitted to ha protective plates tha from the bottom of Describe the floor a hazardous areas th 19.3.2.1, 19.3.5.9 Area Separation N// a. Boiler and Fuel-F b. Laundries (larger c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo	esistance rating (with 3/4 hour an automatic fire extinguishing ice with 8.7.1 or 19.3.5.9. d automatic fire extinguishing ed, the areas shall be er spaces by smoke resisting s in accordance with 8.4. colosing or automatic-closing ive nonrated or field-applied at do not exceed 48 inches the door. and zone locations of lat are deficient in REMARKS. Automatic Sprinkler A Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms	K	321			
	(over 50 square fee g. Laboratories (if of Hazard - see K322) This REQUIREMEN by: Based on observat revealed that the fa proper protection for areas located throu 101 (2012 edition), sections 8.7.1.1, 8. These deficient find	et) lassified as Severe			<ol> <li>There were no specific residents identified. A new ceiling tile has been of to fill the area around the electrical conduit, and a special fire rated caulki has been ordered to fill in any gap. All excess combustibles and unused item from the therapy area have been removed.</li> <li>All residents could be affected. Phys Plant Director and maintenance assist</li> </ol>	ng ns sical	

Facility ID: 00938

		AND HUMAN SERVICES			I	FORM	02/17/2022 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (> 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245052	B. WING			12/2	22/2021
	PROVIDER OR SUPPLIER	CARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE 310 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 321 K 341 SS=D	observation that the around electrical co the Physical Therap 2. On 12/22/2021, by observation that Physical Therapy ro the therapy area ind waiting areas that is that is being used a combustibles, walk therapy equipment. as a storage room rated construction a self-closing door. An interview with th verified these defice discovery. Fire Alarm System CFR(s): NFPA 101 Fire Alarm System A fire alarm system components approvaccordance with NF and NFPA 72, Natio provide effective wa building. In areas n detection is installe unit. In new occupa at notification applia and supervising sta	at 1:19 PM, it was revealed by ere are vertical penetration onduit that are located within by mechanical room. , at 1:32 PM, it was revealed there is an area of the bom that is open to the rest of cluding the reception and s greater than 100 square feet as a storage room for excess ers, wheelchairs, and unused . This area that is being used is not protected through fire and is also not protected by a the Maintenance Supervisor ient findings at the time of - Installation	КЗ		have been educated on NFPA 101 (2 edition) Life Safety Code sections, 8. 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 ar protected by a fire barrier with a 1-ho fire rating will be performed Daily for weeks, weekly for 4 weeks, then mor x 4 months. Results of the audit will b reported at QAPI for further oversigh 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 b used once received.	.7.1.1, re bur 2 nthly be t and d	3/10/22

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION ()		SURVEY	
		245052	B. WING		40/0	0/0004	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/2	2/22/2021	
	EAD RESTORATIVE			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE	
K 341	Continued From p paths are monitore 18.3.4.1, 19.3.4.1,	ed for integrity.	K 34	1			
	by: Based on observa facility failed to ins system in accorda NFPA 101 (2012 e sections 19.3.4.1 a (2010 edition), Nat Code section 17.7	ENT is not met as evidenced ation and staff interview, the tall and maintain the fire alarm nce with the requirements of dition), The Life Safety Code, and 9.6, as well as NFPA 72 tional Fire Alarm and Signaling .4.1. This deficient finding ated impact on the residents		<ol> <li>No residents were identified. A sp baffle will be constructed to remove to smoke detector from direct air flow.</li> <li>All residents have the potential to affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition Safety Code sections, 19.3.4.1 &amp; 9.6 well as NFPA 72 (2010 edition), Nation Fire Alarm and Signaling Code section 17.7.4.1.</li> <li>An audit to ensure that all smoke</li> </ol>	the be n) Life i, as onal		
	On 12/22/2021 at revealed, that the linking corridor bet senior apartments	12:19 PM, observation smoke detectors located in the ween the care center and the was installed in the direct air hin 36 inches of a HVAC vent		<ul> <li>detectors are installed in a compliant fashion will be performed weekly x 8 weeks then monthly for 4 months, ur 100% compliance is achieved. Result the audit will be reported at QAPI for further oversight and review.</li> <li>4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.</li> <li>5. The baffle will be installed by 2/18/2</li> </ul>	ntil Its of d		
K 345	verified this deficie discovery.	he Maintenance Supervisor ent finding at the time of - Testing and Maintenance	K 345			3/10/22	
	CFR(s): NFPA 101 Fire Alarm System						

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		AND HUMAN SERVICES			F	ORM /	02/17/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION (X 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245052	B. WING	÷		12/22/2021	
NAME OF F	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 345	with the requirement Electric Code, and and Signaling Code acceptance, mainte available. 9.6.1.3, 9.6.1.5, NF This REQUIREMEN by: Based on a review and staff interview, maintain the fire ala (2012 edition), Life and NFPA 72 (2010 and Signaling Code 14.4.5.3. These de widespread impact facility. Findings include: 1. On 12/22/2021,	approved program complying hts of NFPA 70, National NFPA 72, National Fire Alarm a. Records of system enance and testing are readily	K	345	DEFICIENCY)		
	inspection document Maintenance Super provide any current a semiannual inspection had been complete 2. On 12/22/2021, by a review of avail inspection document Maintenance Super provide any current an annual fire alarm completed. 3. On 12/22/2021,	ntation and an interview with visor, that the facility could not documentation verifying that ection of all initiating devices			<ul> <li>14.3.1, and 14.4.5.3, rules pertaining fire alarm system - testing and maintenance.</li> <li>3.An audit to ensure the completion of fire alarm inspections will be performed monthly x 2 months, then every 6 mo x 12 months. Results of the audit will reported at QAPI for further oversight review.</li> <li>4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.</li> </ul>	of all ed onths be t and	

Facility ID: 00938

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		AND HUMAN SERVICES & MEDICAID SERVICES		F	TED: 02/17/2022 ORM APPROVED NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION (X3 G 01 - MAIN BUILDING 01	3) DATE SURVEY COMPLETED
		245052	B. WING		12/22/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-
MOORHE	EAD RESTORATIVE C	ARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
K 345	Maintenance Super provide any current	ntation and an interview with visor, that the facility could not documentation verifying that pection of all smoke detection	K 34	5	
		e Maintenance Supervisor ent findings at the time of Installation	K 35 <sup>.</sup>	I	3/10/22
	construction type, a approved automatic accordance with NF Installation of Sprin In Type I and II con measures are perm sprinkler protection or local regulations In hospitals, sprinkl closets of patient sl of the closet does r sprinkler coverage required by NFPA 1 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9 This REQUIREMEN by: Based on observat facility failed to insta system per NFPA 1	d hospitals where required by ire protected throughout by an c sprinkler system in FPA 13, Standard for the kler Systems. struction, alternative protection nitted to be substituted for in specific areas where state prohibit sprinklers. ers are not required in clothes eeping rooms where the area not exceed 6 square feet and covers the closet footprint as 3, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5,		1. No specific resident was identified. quick response type of fire sprinkler he have been separated from the standa response fire sprinkler heads.	eads

Facility ID: 00938

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		AND HUMAN SERVICES			FOR	D: 02/17/2022 MAPPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245052	B. WING		1	2/22/2021
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MOORH	EAD RESTORATIVE C	CARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Systems, section 8 could have an isola within the facility. Findings include: On 12/22/2021 at 1 that there are quick heads located in the area that are in the standard response An interview with th verified this deficien discovery. Sprinkler System - CFR(s): NFPA 101 Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe maintained in a sec available. a) Date sprinkler s	<ul> <li>The Installation of Sprinkler .3.3.2. This deficient finding ted impact on the residents</li> <li>:19 PM, observation revealed response type of fire sprinkler e Physical Therapy reception same compartment as fire sprinkler head.</li> <li>Maintenance Supervisor nt finding at the time of</li> <li>Maintenance and Testing and standpipe systems are and maintained in accordance idard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily</li> <li>system last checked</li> </ul>		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, sectior 8.3.3.2. An additional fire sprinkler head box was installed in the Physical Therap 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, ur 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.	и, У И

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	-	AND HUMAN SERVICES	1		FORM	02/17/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	IPLE CONSTRUCTION ( NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245052	B. WING		12/2	22/2021
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE O	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 353	Continued From pa	ige 11	К 3	53		
	system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMEI by: Based on observat and staff interview, system is not main NFPA 101 (2012 ec section 9.7.5, and Standard for the Ins Maintenance of Wa Systems, sections a deficient finding con the residents within Findings include: On 12/22/2021, at there were 6 unsect were not protected within the spare spi in the Physical The An interview with the verified this deficient discovery. HVAC CFR(s): NFPA 101 HVAC Heating, ventilation	NT is not met as evidenced tions, documentation review, the automatic sprinkler tained in accordance with dition) The Life Safety Code, NFPA 25 (2011 edition) the spection, Testing, and atter Based Fire Protection 5.4.1.4 and 5.4.1.4.2. This uld have an isolated impact on a the facility. 1:35 PM, it was revealed that from being damaged, stored rinkler head box that is located rapy mechanical room 112. The Maintenance Supervisor at finding at the time of	K 5.	<ol> <li>There were no residents identifie unsecured fire sprinkler heads have secured by installing an additional fir sprinkler head box in the Physical Therapy mechanical room.</li> <li>All residents had the potential to b affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition Life Safety Code, section 9.7.5, and 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance Water Based Fire Protection System sections 5.4.1.4 and 5.4.1.4.2</li> <li>An audit will be done weekly x 8 w then monthly for 4 months, until 100 compliance is achieved. to ensure proper storage of sprinkle heads will be achieved. Results of th audit will be reported at QAPI for fur oversight and review.</li> <li>Maintenance Director will be responsible for corrective actions an monitoring of compliance.</li> </ol>	been re n), NFPA e of ns, veeks % r ne ther	3/10/22

Facility ID: 00938

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					10.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DATE SURVEY
		245052	B. WING		12/22/2021
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MOORHE	AD RESTORATIVE C	ARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 521	Continued From pa	ge 12	K 521		
	by: Based on a review and staff interview, inspect the fire and NFPA 101 (2012 ec sections 9.2 and 19 the Standard for Fir Protectives, section NFPA 90A (2012 ec Installation of Air-Ca Systems, section 5 edition) the Recom Installation of Smok sections 6.5.11, 6.5 finding could have a residents within the Findings include: On 12/22/2021 at 1 available fire damp documentation and Maintenance Super facility could not pro documentation veri damper testing and completed within the An interview with th verified this deficier discovery.	2:00 PM, during a review of all er test and inspection an interview with the rvisor, it was revealed that the ovide any current fying that the fire and smoke inspections have been		<ol> <li>No specific residents were identified Summit Fire Protection has been contacted and the fire and smoke damp 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, a 19.4.10 and 19.5.5, NFPA 90A (2012 edition) the Standard for the Installation Air Conditioning and Ventilating System 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</li> <li>An audit will be done weekly x 8 wee 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.</li> <li>Maintenance Director will be responsible for corrective actions and monitoring of compliance.</li> </ol>	er I. nd of s, I Ks
K 712 SS=F	discovery. Fire Drills		K 712		3/10/22

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		AND HUMAN SERVICES				FORM	02/17/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245052	B. WING	i	12/22/2021		
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C	CARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
-	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			712	1.There were no specific residents identified. A fire drill was conducted	and a	
	Code, sections 19.3 deficient findings co on the residents with Findings include: 1. On 12/22/2021, review of all availab interview with the M revealed that the fa drills for the overnig months since their 2. On 12/22/2021, review of all availab interview with the M revealed that the fa	at 11:00 AM., during the ole fire drill documentation and laintenance Supervisor, it was cility did not conduct 1 of 2 fire ght shift within the last 6 last survey was conducted. at 11:00 AM., during the ole fire drill documentation and laintenance Supervisor, it was cility had not transmitted a fire cate that notifcation devices			fire alarm signal was transmitted. 2. All residents had the potential to the affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition Life Safety Code, sections, 19.7.1.2 19.7.1.4 3. An audit to ensure that fire alarm are being conducted will be done were the sweeks then monthly for 4 months, 100% compliance is achieved. . Results of the audit will be reported QAPI for further oversight and revie 4. Maintenance Director will be responsible for corrective actions ar monitoring of compliance.	d n), 2 and tests eekly x until d at w.	

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		AND HUMAN SERVICES & MEDICAID SERVICES				NTED: 02/17/2022 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			K3) DATE SURVEY COMPLETED
		245052	B. WING	i		12/22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MOORHE	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
K 712	Continued From pa	ge 14	ĸ	712		
K 751 SS=F	verified these defici discovery.	e Maintenance Supervisor ent findings at the time of the , and Loosely Hanging Fabr	K	751		3/10/22
	Draperies, curtains loosely hanging fab accordance with 10 draperies: at showe patient sleeping roc compartments; and in sprinklered comp drapery or curtain p square feet or total percent of the wall. 18.7.5.1, 18.3.5.11, This REQUIREMEN by: Based on observat privacy curtains in t requirements for Fu Decorations for use accordance with pro (2012 edition), Life and 19.7.5.1. Thes a widespread impact facility. Findings Include: 1. On 12/22/2021, tour, observations r divider curtain locat	a, and Loosely Hanging Fabrics including cubicle curtains and ric or films shall be in .3.1. Excluding curtains and ers and baths; on windows in om located in sprinklered in non-patient sleeping rooms partments where individual anels do not exceed 48 area does not exceed 20 19.7.5.1, 19.3.5.11, 10.3.1 NT is not met as evidenced ions and staff interview, the he facility do not meet the urnishing, Bedding, and e in health care occupancies in ovisions of the NFPA 101 Safety Code, sections 10.3.1 the deficient findings could have ct on the residents within the at 12:13 PM during the facility evealed that the privacy red in resident room 401 did ng attached to them stating			<ol> <li>There were no specific residents identified. The privacy divider located room 401, 402 and the 200 wing spa room have been removed and replace with a new divider that is fire retardar 2. All residents have the potential to affected. Physical Plant Director and maintenance assistant have been educated on NFPA 101 (2012 edition Life Safety Code, sections 10.3.1, an 19.7.15.1</li> <li>An audit to ensure that all furnishin bedding, and decorations are inherent fire retardant will be performed week weeks then monthly for 4 months, un 100% compliance is achieved. Results of the audit will be reported and</li> </ol>	ced nt. be n), id ng, ntly ly x 8 itil

Facility ID: 00938

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		AND HUMAN SERVICES			FORM	D: 02/17/2022 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			. ,	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245052	B. WING _		12	2/22/2021
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP C		
MOORHI	EAD RESTORATIVE C	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 751	Continued From pa	ige 15	K 75	51		
	that it is "inherently	•		QAPI for further oversight a 4. Maintenance Director will		
	tour, observations r divider curtain locat	at 12:14 PM during the facility revealed that the privacy ted in resident room 402 did ng attached to them stating fire retardant".		responsible for corrective a monitoring of compliance.		
	tour, observations r divider curtain locat	at 1:45 PM during the facility revealed that the privacy ted in the 200 wing spa did not ttached to them stating that it tardant".				
K 761 SS=F	verified these deficient discovery.	e Maintenance Supervisor ient findings at the time of the ection & Testing - Doors	K 76	61		3/10/22
	Fire doors assemble annually in accordation for Fire Doors and a Non-rated doors, in patient rooms and a routinely inspected maintenance progra Individuals perform testing possess know that demonstrates a Written records of i maintained and are 19.7.6, 8.3.3.1 (LSC 5.2, 5.2.3 (2010 NF	ing the door inspections and owledge, training or experience ability. nspection and testing are available for review. C)				

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		AND HUMAN SERVICES			FORM	: 02/17/202 APPROVEI . 0938-039
			IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY IPLETED	
		245052	B. WING		12	22/2021
	ROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
К 901	and staff interview, the fire door inspect edition), Life Safety , and NFPA 80 (20 Doors and Other O 5.2.1. This deficient widespread impact facility. Findings include: On 12/22/2021, at review of available documentation and Maintenance Super provide any current the fire door inspect within the last 12 m An interview with th verified this finding Fundamentals - Bu CFR(s): NFPA 101 Fundamentals - Bu Building systems an 1 through 4 require Categories are deter	<ul> <li>of available documentation the facility failed to conduct stions per NFPA 101 (2012</li> <li>code, sections 8.3.3.1, 19.7.6</li> <li>10 edition), Standard for Fire pening Protectives, section at finding could have a on the residents within the</li> <li>11:50 AM, it was revealed by a fire door test and inspection an interview with the rvisor, that the facility could not a documentation verifying that stion had been completed bonths.</li> <li>Maintenance Supervisor at the time of discovery.</li> <li>ilding System Categories re designed to meet Category ments as detailed in NFPA 99.</li> <li>ermined by a formal and ssessment procedure fied personnel.</li> </ul>	К 76	<ol> <li>No residents were identified. A Doors have been inspected.</li> <li>All residents have the potential affected. Physical Plant Director a maintenance assistant have been educated on NFPA 101 (2012 edited Life Safety Code, sections 8.3.3.</li> <li>T.6, and NFPA 80 (2010 edited Standard for Fire Doors and Othed Opening Protectives, section 5.2.</li> <li>An audit to ensure that all fire of be inspected will be done weekly weeks then monthly for 4 months 100% compliance is achieved. Re the audit will be reported at QAPI further oversight and review.</li> <li>Maintenance Director will be responsible for corrective actions monitoring of compliance.</li> </ol>	to be and tion), l, and n), er 1.3. doors will r x 8 , until esults of for	3/10/22
	This REQUIREME	NT is not met as evidenced				

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		AND HUMAN SERVICES			FORM	02/17/2022 APPROVED 0938-0392
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G <b>01 - MAIN BUILDING 01</b>	(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		12/	22/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MOORHE	EAD RESTORATIVE C	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 901	Continued From pa	ige 17	K 90	1		
	and staff interview, provide a complete NFPA 99 (2012 edi Code, section 4.1. have a widespread the facility. Findings include: On 12/22/2021, at available document Maintenance Super facility could not pro-	of available documentation the facility has failed to facility Risk Assessment per tion), Health Care Facilities This deficient finding could impact on the residents within 11:30 AM, during a review of tation and an interview with rvisor, it was revealed that the poide a completed utility risk thent at the time of the		<ol> <li>There are residents identified. The Utility Risk Assessment was update 2.All residents have the potential to affected. Physical Plant Director are maintenance assistant have been educated on NFPA 99 92012 edition Health Care Facilities Code, section 3. An audit to ensure that the utility assessment is updated will be performental for 6 months. Results of the will be reported at QAPI for further oversight and review.</li> <li>Maintenance Director will be responsible for corrective actions a monitoring of compliance.</li> </ol>	ed o be nd n), n 4.1 risk ormed ne audit	
K 911 SS=E	verified this deficient discovery. Electrical Systems CFR(s): NFPA 101 Electrical Systems List in the REMARH Chapter 6 Electricat are not addressed are deficient. This i applicable Life Safe citation, should be Chapter 6 (NFPA 9	- Other KS section any NFPA 99 I Systems requirements that by the provided K-Tags, but nformation, along with the ety Code or NFPA standard included on Form CMS-2567.	K 91	1		3/10/22
	by: Based on observa	tions and staff interview, the nitor conditions affecting the		1.No residents were identified. An electrical outlet cover has been put	in	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/17/2022 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION () 01 - MAIN BUILDING 01		E SURVEY PLETED
		245052	B. WING			12/2	22/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 911	edition) Life Safety NFPA 70, (2011 edi section 422.4. The have a patterned in the facility. Findings include: 1. On 12/22/2021, tour, observations r electrical outlet loca loading clothes was missing the outlet of electrical connection 2. On 12/22/2021, tour, observations r fan that is located in has exposed live el	ystem per NFPA 101 (2012 Code, section 9.1.2, and tion), National Electrical Code, se deficient findings could npact on the residents within at 12:34 PM, during the facility evealed that there is an ated behind the white front sher in the laundry room that is over and is exposing live	KS	)11	<ul> <li>place behind the washer in the laund room. A replacement canopy for the ceiling fan in the main dining room habeen ordered and will be installed.</li> <li>2. All residents have the potential to 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 Ele Code, section 422.4.</li> <li>3. An audit will be done weekly x 8 w then monthly for 4 months, until 100° compliance is achieved to make sure all systems are in safe condition and covers are in place. Results of the at will be reported at QAPI for further oversight and review.</li> <li>4. Maintenance Director will be responsible for corrective actions and monitoring of compliance.</li> </ul>	as be n), d ctrical veeks % e that I wire udit	
	verified these defici discovery. Electrical Systems CFR(s): NFPA 101 Electrical Systems Maintenance and T	e Maintenance Supervisor ent findings at the time of the - Essential Electric Syste - Essential Electric System esting ther alternate power source	К 9	18			3/10/22
	and associated equiservice within 10 securities of the criterion is not met	ipment is capable of supplying conds. If the 10-second during the monthly test, a ovided to annually confirm this					

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		AND HUMAN SERVICES			FORM	02/17/2022 APPROVED 0938-0391
			` '	LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245052	B. WING	9	12/	22/2021
	PROVIDER OR SUPPLIER	CARE CENTER	•	STREET ADDRESS, CITY, STATE, Z 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 918	Maintenance and te transfer switches at with NFPA 110. Generator sets are under load 30 minu day intervals, and e months for 4 contin under load conditio simulated cold start transfer of all EES I competent personn stored energy powe accordance with NF circuit breakers are program for periodi components is esta manufacturer requi maintenance and te readily available. El circuits are marked separate from norm the possibility of da source is a design o installations. 6.4.4, 6.5.4, 6.6.4 (I 111, 700.10 (NFPA This REQUIREMEN by: Based on documen interview, the facilit the emergency gen edition), The Life Sa and NFPA 110 (201 Emergency and Sta 8.4.2. This deficier	e safety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised tes 12 times a year in 20-40 exercised once every 36 uous hours. Scheduled test ns include a complete t and automatic or manual loads, and are conducted by tel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder inspected annually, and a cally exercising the ablished according to rements. Written records of esting are maintained and ES electrical panels and , readily identifiable, and nal power circuits. Minimizing mage of the emergency power consideration for new	K	918 1.No residents were ide test of the generator at 3 load was completed on 2.All residents have the affected. Physical Plant maintenance assistant h educated on NFPA 101 ( Life Safety Code, section NFPA 110 (2010 edition) Emergency and Standby	30% of it's kilowatt 1/26/21 potential to be Director and nave been (2012 edition), ns 9.1.3, and o, Standard for	

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		AND HUMAN SERVICES			FOF	D: 02/17/2022 M APPROVED O. 0938-0392
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245052	B. WING		1	2/22/2021
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MOORHI	EAD RESTORATIVE C	ARE CENTER			810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From pa Findings include:	-	K 9	918	section 8.4.2. 3. An audit to ensure that generator	
	review of available inspection document the Maintenance Su not provide or docu the emergency gen	11:13 AM, it was revealed by a emergency generator test and ntation and an interview with upervisor, that the facility could ment information verifying that erator had been tested ent of the generator kilowatt			testing is being done will be done weekly 8 weeks then monthly for 4 months, unti 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.	
	verified these findin	e Maintenance Supervisor Igs at the time of discovery. It - Power Cords and Extens	K 9	920		3/10/22
	Extension Cords Power strips in a para used for component patient-care-related (PCREE) assemble by qualified personn 10.2.3.6. Power str may not be used for electronics), except rooms that do not up PCREE meet UL 13 strips for non-PCRE (outside of vicinity) care rooms, power standards. All power precautions. Exten substitute for fixed Extension cords us immediately upon of	atient care vicinity are only ts of movable delectrical equipment es that have been assembled nel and meet the conditions of rips in the patient care vicinity r non-PCREE (e.g., personal tin long-term care resident ise PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL er strips are used with general sion cords are not used as a wiring of a structure. ed temporarily are removed completion of the purpose for ed and meets the conditions of				

Facility ID: 00938

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		i í	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
	245052		B. WING		12/22/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD RESTORATIVE (	CARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 920	<ul> <li>10.2.4.</li> <li>10.2.3.6 (NFPA 99) (NFPA 70), 590.3(I This REQUIREME by: Based on observa facility failed to mor facility's electrical se edition) Life Safety (2012 edition), Hea section 10.2.3.6 (2 (2011 edition), Nati 400-8, 590.3(D). T have an isolated in the facility.</li> <li>Findings include:</li> <li>1. On 12/22/2021, tour, observations front loading clother multi-plug power ta</li> <li>2. On 12/22/2021, tour, observations extension cord plug tap located in the la suspended heater.</li> </ul>	at 12:42 PM, during the facility revealed that there is a white estimate the residence of the there is a white estimate the residence of the residence of the system per NFPA 101 (2012). Code, section 9.1.2, NFPA 99 alth Care Facilities Code, (3), 10.2.4, and NFPA 70, for all Electrical Code, sections these deficient findings could have the residents within the resident of the resident is plugged into a section. The section is the resident is plugged into a section of the residence of the revealed that there is a section. The revealed that there is a matter of the revealed in the laundry room. The revealed that there is a matter of the revealed that there is a matter of the revealed that there is a matter of the revealed that there is an an ultiplug power aundry room below the revealed the revealed the revealed the revealed the revealed that there is a matter of the revealed th	K 92	<ul> <li>1. No residents were identified. T extension cord and multi-plug pov in the laundry room have been re 2.All residents had the potential to affected. Physical Plant Director a maintenance assistant have beer educated on NFPA 101 (2012 edi Life Safety Code, sections 9.1.2, NFPA 99 (2012 edition), Health C Facilities Code, section 10.2.3.6 (2) &amp;(3), 10.2.4, and NFPA 70,(20 edition), National Electrical Code, 400-8, 590.3(D).</li> <li>3. An audit to ensure that no mult power taps or extension cords are used will be done weekly x 8 wee monthly for 4 months, until 100% compliance is achieved. Results of audit will be reported at QAPI for oversight and review.</li> <li>4. Maintenance Director will be responsible for corrective actions monitoring of compliance.</li> </ul>	ver tap moved. b be ind tion), and are 11 sections i-plug b being ks then of the further	

Facility ID: 00938

If continuation sheet Page 22 of 22

# PRINTED: 02/14/2022 FORM APPROVED

Minnesc	ta Department of He	ealth				ATTROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COMP	SURVEY PLETED
		00938	B. WING		12/2	C 2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENU EAD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correputsion of a survey found that the deficient of the end of the end of the end of the minnesota Depermination of w corrected requires requirements of the Minnesota MN Regulate and MN Regulate and MN Regulate and the end of t	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is siency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health. hether a violation has been compliance with all e rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result fror orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was conduct by surveyors from the Health (MDH). You compliance with the	TS: /22/21, a standard licensing ted completed at your facility the Minnesota Department of r facility was found NOT in e MN State Licensure. The orders were issued.				
	epartment of Health	DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE		(X6) DATE
	ically Signed	JENSOFFLIER REPRESENTATIVES SIC		IIILE		01/30/22

STATE FORM

### PRINTED: 02/14/2022 FORM APPROVED

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00938	B. WING			22/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
MOORH	EAD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	SUBSTANTIATED: H5052149C (MN79 cited at 0900 and 0 H5052157C (MN58 cited at 0900 H5052162C (MN56 cited at 0920	9264) with licensing orders				
	SUBSTANTIATED: H5052154C (MN74 H5052155C (MN62 H5052156C (MN59 H5052158C (MN57 H5052159C (MN57 H5052160C (MN57 H5052161C (MN56 H5052164C (MN57	4674) 2868) 9623) 7537) 7152) 7071) 5989) 7738), however NO licensing lue to actions implemented by				
	AND The following comp UNSUBSTANTIATI H5052150C (MN78 H5052151C (MN74 H5052153C (MN74	3262) 5159) 1974)				
	correction that you	our electronic plan of have reviewed these orders, e when they will be completed.				
	the State Licensing	nent of Health is documenting Correction Orders using Tag numbers have been				

STATE FORM

LZD411

If continuation sheet 2 of 73

### PRINTED: 02/14/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00938		B. WING			C 22/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHE	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 2 sota state statutes/rules for	2 000			
	appears in the far I Tag." The state sta listed in the "Summ column and replace the correction orde the findings which a statute after the sta as evidence by." Fo findings are the Su and Time Period fo You have agreed to receipt of State lice the Minnesota Dep Informational Buller http://www.health.s obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for Sta enter the word "CC available for text. Y electronic State lice heading completion be corrected prior to the Minnesota Dep is enrolled in ePOC not required at the state form. PLEASE DISREGA FOURTH COLUMM "PROVIDER'S PLA APPLIES TO FEDE	o participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
2 265	MN Rule 4658.008 Resident Health St	5 Notification of Chg in	2 265			2/18/22

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00938	B. WING		C 12/22/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OORHE	EAD RESTORATIVE (	CARE CENTER	COND AVENUI EAD, MN 5656			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
REFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	age 3	2 265			
	policies to guide st physicians, physici practitioners, and it legal representative member of a reside accident, or death. nursing services, a attending physician development of the	ust develop and implement aff decisions to consult an assistants, and nurse f known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of nd the medical director or an n must be involved in the ese policies. The policies mus address at least the ation times for:				
		involving the resident which d has the potential for requiring ion;				
	physical, mental, c example, a deterio	t change in the resident's or psychosocial status, for ration in health, mental, or s in either life-threatening al complications;				
	example, a need to	Iter treatment significantly, for discontinue an existing form adverse consequences, or to of treatment;				
	D. a decision resident from the n	to transfer or discharge the ursing home; or				
	E. expected ar	nd unexpected resident deaths				
	by:	ent is not met as evidenced				
	facility failed to ens	and document review, the sure the physician was notified in condition for 1 of 2 residents		Corrected		

STATE FORM

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C 12/22/2021	
		00938	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 4	2 265			
	(R8) reviewed for r	notification of change.				
	Findings include:					
	10/26/21, identified decision making ar included cerebrova hemiparesis (weak (inability to speak of dependence. The I behavior concerns	mum Data Set (MDS) dated R8 was independent with ad had diagnoses which ascular accident (stroke), cness on one side), aphasia or find words) and alcohol MDS indicated R8 had no and required the assistance of ies of daily living (ADL's).	F			
	a substance abuse dependent as evide judgement and poo plan instructed staf associated with dri activities and monif beverages were no identified if staff su staff were to contac monitoring and me care plan further in acetaminophen, ga levetiracetam (seiz escitalopram (antic intoxicated. The ca complete room che	sed 5/27/21, identified R8 had e disorder and was alcohol enced by history, with impaired or impulse control. The care ff to educate R8 on the risk nking alcohol, encourage tor R8 to ensure alcoholic ot consumed. The care plan spected alcohol intoxication, ct the provider for increased dication hold parameters. The istructed staff to hold aspirin, abapentin (pain medication), cure medication) and depressant) when R8 was are plan identified staff were to ecks weekly for alcohol at ne week and staff were to oserved alcohol.				
	signed by the provi included when R8 hold aspirin, acetar	ary Report dated 12/21/21, ider identified current orders was intoxicated staff were to minophen, gabapentin, and eport instructed staff to monito	r			

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or contraction	IDENTIFICATION NOMBER.	A. BUILDING:			
		00938	B. WING		C 12/22/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	age 5	2 265			
	blood sugars every intoxicated.	/ hour when R8 was				
		parameters for the length of ation or to complete hourly s.				
	Review of R8's pro 12/21/21, revealed	gress notes from 9/8/21, to the following:				
	direct care staff R8 indicated a friend h visiting. The note ic R8's vital signs whi and noted R8 was lacked evidence th	b.m. the nurse was informed by appeared intoxicated and R8 had provided him a drink while dentified the nurse assessed ich were within normal limits alert and oriented. The note he provider had been updated, ad been held and blood sugars ad as ordered.				
	8:00 p.m. R8 was r went to administer another resident's in a pop bottle. The and not oriented. R and the nurse adm notified of R8's cor alcohol. The nurse had been drinking drinks were taken t into the sink. Both	5 p.m. the note identified at not in his room when the nurse R8's insulin. R8 was found in room drinking drinks that were e note identified R8 to be weak 88 agreed to take his insulin inistered. The supervisor was ndition as the room smelled of asked both residents if they and they both denied. The from both residents and poured residents shut themselves in ights off and door supported by	t			
	a bed so staff were able to assist R8 to to open the door. F confused and incol evidence the provide	e not able to enter. Staff were b bed after the nurse was able R8 had been noted to be herent. The note lacked der had been updated, any een held and blood sugars had				

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TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00938	B. WING		C 12/22/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHE	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 265	Continued From pa	age 6	2 265			
		dication administration records 21/21 revealed the following:				
	-September 2021, identified on 9/30/21, no medication had been held or additional blood sugars had been checked.					
		dentified on 11/24/21, no en held or additional blood hecked.				
	licensed practical r were expected to c impairment. LPN-/ suspected of drinki completed an incid vital signs. LPN-A checks were expect stated she had only	v on 12/21/21, at 10:37 a.m. hurse (LPN)-A identified staff observe R8 for signs of alcohol A revealed if R8 had been ng alcohol she would have ent report and checked R8's stated she was unaware room oted to be completed. LPN-A y been working in the facility for and was not aware of any othe 3.				
	LPN-D indicated or impaired and smell contacted the direct received instruction stated he was unsu alcohol as he had re visitors during his s	on 12/21/21, at 3:43 p.m. n 11/24/21, R8 appeared to be led of alcohol. LPN-D stor of nursing (DON) and n to remove the alcohol. LPN-D ure how R8 received the not left the facility nor had any shift. LPN-D indicated R8				
	he entered to chec administer his insu provider had not be	e other residents room when k R8's blood sugar and lin. LPN-D confirmed the een contacted and no further been completed on R8.				
		/ on 12/21/21, at 4:37 p.m. the had a history of alcohol abuse.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED		
			A. BUILDING:			с	
		00938	B. WING			12/22/2021	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IOORHE	EAD RESTORATIVE O	CARE CENTER	COND AVENUI EAD, MN 5656	-			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
2 265	Continued From pa	ige 7	2 265				
	provider, follow the and to follow the ca was suspected to b she had been notifi and had instructed and monitor R8. DO notified the provide intoxicated for furth R8's order for holdi hourly blood sugars being impaired had During an interview nurse practitioner ( primary provider an with R8 the risks as stated she expecte further direction wh confirmed she had 11/24/21, incident. the orders to hold F hourly blood sugars A policy on change and not provided. SUGGESTED MET administrator or de and implement poli the physician notific and assurance con audits to ensure co	ere expected to notify the orders to hold medications are plan as outlined when R8 be intoxicated. DON confirmed ed of the incident on 11/24/21 the nurse to notify the provide DN stated staff should have r when R8 was noted to be per instruction. DON confirmed ng medications and checking s when R8 was suspected of no length of time identified. Pon 12/22/21, at 11:08 a.m. NP) identified she was R8's ad indicated she had discussed ssociated with alcohol use. NP d staff to contact her for en R8 was intoxicated. NP not been notified of the NP stated she was not aware R8's medications and check is lacked a length of time. of condition was requested THOD OF CORRECTION: The signee could develop/revise cies and procedures related to cation. The quality assessment mittee could perform random mpliance. R CORRECTION: Twenty One	r d t				
2 830		0 Subp. 1 Adequate and	2 830			2/18/22	
	Proper Nursing Ca	re; General					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		C 12/22/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		2810 SEC	OND AVENU	JE NORTH		
MOORHI	EAD RESTORATIVE C	CARE CENTER MOORHE	EAD, MN 565	560		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 8	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident n bed.				
	This MN Requirem by: FALLS	ent is not met as evidenced		Corrected		
	review, the facility f reassess, for root of and failed to impler further falls for 1 of fall with a fracture a	ion, interview, and document ailed to comprehensively cause analysis following falls, ment interventions prevent f 2 resident (R13) who had a and remained at risk for falls ents (R20) who had a recent med at risk for falls.				
	(SCSA) Minimum E 11/20/21, identified included diabetes, vascular disease. T intact cognition and with activities of da mobility, transfers,	hange of Status Assessment Data Set (MDS) dated R20 had diagnoses which Osteoarthritis and peripheral The MDS identified R20 had I required extensive assistance ily living (ADL's) of bed toileting and locomotion. The Was unable to maintain his				
	balance during tran	sitions without physical DS identified R20 used a				

STATEMEN	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED			
		00938	B. WING	B. WING		C 12/22/2021			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE					
MOORHEAD RESTORATIVE CARE CENTER 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
2 830	Continued From pa	ige 9	2 830						
	occasionally ambul	nair for mobility and ated with assistance of two not identify R20 had any falls ssment.							
	11/20/21, identified assistance with AD mobility, transfers a related to recent C0 medical conditions diabetes, values de foot/ankle) and chro R20 was at risk for	Area Assessment (CAA) dated R20 required extensive L's which included bed and had a decline in condition OVID-19 diagnosis, and other such as heart failure, formity (deformity of onic pain. The CAA identified falls related to impaired in use and wounds on his feet.							
	R20 had poor mem with dementia, and of two staff with be mobility. The care p risk for falls and us transfers. The care interventions were within reach with pr gripper socks when wheelchair. The ca	plan revised 12/9/21, revealed ory, was recently diagnosed required extensive assistance d mobility, transfers and blan revealed R20 was at high ed a full mechanical lift for all plan revealed the following fal to be implemented, call light rompt answering, wearing a ambulating or in the re plan lacked any information ations resulting from R20's fall	I						
	assistant care guid R20 was dependen full body mechanica extensive assistant the following safety use his call light, gr or in wheelchair, cla R20's Kardex lacke	de Kardex Report (nursing e) dated 12/21/21, revealed at on two staff and the use of al lift for all transfers, required be with bed mobility and had r interventions; reminders to ripper socks on when walking ear path to his bathroom. ed any indication R20 had or any updated interventions							

	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00938	B. WING		C 12/22/2021			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, 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 ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
2 830	Continued From pa	age 10	2 830					
	following his fall.							
	dated 8/24/21, ider history of one to tw was ambulatory an assessment reveal and diagnosis whic risk for falls. The ar risk score was a ni identify what the fa Review of R20's fa 11/4/21, identified seated on the floor wheelchair and his room. The incident was too high and re socks on, though h morning. The incid been transferring h his bed, missed the report revealed R2 positioning of his b incident report did		,					
	identified R20 was on the following inf fall, used narcotic r memory recall with the assessment. T R20 was frequently behaviors, was cor independently com	all Assessment date 11/28/21, at moderate risk for fall based ormation; R20 had a recent medication and had no in the last seven days prior to he fall assessment identified / incontinent, had no nfined to a chair, was unable to e to a standing position and a e coordination. The fall						

PREFIX (EACH DEFICIENCY MUS	CENTER 2810 SE MOORH	B. WING DDRESS, CITY, ST COND AVENUE EAD, MN 5656 PREFIX TAG	E NORTH 0 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION	12/2	C 22/2021
MOORHEAD RESTORATIVE CARE         (X4) ID PREFIX TAG       SUMMARY STATEME (EACH DEFICIENCY MUS' REGULATORY OR LSC IDE         2 830       Continued From page 1*	CENTER 2810 SE MOORH	COND AVENUE EAD, MN 5656 ID PREFIX	E NORTH 0 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION		
(X4) ID PREFIX TAGSUMMARY STATEME (EACH DEFICIENCY MUS REGULATORY OR LSC IDE2 830Continued From page 1	CENTER MOORH	EAD, MN 5656	0 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION		
2 830 Continued From page 1	T BE PRECEDED BY FULL ENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION		() (-)
1 5	1		CROSS-REFERENCED TO THE DEFICIENCY)		(X5) COMPLET DATE
review of R20's prior fall		2 830			
	s.				
the bed table positioned On 12/20/21, at 4:45 p.m interview with R20's fam indicated R20 was often she came to visit. FM-A declined both physically arrival to the facility appr prior. FM-A stated prior hospital and subsequen he used to be very sharp with his appearance. FM recently fallen in the faci what the cause was or v implemented to prevent indicated she felt R20 w retain information given indicated R20's bed was he could sit at the side of the floor, as R20 was ov However, she indicated was at risk for sliding off On 12/21/21, at 10:15 at laying in bed on his back approximate 30 inches f	k, faced the television, he wore a white short wraps on and gripper aised approximately 30 and he had a rolling over to the left of his bed. In. during a telephone hily member (FM)-A, times disheveled when stated she felt R20 had and cognitively since his roximately four months to R20's admission to the t admission to the facility, o mentally and took care M-A stated R20 had lility, though was unsure what the facility had further falls. FM-A as no longer able to to him consistently. FM-A s raised off the floor, so of his bed with his feet on ver six feet, six inches tall. she was not sure if R20 f of his bed. Im. R20 was observed k, R20's bed was raised from the floor. (NA)-C , proceeded to assist him and left his room. R20 bed was raised				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00938	B. WING			C 22/2021
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
OORHE	AD RESTORATIVE C	CENTER				
			EAD, MN 5656			(1.1-)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	positioned in front of his right hand. R20 with a white sheet, feet and his left foo with a bed sheet be R20's right foot dar leaned on the rollin the sandwich and v bed was elevated a the ground, his left ground. -at 12:01 p.m. R20 his over the bed tab	with an over the bed table of him, he held a sandwich with 's lower legs were covered he wore gripper socks on both t was positioned on the floor etween his foot and the floor. ngled from the bed. R20 g over the bed table, as he ate vatched the television. R20's approximately 30 inches from foot touched fully on the was observed to push off of ole with his left hand, the table then moved his legs onto the				
	bed, and laid on his his left side, within be be on. R20's be approximately 30 ir - at 2:40 p.m. R20	back. R20's call light was on his reach, was not observed to d remained elevated hches from the ground. was observed laying on his vered with a sheet from his	)			
	mid lower legs to hi - at 5:00 p.m. R20 his back, his eyes within reach on his					
	On 12/22/21, at 7:0 laying on his back i from his ankles to h	17 a.m. R20 was observed n bed, covered with a sheet his torso. R20's bed was raised nches from the floor.	ŀ			
	NA-C stated R20 re with bed mobility, d felt he was not able	25 a.m. during an interview equired extensive assistance ressing, personal hygiene, and to recall information. NA-C d was kept raised due to R20's				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		C 12/22/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	•		
		2810 SE				
OORHE	EAD RESTORATIVE (	CARE CENTER MOORHI	EAD, MN 5656	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 13	2 830			
2 830	She stated R20 red mechanical lift for a supposed to bear v indicated R20 had not sure if he was a On 12/21/21, at 11 LPN-A stated R20 with his ADL's and fluctuated over the stated R20 preferre of the floor due to b the edge of his bed non-weight bearing ulcers and used a transfers. LPN-A in	:00 a.m. during an interview, required extensive assistance indicated R20's cognition coarse of the day. LPN-A ed to keep his bed elevated off his height and wanting to sit at d. She indicated R20 was g at that time due to his foot full mechanical lift for all idicated she was not aware of ated she was not aware of any				
	NA-A indicated R2 assistance with be dressing. NA-A ind fluctuate over the o needs should be a was not aware if R admission and indi	40 a.m. during an interview, 0 required extensive d mobility, transfers and icated R20's cognition would course of the day and his nticipated. NA-A stated she 20 had any falls since his cated R20 was not weight e and required the use of a full				
	interview with R20' indicated he had co being completed ro decline in cognition appear disheveled and he oftentimes seated at the edge	:46 p.m. during a telephone s family member (FM)-B oncerns with R20's cares not outinely and R20's recent h. He indicated R20 would , his room would be in disarray would be either laying in bed of of the bed. FM-B indicated he ad fallen in September, but				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED
	OF CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING:			
		00938	B. WING		C 12/22/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE. ZIP CODE		
		2810 SF				
OORH	EAD RESTORATIVE (	CARE CENTER MOORH	EAD, MN 5656	0		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
2 830	Continued From pa	age 14	2 830			
	aware of any interv risk for falls. FM-B usually elevated ap the floor, as he was at the edge of the k with R20's changin self care, he felt R2 for slipping out of h On 12/21/21, at 4:1 LPN-C stated R20 his cares and felt F indicated his cognit course of the day. I aware of R20 havin of any fall prevention On 12/21/21, at 4:5 trained medication required extensive except for eating, h TMA-B stated she was not always abl TMA-B indicated sh having any falls sin indicated he should general safety. On 12/22/21, at 8:4 NA-B stated R20 w ADL's and felt he h month, following hi	had happened and was not ventions in place to mitigate his indicated R20's bed was oproximately 30 inches from s so tall and he could easily sit bed. However, FM-B indicated g cognition and decline in his 20 was at high risk for fall and his bed. 19 p.m. during an interview required assistance with all of R20 had a poor memory and tion would fluctuate over the LPN-C indicated she was not ng any falls, nor was she aware on interventions in place. 58 p.m. during an interview a aid (TMA)-B stated R20 assistance with all cares he required set up assistance. felt R20 had memory loss and le to recall events or his needs he was not aware of R20 icce his admission, and d have gripper socks on for 14 a.m. during an interview vas totally dependent for his had declined within the past s COVID-19 illness. NA-B l's had memory loss and was				
	She indicated R20 always able to reca needs were to be a had not fallen when	recall instructions or events. used his call light, but was not all what he wanted and his anticipated. NA-B indicated R20 n she was working and was no len since his admission. NA-B	)			

STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           NND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00938	B. WING			C 22/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHE	EAD RESTORATIVE (	CARE CENTER	COND AVENUE			
		MOORH	EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 15	2 830			
	approximately 30 ir could sit at the edg the floor. NA-B indi for falls and made	preferred his bed raised nches from the ground so he e of his bed with his feet on cated she felt R20 was at risk sure she routinely checked on d he had not observed R20 fer himself.				
	R13					
	11/17/21, identified had diagnoses whi disease, diabetes r renal dialysis. R13' extensive assistant living (ADL's) which transfers, locomotion hygiene and bathin	linimum Data Set (MDS) dated R13 was cognitively intact and ch included end stage renal nellitus and dependence on s MDS indicated he required ce with most activities of daily n included bed mobility, on, dressing, toileting, persona g. The MDS identified R13 had ry since admission.				
	required extensive with most ADL's wh mobility, toileting an indicated R13 was to gait/balance issu admission. The car anticipate and mee	vised 12/20/21, identified R13 assistance of one to two staff nich included transfers, bed nd walking. The care plan at moderate risk for falls due ues and had multiple falls since re plan instructed staff to st resident's needs, ensure within reach and staff were to use his call light.				
		ll risk assessments from 21, revealed the following:				
	R13 to be high risk falls, hypoglycemic	all risk assessment determined for falls due to a history of (used to treat Diabetes n use, sometimes had memor				

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPLE	
		00938	B. WING		C 12/22/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
IOORHE	EAD RESTORATIVE	CARE CENTER	COND AVENUE EAD, MN 5656	-		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLE DATE
2 830	Continued From pa	age 16	2 830			
		hands on assistance to move and decrease noted in n.				
	R13 to be at mode of falls, hypoglycer	all risk assessment determined rate risk for falls due to history nic medication use, sometimes rment and exhibited loss of ding.				
	Review of R13's pi 12/21/21, revealed	ogress notes from 11/11/21, to the following:				
	fall while in his roo on the bed when h to bed, vital signs a	a.m. R13 had an unwitnessed m. R13 stated he was sitting e fell. R13 was assisted back and neurological checks were ed to be within normal limits				
	charting: R13 had reopened on his le dried and treated. vital signs were W	p.m. post fall follow- up a small skin tear which ft elbow and staff cleaned, R13's neurological checks and NL. The progress note lacked he fall occurred or how the fall				
	a.m. in the hallway on the floor with his feet faced the door light had been with it. R13 stated he g smoke and he fell assisted R13 off th had a swollen right	a.m. R13 was found at 1:15 a few steps from his door lying s head against the wall and his way to his room. R13's call in reach and he had not used of up because he wanted to go on the way. Three staff e floor and it was noted R13 c elbow. R13 complained of pain at a seven on a scale of				
	one to ten. Tylenol	500 mg. was administered to gns and neurological signs				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00938	B. WING	B. WING		C 22/2021
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OORHE	AD RESTORATIVE O	CARE CENTER	COND AVENUE			
			EAD, MN 5656		0000000101	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	been placed on oxy to 88% . The nurse of nursing (DON) w - 12/20/21, at 3:22	found to be WNL. R13 had /gen due to sats had dropped practitioner (NP) and director /ere notified of the fall. p.m. R13 had been sent to the hat morning at 9:15 a.m. for				
	assessment of his pain noted. R13 ref order for surgery.	right arm due to swelling and curned to the facility with an				
	a comprehensive a determine a root ca lacked documentat	ress notes lacked evidence of ssessment of R13's falls to ause of his multiple falls, and ion of appropriate mented to minimize his falls.				
	Review of facility in to 12/21/21, revealed	ncident reports from 11/15/21, ed the following:				
	went to answer R12 the floor. R13 state bed and he fell out	a.m. unwitnessed fall- staff 3's call light and found him on d he had been sitting on the of bed. An abrasion was noted alp. R13 was assisted to bed over (total body) lift.	E			
	the floor next to his forward. R13 stated was transferred, as was noted to be blo	a.m. R13 was found sitting on bed with both legs stretched d he rolled from the bed. R13 seessment completed and R13 eeding from an old wound elbow. The wound was ed.				
	No incident report I which occurred on	nad been provided for the fall 12/20/21.				
		ent reports lacked evidence of ssessment of R13's falls to				

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED			
		00938	B. WING	B. WING		C 12/22/2021			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE					
MOORHEAD RESTORATIVE CARE CENTER       2810 SECOND AVENUE NORTH         MOORHEAD, MN 56560									
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE			
2 830	Continued From pa	ae 18	2 830						
	determine a root ca lacked documentat	use of his multiple falls, and							
	ortho clinic appoint splint covered with Licensed Practical belt to R13's waist	7 p.m R13 returned from his ment and was noted to have a ace wrap to his right arm. Nurse (LPN)-A applied the gait while he was in his wheelchair nd, pivoted R13 to his right	t						
	side and assisted F bed. LPN-A remove waist and assisted ensured R13's call reminded R13 to ca	R13 to sit on the edge of his ed the gait belt from R13's him to lay in the bed. LPN-A light was within reach and all for assistance when lized understanding.							
	fallen and broke his indicated he had be and they had plann future to repair his a used the call light p R13 indicated he w call staff for assista to bother the staff. reminded him to us	5 p.m. R13 stated he had arm during the night. R13 een at the clinic earlier that day ed on surgery in the near arm. R13 stated he had not rior to his fall the night before. as aware he was expected to nce however he did not want R13 stated staff frequently e his call light and he was <i>r</i> e fallen without staff							
	(NA)-D stated R13 required assistance NA-D indicated stat use his call light an have called for assi to self transfer desp stated he had been	4 p.m. nursing assistant was alert and oriented and of one staff with transfers. If frequently reminded R13 to d R13 understood he should istance and yet he continued bite the reminders. NA-D informed of R13's fall on v R13 had injured his right							

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00938	B. WING	B. WING		C 12/22/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IOORHI	EAD RESTORATIVE	CARF CENTER		-			
			EAD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 19	2 830				
	light within reach a	fter providing cares to R13.					
	(TMA)-B stated R1 required assistance TMA-B indicated s fall on 12/20/21, ar his right arm. TMA reminded R13 to u continued to self tr had only been awa and had not heard time. On 12/22/21, at 8:3	18 p.m. trained medication aid 3 was alert and oriented and e from staff with all ADL's. he had been informed of R13's nd was aware he had injured -B stated staff frequently se his call light however he ansfer. TMA-B indicated she ire of R13's fall on 12/20/21, of any other falls prior to that 38 a.m. LPN-A stated R13 was					
	couple of nights ag arm. LPN-A stated assessed the resid necessary and not she was not sure v were after a reside the facility did not h follow after a reside	indicated R13 had fallen a go and had broken his right d when a fall occurred, she lent, provided treatment as ified the family. LPN-A stated what the facility expectations nt fall occurred and confirmed have a process in place to ent had a fall to determine root w interventions to prevent					
	was at risk for falls five falls since adm confirmed she had exact number as the tracking or trending facility had not com R13's latest fall on expectation was for assessment of R13 included checking checks, treat R13 in	:20 p.m. DON confirmed R13 and stated R13 had four or hission to the facility. DON been unable to determine the he facility lacked a process for g falls. DON confirmed the hpleted an incident report on 12/20/21. The DON stated her r staff to complete an 3 after a fall occurred which vital signs and neurological f any injuries had occurred, h and DON. DON verified the					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00938	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/22/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE	•	
IOORHI	EAD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	facility lacked a pro root cause and to in prevent future falls. On 12/22/21, at 12: (DON) confirmed R identified a potentia confirmed R20's m comprehensive ass risk and failed to id DON stated R20's over the course of t November and indi to recall instructions DON stated R20 pr elevated from the g on the edge of his R able to transfer him he may not always with transfers due t DON indicated R20 included to keep his gripper socks when plan lacked fall inte November. The DO changing cognition falls and should has place, such as grip assistance with sitti bars to aid in position	cess to assess each fall for mplement new interventions to 47 p.m. the director of nursing 20's fall on 11/4/21, had not al root cause for his fall, and edical record lacked a sessment of R20's fall, his fall entify fall interventions. The cognition had been fluctuating the day since he had COVID in cated R20 would not be able s given to him routinely. The referred to have his bed yround in order to be able to sit bed. She indicated R20 was uself upon admission, and felt recall he needs assistance o decline in his strength. The 's current fall interventions s call light within reach, wear n up and confirmed R20's care rventions related to his fall in ON stated due to R20's she felt he was at high risk for ve further fall interventions in per socks on in bed, ing on the edge of bed, grab			- <u>'</u>	
	The Director of Nur policies and procect implement measure falls receive the new	THOD OF CORRECTION: rsing or designee could review lures, train staff, and es to assure residents with cessary services to keep them of nursing or designee, could				

STATE FORM

LZD411

If continuation sheet 21 of 73

TATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					с	
		00938	B. WING		12/22/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 21	2 830			
		udits of the delivery of care; to care and services are				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
	DIALYSIS					
	facility failed to ens was consistently m	v, and document review, the sure the dialysis access site onitored and assessed for 2 of nd R19) reviewed for dialysis.	f			
	Findings include:					
	11/15/21, identified included debility (p renal disease, and The MDS identified and received super living (ADL's) of tra mobility. The MDS	nimum Data Set (MDS) dated R10 had diagnoses which hysical weakness) end stage mia, diabetes and heart failure I R10 was cognitively intact rvision with activities of daily insfers, dressing, and bed identified R10 received g the seven day look back				
	R10 had diagnoses stage renal disease respiratory disease identified R10 rece transfers, toileting, dressing, bed mob	IDS dated 8/16/21, identified s which included debility, end e, hear failure, chronic e and diabetes. The MDS ived extensive assistance with and required supervision with ility and personal hygiene. The D received dialysis care.				
	dated 8/16/21, ider hospitalized with a	are Area Assessment (CAA) ntified R10 was recently pulmonary infection, received tigued after dialysis sessions.				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00938	B. WING		C 12/22/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE O		COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI		(X5) COMPLET DATE
2 830	Continued From pa	age 22	2 830	DEFICIENC	JY)	
	times a week, fatig oriented though ha CAA lacked docum (intravenous access monitoring of thrill a of check fistula pat R10's current care revealed R10 had a received hemodially care plan lacked do site, or any required or post dialysis ass R10's nursing assis 12/22/21, lacked ar dialysis, or had a fis R10's physician ord identified R10 rece week. R10's care p of R10's fistula or co	plan revised 10/19/21, end stage renal disease, /sis and had diabetes. The ocumentation of R10's fistula d monitoring of thrill and bruit essment. stant care guide printed hy indication R10 received				
		ord lacked any documentation and thrill was routinely				
	R10 stated he rece week from at a dial town. R10 stated he upper left arm, lifter revealed a thick wh four inches long an upper left arm. He monitored his fistul	2 p.m. during an interview, ived dialysis three times a ysis clinic in a neighboring e had a fistula site on her d the sleeve to his top and hite bandage approximately d three inches wide on his indicated the dialysis clinic a and stated the facility ever looked at his dialysis site				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING: _			
		00938	B. WING		C 12/22/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 23	2 830			
	episodes of profuse though had a low b occasions which re dialysis center. R10 currently monitoring they checking his b the facility. On 12/21/21 at 12: licensed practical n received dialysis th indicated R10 took and stated she did return. LPN-A confi fistula bruit and thri order was in place dialysis center wou complications from	n. R10 stated he had no e bleeding from the site, lood pressure on a couple of equired medication from the D stated the facility was not g his access site, nor were blood pressure upon return to 12 p.m. during an interview hurse (LPN)-A stated R10 ree times a week. LPN-A care of his own access site not check his fistula upon irmed she did not check R10's ill for function, indicated no to do so. LPN-A indicated the Id call if R10 had any his run and would let her I further monitoring.				
	LPN-C stated he be his left upper arm a times a week. LPN check R10's vital si if needed. He indica complications, such blood pressure, dur call and notify them confirmed he did no and had never chee On 12/21/21, at 5:0	h as hemorrhaging or low ring dialysis the center would n of needed monitoring. LPN-C ot monitor R10's fistula site cked R10's bruit and thrill. 08 p.m. during an interview,	2			
	received dialysis th bring back a red fo She indicated she upon return when h	aid (TMA)-B stated R10 ree times a week and would lder following his appointment. would check R10's vital signs he had issues with low blood ted she did not routinely check				

ORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			PLETED
IDER OR SUPPI IFR	00938				~
IDER OR SUPPLIER	00938		B. WING		C 22/2021
	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
RESTORATIVE	CARE CENTER	COND AVENUE EAD, MN 5656			
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
ntinued From pa	age 24	2 830		')	
0's vital signs u	pon return and stated licensed I 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.					
erview with Sant arge nurse (RN) lysis three times ted she would e nitored for blee ility along with h 0 had a history dialysis runs, a od pressure wa -A stated she u 0 had any comp felt it was very nitored him. RN ctice to check F d monitor his fis	26 a.m. during a telephone ford Dialysis registered nurse, p-A, confirmed R10 received s a week at their clinic. RN-A expect R10's fistula to be ding upon his return to the his vital signs. She indicated of low blood pressure following nd felt it was important R10's s monitored upon his return. sually contacted the facility if plications during his session, important the facility routinely I-A stated it was a standard of R10's fistula's bruit and thrill tula due to risk for bleeding, e, infection and death if e not identified in a timely				
eived daily thre	e times a week and indicated cesses in place for monitoring				
npli nne 12/ eive	cations were er. /22/21, at 8: ed daily thre were no proc	cations were not identified in a timely	22/21, at 8:38 a.m. TMA-A confirmed R10 daily three times a week and indicated were no processes in place for monitoring fistula or check his vitals signs post	22/21, at 8:38 a.m. TMA-A confirmed R10 ed daily three times a week and indicated were no processes in place for monitoring fistula or check his vitals signs post	22/21, at 8:38 a.m. TMA-A confirmed R10 ed daily three times a week and indicated were no processes in place for monitoring

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _			C	
		00938	B. WING			12/22/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IOORHE	EAD RESTORATIVE O	CARE CENTER					
	STIMMA DV STA		EAD, MN 5656	PROVIDER'S PLAN OF	CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ige 25	2 830				
	11/17/21, identified had diagnoses which disease, diabetes merenal dialysis. R13's extensive assistance living (ADL's) which transfers, locomotic hygiene and bathin received dialysis. R13's care plan rew required dialysis re Interventions listed take blood pressure resident to go to dia labs and report to comonitor/document/ symptoms of infect swelling, warmth or resident to relieve of the disease and tree instruction to staff t bleeding or any oth Review of R13's phentified Diabetic Diet. The of dialysis treatments Review of R13's prentified assessments. Review of R13's dialysis dialysis treatments Review of R13's dialysis dialysis dialysis treatments	inimum Data Set (MDS) dated R13 was cognitively intact and ch included end stage renal nellitus and dependence on s MDS indicated he required ce with most activities of daily n included bed mobility, on, dressing, toileting, persona g. The MDS identified R13 vised 12/20/21, identified R13 lated to renal failure. included: do not draw blood of e in arm with graft, encourage alysis appointments, monitor loctor as needed, report as needed any signs or ion to access site: redness, r drainage and wok with discomfort for side effects of eatment. The care plan lacked o monitor dialysis site for er adverse reactions. hysician orders signed on R13 was prescribed a prders lacked orders for or monitoring parameters. ogress notes from 11/17/21, to a lack of any post-dialysis					
	following:						
	epartment of Health	p.m. R13's blood pressure					

	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00938	B. WING		C 12/22/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
IOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 26	2 830				
	(an access for dialy was clean, dry and the thrill (a rumbling bruit (a rumbling se noted.	nd the dressing to his fistula ysis) site to his left upper arm intact. The record revealed g sensation you can feel) and ensation you can hear) were ealth record (EHR) lacked any					
	On 12/20/21, at 4:3 dialysis three times Wednesday and Fr dialysis on Sunday, current week due to indicated the nursin sugar and escorted he returned from di actions had been c such as checking h checking his vital s and pointed to his c by a bandage and s place from the dialy nursing staff had no removed the banda		4				
	nurse (LPN)-A enter returned from dialy sugar and administ abdomen area. LPI contained informati and placed it on the	46 a.m. licensed practical ered R13's room after R13 sis, checked R13's blood tered insulin to R13's right N-A picked up the folder which ion about R13's dialysis run e desk at the nurse's station.					
	R13 returned from blood sugar and so dialysis center into	dialysis she would check his an the information from the R13's EHR. LPN-A indicated of what the process was at					

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00938	B. WING			C 12/22/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
IOORH	EAD RESTORATIVE (	CARE CENTER 2810 SEC		E NORTH			
		MOORH	EAD, MN 5656	60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 27	2 830				
	assessments. LPN completed a post-c and further stated s	oleting post- dialysis -A confirmed she had not dialysis assessment on R13 she had never completed one she began her employment					
	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.						
	(DON) confirmed the post- dialysis assess monitoring of R13's when R13 returned facility received the	20 p.m. director of nursing the facility did not complete ssments which included s access site and vital signs from dialysis. DON stated the dialysis run information from and scanned it into R13's					
	(DON) stated the fa procedure in place fistula/site monitori process of educatin dialysis assessmer a professional stan who received hemo complications such pressure post dialy	06 p.m. the director of nursing acility had no current policy or for post dialysis assessments, ng and was currently in the ng staff and implementing post nts. The DON confirmed it was idard of practice for residents odialysis to be monitored for a s bleeding, low blood rsis and their access site daily. The DON confirmed					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING			C <b>22/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MOORHE	EAD RESTORATIVE C	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 28	2 830			
	access site or post	dialysis needs.				
	facility each resider provisions of dialys professional standa identified it was the assess and monitor dialysis for any com signs, medication n residents dialysis a SUGGESTED MET The Director of Nur	evealed it was the policy of the nt who received the care and is were consistent with the ards of practice. The policy facility's responsibility to r residents who received applications by checking vital nanagement and monitoring ccess sites. THOD OF CORRECTION: rsing or designee could review lures, train staff, and				
	implement measure receive the hemodi director of nursing of random audits of th appropriate care ar TIME PERIOD FOR	es to assure residents that alysis to keep them safe. The or designee, could conduct le delivery of care; to ensure ad services are implemented. R CORRECTION: Twenty-one				
2 900	(21) days. MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			2/18/22
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING	): 	
		00938	B. WING		C 12/22/2021
AME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	
IOORHE	EAD RESTORATIVE (	CARE CENTER			
(X4) ID	SUMMARY ST		IEAD, MN 56	PROVIDER'S PLAN O	F CORRECTION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLE
2 900	Continued From pa	age 29	2 900		
	receives necessar	who has pressure sores by treatment and services to revent infection, and prevent veloping.			
	by: Based on observat review the facility fa comprehensively a implement pressur of 1 resident (R20) worsening pressure caused actual harn three (3) pressure unstagable ulcer, d pressure ulcer on t	ent is not met as evidenced ion, interview and document ailed to accurately and ssess, monitor, develop and e relieving interventions for 1 reviewed for current, e ulcers. This deficient practic n when R20's left heel stage ulcer worsened to an levelopment of an unstagable he top left foot and an right foot pressure ulcer which		Corrected	
	Subcutaneous fat r tendon or muscle is present but does n loss. May include u Unstagable ulcer; v	Ilcer; full thickness tissue loss may be visible but bone, s not exposed. Slough may be ot obscure the depth of tissue indermining or tunneling wound bed cannot be ne presence of slough or	9		
	eschar Slough; non-viable brown tissue; usua and mucinous in te	yellow, tan, gray, green or Ily moist, can be soft, stringy exture. Slough may be adhered wound or present in clumps	nt		
	Eschar tissue: dea	d or devitalized tissue that is			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00938	B. WING			C 12/22/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
моорні	EAD RESTORATIVE O	CARE CENTER 2810 SEC		E NORTH			
		MOORHE MOORHE	EAD, MN 5656	60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	nge 30	2 900				
	tissue and eschar a	ay appear scab like. Necrotic are usually firmly adherent to und and often the sides/edges					
	Findings include:						
	(SCSA) Minimum E 11/20/21, identified included diabetes, vascular disease. T intact cognition and with activities of da mobility, transfers, The MDS identified developing pressur had the following pr in place; pressure r and application of r ointments/medicati The MDS incorrect unhealed pressure	hange of Status Assessment Data Set (MDS) dated R20 had diagnoses which osteoarthritis and peripheral The MDS identified R20 had d required extensive assistance ily living (ADL's) of bed toileting and personal hygiene. I R20 was at risk for re ulcers and identified R20 ressure relieving interventions relieving device for chair, bed, non-surgical dressings and ons to areas other than feet. Ily identified R20 had no ulcers or other open areas.					
	11/20/21, identified assistance with AD mobility, transfers a condition related to and other medical of failure, diabetes, va foot/ankle in which faces downwards) identified R20 was pressure ulcer/injur	Area Assessment (CAA) dated R20 required extensive L's which included bed and R20 had a decline in recent COVID-19 diagnosis, conditions such as heart arus deformity (deformity of the lateral part of the foot and chronic pain. The CAA admitted to the facility with a ry to his left heel and right					
	changes. The CAA pressure relieving i pressure redistribut	received daily dressing identified the following nterventions were in place; ting device to bed, wheelchair ffer repositioning periodically					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
			A. BUILDING:			
		00938	B. WING		C 12/22/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUI EAD, MN 5656			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION (	X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COM THE APPROPRIATE D	IPLET ATE
2 900	Continued From pa	age 31	2 900			
	skin would be chec The CAA lacked ar pressure ulcers suc measurements and worsening.	er, the CAA identified R20's sked weekly by licensed staff. ny characteristics of R20's ch as stage, tissue type, d any signs of healing or ord lacked any further				
	R20's current care R20 had poor mem with dementia, and of two staff with be dressing. The care potential for pressu open wounds on hi plan did not addres foot pressure ulcer redistributing devic	plan revised 12/9/21, revealed nory, was recently diagnosed required extensive assistance d mobility, transfers and plan revealed R20 had a ure ulcer development, had is legs, and feet. R20's care as the bilateral unstageable s, use of a pressure e to bed or wheelchair, or dically with toileting or list any				
	assistant care guid	de Kardex Report (nursing e) dated 12/21/21, lacked any interventions for staff to follow.				
	R20's current phys revealed the follow	ician orders signed 12/21/21, ing;				
	(specialized pressu foot, very important	8/21, for Prevalon boots ure relieving boots) on right t to keep the Prevalon boot on may remove to walk, one time				
	gentle soap and wa entire leg, cover op	21, cleanse legs and feet with ater. Apply Aquaphor (lotion) to ben wounds with Adaptic ( is a esigned to help protect the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00938	B. WING			C 22/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 32	2 900			
	adhering to the work knee) with Kerlix for eight fashion. Char every day shift for u	nting the dressing from und.) Wrap entire leg (foot to illowed by ace wrap in a figure nge daily and prn (as needed) ulcer. :41 a.m. R20 was interviewed,				
	he indicated he had he had long term a was new since he R20 then, abruptly about many randor	d a sore on his right foot that nd indicated his left foot sore was admitted to the facility. changed subjects, talked n topics and was unable to stion or provide any more				
	laying in bed, on his Both of R20's feet in mattress, wrapped covered with grippe were pressed again	:39 p.m. R20 was observed s back, faced the television. rested directly on a regular with ACE bandages and were er socks. R20's left foot toes not the footboard of his bed ested on the mattress on the s foot.				
	laying in bed on his (NA)-C stood next and proceeded to a cares. R20's bilater feet to his knees w gripper socks on his	:15 a.m. R20 was observed back, nursing assistant to R20's bed, on his left side assist R20 with incontinence ral legs were wrapped from his ith ACE bandages and he wore is feet. Following incontinence bserved to tell R20 to use his				
	placed both heels of assisted NA-C to m head of his bed. R2 wrapped feet on the aspect of his right f standard mattress.	him up in bed. R20 then on the mattress of the bed, and nove himself up towards the 20 then rested both of his ACE e bed, his left heel and lateral foot rested directly on the NA-C was not observed to relief to his feet, nor did she				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		SURVEY PLETED			
			A. BUILDING.	A. BUILDING:		с			
		00938	B. WING		12/2	22/2021			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE					
MOORHEAD RESTORATIVE CARE CENTER 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560									
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	THE APPROPRIATE	COMPLET DATE			
2 900	Continued From pa	age 33	2 900						
	offer use of his Pre	valon boots.							
	- at 10:45 a m R20	) was observed laying in bed							
		re legs and feet were visible or	ı						
	his bed. R20's left l	heel was laying directly on his							
		and his right foot rested on the							
		n the lateral aspect of his foot.							
		ed practical nurse (LPN)-A was	5						
		e R20's legs and feet, and blete R20's dressing changes							
		oot ulcer, left heel ulcer and							
		ateral aspect of his right foot.							
		an gripper socks to both of							
		t observed to elevate or offload							
		eft heel and lateral aspect of							
	his right foot rested mattress.	l directly on the standard							
		was observed seated on the							
		h an over the bed table							
		of him, he wore gripper socks							
		ht leg was inverted and his s foot rested directly on the							
	floor.	s loot rested directly on the							
	- at 2:40 p.m. R20	was observed lying on his							
		vered with a sheet from his							
		is upper torso. R20's left heel							
		of his right foot rested directly							
	on the standard ma	attress.							
	On 12/21/21. at 10	:25 a.m. during an interview							
		equired extensive assistance							
		ransfers, dressing and							
		NA-C indicated R20 was able							
		f and used his feet to help							
		d. NA-C indicated R20 had							
		h of his feet which oftentimes							
		ge coming from them and )'s sheets. NA-C indicated she							
	epartment of Health	S Sheets. MA-O Indicated She							

STATEME	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED				
		00938	B. WING	B. WING		C 12/22/2021				
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE						
MOORHEAD RESTORATIVE CARE CENTER 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560										
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE				
2 900	felt R20 had a poor would fluctuate ove 12:08 p.m. during a indicated R20 wore he was in bed and relieving intervention his feet in bed. On 12/21/21, at 11: LPN-A stated R20 requi- his bilateral foot ulos since R20's admiss indicated she comp daily and felt the ar- drainage present of stated she did not of measurements or a bilateral foot presss a wound clinic and 12:10 p.m. during a stated R20 was sup when he was in bed LPN-A indicated she foot ulcers were pre R20 had no pressu place. On 12/21/21 at 11:2 NA-A indicated R20 assistance with bed dressings to his fee indicated she to ug boots but was not so able to move his ex-	rege 34 rememory and his cognition or the course of the day. At a follow up interview, NA-C e Prevalon boots at night when was not aware of any pressure ons in place such as elevating 00 a.m. during an interview, required extensive assistance indicated R20's cognition course of the day. She ired daily dressing changes to cers, which had been present sion to the facility. LPN-A oleted R20's dressing changes eas were improving by less in his old dressings LPN-A complete R20's ulcer assessments, believed R20's ure ulcers were monitored by R20's primary physician. At a follow up interview, LPN-A oposed to wear Prevalon boots d, but refused to wear them. e did not feel R20's bilateral essure related and confirmed re relieving interventions in 40 a.m. during an interview, 0 required extensive d mobility, transfers and cated R20 required daily et and legs due to ulcers and pht R20 might have special sure. She indicated R20 was attermities and was not aware eving interventions for his feet								

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED			
			A. BUILDING: B. WING		C				
		00938			12/22/2021				
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE					
MOORHEAD RESTORATIVE CARE CENTER 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560									
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
2 900	Continued From pa	age 35	2 900						
	interview with R20' indicated he had co being completed ro decline in cognition chronic foot ulcers deformity, though w foot ulcers to his le recently notified by by a podiatrist for fo had concerns R20 and stated he had boots or his feet of On 12/21/21, at 2:4 was reviewed with had pressure ulcer foot and were last 10/12/21. The DON admitted to the fac ulcer, however, wa ulcer was present of stated she would e foot pressure ulcer which would includ characteristics, ind treatment. Further, care plan did not id interventions in pla pressure ulcers. At to measure and as foot pressure ulcer -at 2:59 p.m. obser DON present. R20 back in bed, his lef aspect of his foot w mattress and his lef	246 p.m. during a telephone is family member (FM)-B procerns with R20's cares not putinely and R20's recent in FM-B indicated R20 had to his right foot due R20's foot vas not aware of any history of ft foot. FM-B indicated he was the facility R20 would be seen pot care. FM-B indicated he had not received routine cares not observed R20's Prevalon f loaded during his visits. 45 p.m. R20's medical record the DON, she confirmed R20 is of his left heel, lateral right measured in the facility on N stated she believed R20 was ility with the lateral right foot is not sure if R20's left heel upon his admission. The DON xpect R20's left heel and right is to be assessed weekly, e measurements, wound ications of healing, and current the DON confirmed R20's lentify any pressure relieving ce for R20's bilateral foot that time, a request was made sess R20's left heel and right s. vation was conducted with was observed laying on his t heel and his right lateral vere laying directly upon R20's ft upper foot and toes were e foot board of his bed. The							

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00938	B. WING		C 12/22/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORHE	EAD RESTORATIVE (		COND AVENUE EAD, MN 5656			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 36	2 900			
	find someone to as to relieve the press p.m. NA- E entered on the right side of sheet which was un NA-E took hold of t R20, the DON and place his feet on th move up in bed. R2 aspect of his foot p R20 was boosted u left R20's room. Th R20's ACE wraps a	ndicated she would need to ssist her to boost R20 up in bec sure from his left foot. At 3:06 d R20's room, the DON stood R20's bed took hold of a lift inderneath R20's mid-body. the lift sheet on the left side of NA-E encouraged R20 to be bed and push to assist to 20's left heel and right lateral pressed against the mattress as up in bed. NA-E immediately he DON proceeded to remove and dressings for e following was observed;				
	drainage (yellow/gr unstagable pressur centimeters (cm) b slough tissue on th 0.2 by 0.2 cm. with presented with epit the pressure ulcer had opened. The D foot pressure ulcer	t, had moderate purulent reenish) and revealed an re ulcer which measured 3.0 y 2.0 cm and had an area of e wound bed that measured the remaining wound bed thelial tissue. The DON stated started as a blood blister which OON confirmed R20's top left had worsened in size, had had purulent drainage.	h			
	purulent drainage a pressure ulcer whic and was covered w eschar tissue. The pressure ulcer had	ad a minimal amount of and revealed an unstagable ch measured 1.3 cm by 1.2 cm vith thick, hard, dark brown DON confirmed R20's left hee d worsened by an increase in bed was no longer able to be ne eschar.				
	drainage and revea	foot lower pressure ulcer, no aled an unstagable pressure red 2.3 cm by 1.2 cm, thick,				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		C 12/22/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
MOORHI	EAD RESTORATIVE O		COND AVENUE			
		MOORHE	EAD, MN 5656	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	nge 37	2 900			
	DON confirmed R2 had worsened by a wound bed was no due to the thick, da The DON confirme ulcers had worsene wear the Prevalon R20 had no current	a tissue on the wound bed. The 0's right lateral pressure ulcer n increase in size and a longer able to be visualized rk reddish brown tissue. d all three of R20's pressure ed and stated R20 refused to boots. The DON confirmed t pressure relieving ce for his unstagable pressure				
	ulcers. On 12/22/21, at 7:0 laying on his back i from his ankles to h	7 a.m. R20 was observed n bed, covered with a sheet his torso. R20's left heel and s right foot rested directly on				
		odiatry progress notes from 1, revealed the following:				
	unspecified severity left heel, varus def in which the lateral downwards) of righ osteomyelitis (infec- ankle and foot. The ulcer was debrided (magnetic resonand	d with an ulcerated right foot, y, a stage 3 decubitus ulcer of formity (deformity of foot/ankle part of the foot faces nt ankle and chronic stion of the bone) involving a note revealed R20's right foot and recommended an MRI ce imaging) and a Prevalon ot for the right foot to protect				
	revealed R20 had s right leg and foot, r from putting pressu any information abo	a follow up visit. The note swelling and redness of the ecommended to prevent R20 ire on his feet. The note lacked out R20's unstagable left heel op of left foot pressure ulcer.	i			

LZD411

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	A. BUILDING:			
		00938	B. WING		C 12/22/2021		
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IOORHI	EAD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 38	2 900				
	right foot. Note rever pressure ulcer was improved from prevent R20's podiatrist em- pressure off of the any information abore pressure ulcer or to R20's podiatry note documentation of the	r a follow up visit of his lateral ealed R20's lateral right foot shallow and appeared vious visit. The note revealed aphasized the need to get all lateral foot. The note lacked out R20's unstagable left heel op of left foot pressure ulcer. es lacked any further he status or progress towards of R20's left heel pressure					
		cility Skin and Wound 31/21, to 10/12/21, revealed					
	left heel which mea wide and had no in evaluation lacked a heel ulcer such as wound bed, presen condition, presence and interventions. I evaluation did not in	R20 had a diabetic ulcer of his asured 0.8 cm long by 0.5 cm dication of depth. The wound any characteristics of R20's lef a description of the ulcer's ace of drainage, peri-wound of pain, current treatment, Further, R20's wound dentify when R20's left heel whether R20's left heel ulcer worsened.					
	the sole of his right by 1.8 cm and had wound evaluation la R20's dorsum right description of the u drainage, peri-woun current treatment, a	R20 had a diabetic ulcer on foot which measured 2.4 cm no indication of depth. The acked any characteristics of foot ulcer, such as a ilcer's wound bed, presence of nd condition, presence of pain and interventions. Further, ation did not identify whether					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
--------------------------	---	---	-----------------------------	--	-----------------------------------	-------------------------	
			A. BUILDING: _			C	
		00938	B. WING			22/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IOORHE	AD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 39	2 900				
	R20's right foot ulc worsened.	er was healing or had					
	his left heel which n and had no indicati evaluation lacked a heel ulcer such as wound bed, present condition, presence and interventions. I evaluation did not i ulcer developed or was healing or had - 10/12/21, indicate his left heel which n	ed R20 had a diabetic ulcer of measured 1.4 cm by 0.8 cm	t				
	evaluation lacked a heel ulcer such as wound bed, presen condition, presence and interventions. I	ion of depth. The wound any characteristics of R20's left a description of the ulcers nce of drainage, peri-wound e of pain, current treatment, Further, R20's wound dentify whether R20's left heel or had worsened.					
	of foot facing upwa which measured 0. indication of depth. any characteristics ulcer, such as a de bed, presence of d presence of pain, of interventions. Furth	d R20's dorsum right foot (part irds) had an unidentified area .8 cm by 0.6 cm and had no . The wound evaluation lacked of R20's dorsum right foot escription of the ulcers wound rainage, peri-wound condition, current treatment, and her, R20's wound evaluation ether R20's right foot ulcer was sened.					
		ord lacked any further ongoing left heel pressure ulcer. In					

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					– c	
		00938	B. WING		12/	22/2021
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
IOORHI	EAD RESTORATIVE (	CARE CENTER	OND AVENUE AD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From pa	age 40	2 900			
	presence or asses	dical record did not identify the sment of R20's lower left ure ulcer (top left foot.)				
	LPN-C indicated sh and indicated his c the course of the d received daily dres feet and ACE wrap LPN-C stated he w relieving intervention	19 p.m. during an interview ne felt R20 had a poor memory ognition would fluctuate over ay. LPN-C indicated R20 sing changes to both of his s for edema management. vas not aware of any pressure ons in place for R20's re ulcers of his left heel, top of right foot.				
	trained medication required extensive except for eating, h TMA-B stated she was not always abl TMA-B stated R20 edema manageme his feet. TMA-B sta pressure relieving i	58 p.m. during an interview aid (TMA)-B stated R20 assistance with all cares he required set up assistance. felt R20 had memory loss and e to recall events or his needs. had ACE wraps on daily for and had ulcers on both of ated she was unaware of any interventions in place for R20's re ulcers of his left heel, top of right foot.				
	LPN-B stated R20 edema manageme his feet, but had no pressure ulcers on was unaware of an interventions in pla	55 a.m. during an interview, had ACE wraps on daily for ent and had ulcers on both of ot seen R20's unstagable his feet. LPN-B stated she by pressure relieving ce for R20's unstagable his left heel, top of left foot and				
		14 a.m. during an interview, /as totally dependent for his				

	T OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING:			
		00938	B. WING		C 12/22/2021	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORHE	AD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE <sup>-</sup> DATE
2 900	Continued From pa	age 41	2 900			
	not always able to n NA-B indicated R20 Prevalon boots whe on his feet, but he n stated she was not relieving intervention unstagable pressur right foot and top of R20's practioner pr from 9/1/21, to 11/2 -9/1/21, revealed R an initial visit at the R20 had a skin ulog the bone. The note his right foot ulcer a recommendations.	<ul> <li>a) had memory loss and was recall instructions or events.</li> <li>b) was supposed to wear en in bed for pressure ulcers refused to wear them. NA-B aware of any pressure ons in place for R20's re ulcers of his left heel, lateral f left foot.</li> <li>c) was seen in the facility for facility. The note revealed er of right foot with necrosis to lacked any characteristic of and lacked any direction or The note lacked any R20's unstagable left heel</li> </ul>				
	a routine visit, had right lower extremit (is indicated for use wounds, leg and fo under compression	20 was seen in the facility for cellulitis right lower extremity, ty wound with Mepilex dressing e on moderately exuding ot ulcers, pressure injuries, n, graft and donor sites and and requested a wound care	]			
	for weight gain rela revealed R20 had o required an MRI. T direction regarding	R20 was seen in the facility ted to fluid retention. The note chronic ulcers on his feet and he note lacked any further R20's chronic ulcers and entation of R20's unstagable ilcer.				
	-10/27/21, revealed	R20 was seen at the facility,				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		00938	B. WING		C 12/22/2021	
NAME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHE	AD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	THE APPROPRIATE DATE	
2 900	Continued From pa	age 42	2 900			
	deep ulcers, with fa note revealed direct wrapping legs per v -11/11/21, revealed for a routine visit, et thickness deep righ ulcer and ulcer of le The progress note dressing, wrapping wound care clinic. -11/24/21, revealed	led right foot and left heel skin at layer exposed. The progress ction to continue dressing and wound care clinic instructions. I R20 was seen in the facility examination revealed skin ht foot ulcers, top of left foot eft heel with fat layer exposed. revealed direction to continue of legs and to follow up with I R20 was seen in the facility				
	and concerns with	liscussed dementia diagnosis worsening. The note did not or left foot pressure ulcers ne time of the visit.				
	interview, R20's pri doctor (MD)-A state pressure ulcers of and top of left foot. seen R20 at the fac not been able to vis she had not been to left heel pressure u ulcer or top of left f was routinely seen however, she would and monitor R20's least weekly for any pressure on R20's could certainly cause expect the facility to relieving intervention	45 p.m. during a telephone imary physician, medical ed she was aware R20 had his lateral right foot, left heel MD-A stated she had last cility on 12/21/21, though had sualize his feet. MD-A stated old of any changes to R20's ulcer, lateral right foot pressure foot ulcer. She indicated R20 by a podiatrist for wound care, d expect the facility to assess pressure ulcers routinely, at y changes. MD-A stated any left heel or the lateral right foot se further injury and she would o routinely implement pressure ons to prevent worsening.				
inesota De		37 a.m. a telephone call was diatrist, a message was left for				

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00938	B. WING		C 12/22/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		2810 SE				
MOORHI	EAD RESTORATIVE (	MOORH	EAD, MN 5656	60		
(X4) ID			ID	PROVIDER'S PLAN OF		
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		
				DEFICIENC	CY)	
2 900	Continued From pa	age 43	2 900			
	a return call. A retu	rn call was received on				
		.m. from R20's podiatrist. He				
		ast seen R20 on 12/16/21, for				
	follow up managen	nent of his lateral right foot				
	•	e podiatrist stated he did not				
		an unstagable pressure ulcer				
		foot during the last two visits				
		anted to be notified of any				
		atrist stated he had seen R20				
		September for management of				
	0	oot chronic pressure ulcer and looked better than when he				
		ted he had not been made				
		ase in size and did not see the				
		sue at the time of R20's most				
		ted he expected the facility to				
	assist R20 to keep	all pressure off of his lateral				
		ordered Prevalon boots to be				
		walking. The podiatrist stated				
		ative to R20's healing to				
		ire on his right foot and would				
		eft heel to be offloaded at all				
		trist stated he felt any pressure ht foot, left heel or any				
		t would worsen existing				
		d could cause new ones to				
	form.					
	A policy was reque	sted, one was not provided.				
	SUGGESTED MET	THOD OF CORRECTION:				
		sing or designee, could review				
		for pressure ulcers to assure				
	they are receiving t					
		to prevent pressure ulcers				
		id to promote healing of				
		he director of nursing or				
		nduct random audits of the				
		ensure appropriate care and				
	epartment of Health	mented; to reduce the risk for				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00938	B. WING		12/22/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
MOORHE	EAD RESTORATIVE O	CARE CENTER	COND AVENU EAD, MN 565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET E DATE
2 900	Continued From pa	ge 44	2 900		
	pressure ulcer deve	elopment.			
	TIME PERIOD FOR (14) days.	R CORRECTION: fourteen			
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920		2/18/22
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,			
	by: Based on observati review, the facility f assistance for 1 of	ent is not met as evidenced on, interview and document ailed to provide shaving 1 resident (R20) who was ty staff for grooming.		Corrected	
	Findings include:				
	(SCSA) Minimum E 11/20/21, identified included diabetes, o vascular disease. T intact cognition and with activities of dai mobility, transfers, f	hange of Status Assessment Data Set (MDS) dated R20 had diagnoses which Osteoarthritis and peripheral The MDS identified R20 had I required extensive assistance ily living (ADL's) of bed toileting and personal hygiene.			
	11/20/21, identified assistance with AD mobility, transfers a	Area Assessment (CAA) dated R20 required extensive L's which included bed and had a decline in condition DVID-19 diagnosis, and other			

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		C 12/22/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 45	2 920			
		such as heart failure, eformity (deformity of onic pain.				
	R20 had poor mem with dementia, and of two staff with be and grooming. R20	plan revised 12/9/21, revealed nory, was recently diagnosed I required extensive assistance d mobility, dressing, bathing D's care plan lacked any preference for facial hair				
	assistant care guid R20 required exter bathing and persor	de Kardex Report (nursing le) dated 12/21/21, revealed nsive assistance with dressing, nal hygiene. R20's care guide r facial hair removal.				
	laying in bed, on hi his eyes were oper coarse facial hair a (5) millimeters (mn	:39 p.m. R20 was observed s back, faced the television, ned and he had thick white approximately three (3) to five n) in length, which covered his er lip, jaw line and neck.				
	interview with R20' indicated R20 was she came to visit. If declined both phys arrival to the facility prior. FM-A stated	45 p.m. during a telephone s family member (FM)-A, oftentimes disheveled when FM-A stated she felt R20 had ically and cognitively since his y approximately four months prior to R20's admission to the equent admission to the facility, groomed.				
	laying in bed on his upper lip, neck and covered with thick	:15 a.m. R20 was observed s back, R20's cheeks, chin, l jaw line continued to be white coarse facial hair 3-5 r. (NA)-C stood next to R20's				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		C 12/22/2021	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 46	2 920			
		assist him with incontinence oom without offering ial hair removal.				
	the side of his bed, positioned in front of his right hand. R20 with a white sheet, feet. R20's cheeks line continued to be	was observed seated on on with an over the bed table of him, he held a sandwich with 's lower legs were covered he wore gripper socks on both , chin, upper lip, neck and jaw e covered with thick white -5 mm long facial hair.				
	back in his bed, co mid lower legs to h chin, upper lip, nec	was observed lying on his vered with a sheet from his is upper torso. R20's cheeks, k and jaw line continued to be white coarse facial hair 3-5				
	laying on his back i from his ankles to h upper lip, neck and	7 a.m. R20 was observed in bed, covered with a sheet his torso. R20's cheeks, chin, Jaw line continued to be white coarse facial hair 3-5				
	NA-C stated R20 re with bed mobility, d felt he was not able indicated she was r	25 a.m. during an interview equired extensive assistance lressing, personal hygiene, and to recall information. NA-C not aware of R20's shaving not offer to assist him with	Ł			
	LPN-A stated R20 with his ADL's and fluctuated over the	00 a.m. during an interview, required extensive assistance indicated R20's cognition coarse of the day. LPN-A aware of R20's preference for				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
						С
		00938	B. WING		12/2	22/2021
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IOORHI	EAD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 47	2 920			
	facial hair removal.					
	NA-A indicated R20 assistance with bed dressing. NA-A indi fluctuate over the c needs should have On 12/21/21, at 12 interview with R20's indicated he had co being completed ro decline in cognition disheveled, unshaw when he visited. FM great care with gro shaven on his head it would bother R20 On 12/21/21, at 4:1	:46 p.m. during a telephone s family member (FM)-B oncerns with R20's cares not outinely and R20's recent a. He indicated R20 appeared yen and generally unclean M-B indicated R20 used to take oming, and used to be clean d and face. FM-B stated he felt 0 if he looked disheveled.				
	his cares and felt R	required assistance with all of 20 had a poor memory and tion would fluctuate over the				
	trained medication required extensive except for eating, h TMA-B stated she was not always abl	58 p.m. during an interview a aid (TMA)-B stated R20 assistance with all cares he required set up assistance. felt R20 had memory loss and e to recall events or his needs he believed R20 was assisted aily.				
	NA-B stated R20 w ADL's and felt he h month, following his	I4 a.m. during an interview vas totally dependent for his ad declined within the past s COVID-19 illness. NA-B had memory loss and was no				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					С	
		00938	B. WING		12/	22/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 48	2 920			
	indicated R20 used always able to reca needs were to be a preferred to be clea been assisted with On 12/22/21, at 12 (DON) indicated sh preference for facia stated R20's cognit overall declining sin COVID-19. The DO R20's shaving prefe expected staff to as he desired.	Ill instructions or events. She is his call light, but was not ill what he wanted and his inticipated. NA-B indicated R20 an shaven and should have facial hair removal daily. A p.m. the director of nursing was not aware of R20's al hair removal. The DON tion had been fluctuating and nee November when he had DN indicated she expected erence to be identified and ssist with facial hair removal if a requested, one was not				
	director of nursing review and revise p to activities of daily or designee could o staff and develop a staff are providing a daily living.	THOD OF CORRECTION: The (DON) or designee could policies and procedures related living. The director of nursing develop a system to educate monitoring system to ensure assistance with activities of R CORRECTION: Twenty-one	1			
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			2/18/22
	must ensure that a which supplies the	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00938	B. WING		C 12/2	; 2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
MOORHI	EAD RESTORATIVE C	CARE CENTER	COND AVENU EAD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	assessment. Subs must be offered to served. This MN Requireme by: Based on observati review the facility fa as prescribed by th residents reviewed Findings include: R1's Admission Re- identified R1 had be 6/11/21, with the dia neuropathy unspec cataract, glaucoma rectal prolapsed, ar (prostate enlargem R1's quarterly Minir 9/16/21, identified F required one staff a and required super	titutes of similar nutritive value residents who refuse food ent is not met as evidenced ion, interview, and document ailed to provide therapeutic diet e physician for 1 of 2 (R1) for therapeutic diet. cord printed 12/22/21, een admitted to the facility on agnoses of visual loss, ified (disease of the nerves), , dysfunction of the bladder, nd benign prostatic hyperplasia	2 965	Corrected		
	or symptoms of a s identified R1 had no	wallowing disorder. The MDS o known weight loss or gain. nat identified dental had been				
	dated 6/24/21, iden	re Area Assessment (CAA) tified R1 was missing most ining teeth were notably				
Minnesota D	R1's care plan revis	sed 6/11/21, identified R1 had				
STATE FOR			6899	LZD411	If continuation	n sheet 50 of 73

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
			A. BUILDING:			
		00938	B. WING		C 12/22/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
NOORH	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID	_	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>\</sup>	HE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	age 50	2 965			
	to risk of choking a chewing, fear and r risk for dehydration age and decreased instructed staff to a explain what was o method when the r plan indicated staff diet as ordered; reg and regular consist R1's current physic dated 12/21/21, ide order for R1 was a	tian Order Summary Report Entified the prescribed diet	ł			
	divided plate, set u	rition Data forms from 8/28/21	,			
		rition Data (Admission) form ved a diet of regular with ktures.				
		utrition Data (Quarterly) form ing on a regular mechanical ar consistencies.				
	R1 was observed of	tion on 12/20/21, at 12:12 p.m. during the noon meal with a ato wedges, and coleslaw.				
	R1 was observed t mashed potatoes, and a slice of ham	tion on 12/20/21, at 5:25 p.m. o have a divided plate, with mixed vegetables, cucumbers, which had not been cut up. R1 el around his plate for his food				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00938	B. WING		12/2	22/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	age 51	2 965			
	was observed to he	e of ham and take a bite. R1 old the slice of ham in his hand ork 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.		,			
		tion on 12/21/21, at 5:40 p.m., intry fried steak, mashed and green grapes.				
	stated he did not ha surgically removed months ago. R1 ind jaw bone was too v was why he did not received an Americ his meat ground up often that happene hard for him to eat needed to keep "m	y on 12/20/21, at 3:31 p.m. R1 ave any teeth as they had been down to the roots several dicated he had been told his veak to handle dentures which t have any. R1 stated he can diet and occasionally had o however was unsure how d. R1 indicated at times it was the meat. R1 stated he unching things" until they ugh or he would have had				
	nursing assistant (I R1 know where his	v on 12/20/21, at 4:35 p.m. NA)-H stated staff were to let s food and drinks were on the ck method. NA-H stated R1 iet.				
	dietary manager (D nutritional assessm the information to t with each resident are staff document	on 12/21/21, at 11:19 a.m. M) identified he completed the nents and the dietician added he dietary slip which went out meal. DM indicated the direct ed the residents' intakes and ny changes or concerns were				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING: _			
		00938	B. WING			C 22/2021
ME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OORHE	AD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656			
X4) ID REFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 52	2 965			
	residents' nutritional not currently on an regular diet. DM de consisted of cutting should have indicat further review, DM lacked information and the sheet ident with meats to be cu- been receiving the working a couple m ordered mechanicat facility had no spec	together they reviewed al status. DM stated R1 was altered diet and R1 received a escribed a mechanical soft diet g up food and each dietary slip ted what size to cut it to. After confirmed R1's dietary slip R1 was on a mechanical soft tified he was on a regular diet ut up. DM confirmed R1 had regular diet since he started nonths ago instead of the al soft diet. DM stated the cial menus to follow for a been prescribed a mechanical				
	registered dietician mechanical soft die meats were to be o in a ground texture grapes and cucum served to someone stated the diets wh food for each resid their dietary slip for a resident had bee included a mechan	on 12/21/21, at 3:55 p.m. (RD) confirmed R1 was on a et. RD stated she expected all cut up unless they were already . RD confirmed foods such as bers should not have been e on a mechanical soft diet. RE nich included the texture of the ent should have been listed or staff to follow. RD confirmed in served the wrong diet which ical soft diet or pureed diet increased risk for choking.				
	stated the chicken tough around the e eat the softer meat	v on 12/21/21, at 6:43 p.m. R1 he ate at his evening meal was dges however he was able to inside. R1 indicated he e grapes however the skin was				
		/ on 12/22/21, at 10:35 a.m. ing (DON) stated the nursing				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION		E SURVEY IPLETED
		00938	B. WING		12/	22/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
NOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 965	staff completed a c identified each resi sent to dietary staff staff would follow o prescribed diets we R1's diet was a me had the potential fo the prescribed diet SUGGESTED MET director of nursing review and revise p ensure the correct director of nursing system to educate system to ensure re similar nutritive value	ommunication form which dent's diet and the forms were . DON indicated she expected rders to ensure correctly ere followed. DON confirmed chanical soft and stated R1 r choking or aspiration when had not been followed. THOD OF CORRECTION: The (DON) or designee could policies and procedures to diet order was served. The or designee could develop a staff and develop a monitoring esidents are provided food of				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreak C. isolation and reduce risk of trans D. in-service e prevention and com E. a resident h immunization progr defined in part 465	0 Subp. 4 A-I Infection Control and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in r detection, investigation, and s of infectious diseases; d precautions systems to smission of infectious agents; ducation in infection trol; ealth program including an ram, a tuberculosis program as i8.0810, and policies and lent care practices to assist in				2/18/22

00938     B. WING     1       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     1       2810 SECOND AVENUE NORTH     1	MPLETED C 2/22/2021
vame of provider or supplier       STREET ADDRESS, CITY, STATE, ZIP CODE         vame of provider or supplier       STREET ADDRESS, CITY, STATE, ZIP CODE         vame of provider or supplier       STREET ADDRESS, CITY, STATE, ZIP CODE         vame of provider or supplier       Street Address, City, State, ZIP CODE         vame of provider or supplier       Street Address, City, State, ZIP Code         vame of provider or supplier       Street Address, City, State, ZIP Code         vame of provider or supplier       Street Address, City, State, ZIP Code         vame of provider or supplier       Street Address, City, State, ZIP Code         vame of provider or supplier       Street Address, City, State, ZIP Code         vame of provider or supplier       Street Address, City, State, ZIP Code         vame of provider or supplier       Street Address, City, State, ZIP Code         vame of provider or supplication       Street Address, City, State, ZIP Code         vame of provider or supplication       Street Address, City, State, ZIP Code         vame of provider or supplication       Street Address, City, State, ZIP Code         vame or provide or supplication       Street Address, City, State, ZIP Code         vame or provide or supplication       Street Address, City, State, ZIP Code         vame or provide or supplication       Street Address, Cores, State, Cores, City, State, ZIP Code         v	(X5) COMPLET
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)         21390       Continued From page 54       21390         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       All Second AVENUE NORTH MOORHEAD, MN 56560	COMPLET
MOORHEAD RESTORATIVE CARE CENTER         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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           21390         Continued From page 54         21390           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	COMPLET
MOORHEAD, MN 56560(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)21390Continued From page 5421390the 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 review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness ofID PREFIX TAG	COMPLET
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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.CorrectedR326'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	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	B. WING			C 22/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MOORHE	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 55	21390			
	thrombosis (blood clot). R326 had been placed on isolation with all services being provided in R326's room.					
	at 12:40 p.m. nursi the noon meal from hallway outside of I meal tray in his har moved a housekee in front of the door R326's room holdin donning a gown or housekeeper who set the meal tray do NA-D moved a dirty to the nightstand. N positioned the beds was in bed with the Observed on the do signs one which re- and the other which don gloves, goggles, go R326's room and s confirmed he had r stated he should ha entering R326's roo facility protocol stat	tion and interview on 12/20/21, ng assistant (NA)-D obtained in the enclosed cart located in R326's room. NA-D with the nd used his other hand to oping cart that had been parked to R326's room. NA-D entered ing the meal tray without gloves, walked passed the was in the room in full PPE and own on the bedside table. y glass from the bedside table VA-D set up the meal tray and side table in front of R326 who head of bed elevated. oor to R326's room were 2 ad "STOP, see charge nurse" in read "Isolation PPE, staff to s, mask, and gown, then doff own, and mask". NA-D exited anitized his hands. NA-D not been wearing PPE and ave worn all the PPE when om. NA-D indicated it was the ff were to wear all PPE any gn on the resident's door				
	Protective Equipme Using Gloves, and	ty policy titled Personal ent Using Protective Eyewear, Using Gowns, undated tive was to prevent the spread				
		ty policy titled Contact 3/23/21, identified contact				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	B. WING			C <b>22/2021</b>
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE (	CARE CENTER				
(X4) ID	SUMMARY ST		EAD, MN 5656	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
21390	Continued From pa	age 56	21390			
	gowns when enteri were to don gloves resident or the resi gown if substantial environment was a remove gloves and resident room. Dise	ed the use of gloves and ng the isolation room. Staff prior to contact with the dents environment, wear a contact with the resident or inticipated. Staff were to I gown prior to leaving the ease was more likely to be cur between a health care ent.				
	MASKS					
		11:50 a.m. to 1:00 p.m. during /ice in the main dining room /bserved:				
	by the the steam ta covered, and a ma below her nose. Th juice (uncovered) f table and placed it DA-A stood next to	dietary assistant (DA)-A stood able cart with goggles on, hair sk worn loosely which hung ne DA-A grabbed a glass of rom the cart, walked over to a on the table in front of R1. R1 who was unmasked, and walked back to the cart.				
	(uncovered), stood the table. DA-A gra sanitizer and walke next to R14 who wa mask which remain below her nose and	A grabbed a glass of juice next to R16 and placed it on abbed the bottle of hand ed over to R14. DA-A stood as unmasked, bent over with ned loosely placed and hung d asked R14 if he wanted to DA-A verbally instructed him gether.				
	mask in the same next to R2 who was	A walked over to R2 with her position worn loosely, stood s unmasked, bent over, and e would like to drink. DA-A				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	or connection	DENTIFICATION NONDER.	A. BUILDING:			
		00938	B. WING			C 22/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHE	EAD RESTORATIVE (		COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 57	21390			
		laced a glass of juice on the ed with her for approximately				
	unmasked, placed table in front of him wanted anything el- cup of coffee. DA-A R30. DA-A stood n while she opened t	A stood next to R30 who was a glass of juice (uncovered) or both over, and asked if he se to drink. R30 requested a A delivered a cup of coffee to ext to R30, visited with him wo coffee creamers and coffee cup. DA's mask me position.	n			
	dining room and co remained loosely w Nursing Assistant ( positioned face ma stood next to DA-A tray. NA-C was not	A stood at the steam table in ontinued to wear mask /hich hung below her nose. NA)-C wore a properly sk which covered the nose, , and handed her a breakfast observed to provide education e nose with the mask.	1			
	plates of food onto manager (DM) wor mask which covere other side of the str observation. DM wa	2:50 p.m. DA-A transferred the food cart. The dietary e a properly positioned face ed the nose and stood on the eam table during the entire as not observed to provide to cover the nose with the				
	mask over her nos	A reached up and pulled up he e, however the mask remained e sanitized her hands the vn below her nose.				
	entered the dining	ness office manager (BOM) room, wore a properly sk which covered the nose,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	– B. WING			C 22/2021
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	12/	
	EAD RESTORATIVE (	2810 SEC	COND AVENUE			
		MOORHE MOORHE	EAD, MN 5656	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 58	21390			
	his meal. DA-A's m loosely, which hung no. BOM was not of to DA-A to cover th -at 1:00 p.m. DA-A and her mask cont Five residents remain DA-A cleaned off the room tables. During an interview NA-A stated staff e covered our mouth especially when pre- and staff. NA-A states	a, and asked if R30 had eaten hask remained positioned g below her nose responded observed to provide education he nose with the mask. remained in the dining room inued in the same position. ained in the dining room while he dirty dishes from the dining of on 12/21/21, at 12:02 p.m. expected to wear a mask that and nose while they worked; esent were around residents ated wearing a mask helped of any germs such as				
	12:37 p.m. DA-A st to keep over her no expected to keep of especially when clo bringing them food infection. During the remained positione her nose then DA-A to cover the nose a During an interview the facility cook (C) to wear a mask over especially when pro-	v/observation on 12/21/21, at tated the mask had been hard ose. DA indicated staff were our mask over the nose ose to residents, visiting, and to help prevent the spread of e interview DA-A's mask ed loosely, which hung below A re-positioned the face mask and walked away v on 12/21/21, at 12:54 p.m. )-A stated staff were expected er the mouth and nose esent around the residents and e to help prevent the spread of				
		v on 12/22/21, at 7:52 a.m. DM aff were expected to wear a				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00938	B. WING			C 22/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
MOORHI	EAD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21390	goggles or a face s and when out amor practice helped pre Review of an undat Protective Equipme identified the purpo masks to prevent tr agents through the face mask so that i while they preforme resident. SUGGESTED MET DON (Director of N review/revise facility contain all compone program, including illnesses in the faci stewardship program	A the mouth and nose and hield when meals were served ing residents. DM identified this vent infection. The d facility policy titled Persona ent - Using Face Masks se was to guide the use of ransmission of infectious air. Staff were to apply the t covered the nose and mouth ad treatment or services for the USING OF CORRECTION: The ursing) or designee could y policies to ensure they ents of an infection control tracking/trending of all lity as well as an antibiotic m. The DON or designee and perform audits to ensure I program is being				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21530	A. The drug regim reviewed at least m currently licensed b This review must b Appendix N of the S Surveyor Procedure Requirements in Lo the Department of	D A.B.C Drug Regimen Review en of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992.				2/18/22

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00938	B. WING			C 22/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IOORHE	EAD RESTORATIVE O	CARE CENTER	COND AVENU			
			EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE
21530	Continued From pa	age 60	21530			
	available through the system. It is not sure irregularities to the and the attending provide a dependence physician visit, or sepharmacist. For pure upon means the area report and the sign of nursing services C. If the attendor with the pharmacist believe being adversely affective physician. If the matter to the if the medical direct physician. If the medical direct physician does not must be referred for assessment and ase by part 4658.0070. the medical direct must refer the matter assessment and ase by part 4658.0070. This MN Requirem by: Based on interview facility failed to ens	acorporated by reference. It is the Minitex interlibrary loan ubject to frequent change. acist must report any director of nursing services obysician, and these reports in by the time of the next ooner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ling physician does not concur t's recommendation, or does ate justification, and the s the resident's quality of life is fected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ther directly to the quality ssurance committee.		Corrected		

STATE FORM

LZD411

If continuation sheet 61 of 73

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	CONSTRUCTION	(X3) DATE	SURVEY
	OF CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING:			
		00938	B. WING			C 22/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		2810 SE				
OORH	EAD RESTORATIVE (	CARE CENTER MOORHI	EAD, MN 5656	60		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE <sup>-</sup> DATE
21530	Continued From pa	age 61	21530			
	(SCSA) Minimum I 11/20/21, identified included diabetes, vascular disease. T intact cognition and with activities of da mobility, transfers, The MDS identified anticoagulant, diurn seven of seven day R20's SCSA Care A 11/20/21, identified assistance with AD mobility, transfers a related to recent C medical conditions diabetes, valgus de foot/ankle) and chr R20 received seve included, antidepre and opioid medicat	change of Status Assessment Data Set (MDS) dated R20 had diagnoses which Osteoarthritis and peripheral The MDS identified R20 had d required extensive assistance ily living (ADL's) of bed toileting and personal hygiene. I R20 received antidepressant, etic, and opioid medications ys during the look back period. Area Assessment (CAA) dated R20 required extensive PL's which included bed and had a decline in condition OVID-19 diagnosis, and other such as heart failure, eformity (deformity of onic pain. The CAA's identified ral different medications which essant, anticoagulant, diuretic, tions.				
	Medication Review revealed the follow	from 8/26/21, to 11/29/21, ing:				
	a recommendation	the pharmacy consultant had for separation of calcium and onse was documented.				
	recommended R20 of Cinnamon at the high,) requested D to treat atrial fibrilla therapeutic level) a	d the pharmacy consultant o's practioner address the use e current dose, (which was too igoxin level (medication used ition, lab helps determine and requested a basic a blood test that measures your				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			С
		00938	B. WING			22/2021
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHE	AD RESTORATIVE O	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 62	21530			
	balance, and kidne sugar your body us keep your body's flu	el, electrolyte and fluid y function. Glucose is a type of es for energy. Electrolytes uids in balance.) The lacked documentation R20's addressed the	F			
	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.					
		edical record lacked harmacy review was ber, 2021.				
	R15					
	11/19/21, identified impairment and have Parkinson's Diseas Mellitus. The MDS antipsychotic medic assessment referen	nimum Data Set (MDS) dated R15 had moderate cognitive d diagnoses which included se, Heart Failure and Diabetes indicated R15 received cation each day during the nce period. The MDS lacked a drug regimen review.				
		physician orders signed R15 received the following				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMI	E SURVEY PLETED
		00938	B. WING			C 22/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MOORHI	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 63	21530			
		medication used to treat 1000 mg. twice a day.				
	used to treat schize	pine Fumerate) (medication ophrenia, bipolar and major r)25 mg. twice daily.				
		onsultant Pharmacist's (CPMR) forms from 6/28/21, ed the following:				
	and update the me (MAR) to administer extended release ( and confirmed the Recommendation r scheduling of Metfor administered at me	endation was made to clarify dication administration record er Isosorbide Dinitrate 30 mg. ER). Physician acknowledged order on 6/30/21. made for direction on the prmin 1000 mg. times to be eal times. The physician confirmed the order on				
	- 7/19/21, the facilit 2021.	y lacked the form for July				
	physician to clarify the ER formulation	endation was made for the if Isosorbide 60 mg. should be or not. The form lacked any ure from the physician.				
	physician to re-eva due to antipsychoti medicines used to mental and emotion potential for a direct who has Parkinson	endation was made for the luate prescribing Quetiapine c medications (are a class of treat psychosis and other nal conditions) have the et drug interaction for someone 's Disease. The form lacked gnature from the physician.				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		BERTH TOX TOT TO MBER.	A. BUILDING:			
00938		00938	B. WING		C <b>12/22/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHI	EAD RESTORATIVE (		COND AVENUE EAD, MN 5656			
(X4) ID	_	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21530	Continued From pa	age 64	21530			
	Tardive Dyskinesia are involuntary mor face, trunk, and ex treated with antipsy assessment compl lacked any respons physician. - 10/29/21, recomm physician to clarify the ER formulation response or signat - 11/29/21, the facil November 2021. - 12/17/21, recomm physician to re-eva due to antipsychoti potential for a direct who has Parkinson any response or sig - 12/17/21, recomm physician to clarify should be the ER fa lacked any response physician. Review of facility for Report printed on the following:	nendation was made to have a (Tardive dyskinesias (TDs) vements of the tongue, lips, tremities that occur in patients ychotic medications) eted as necessary. The form se or signature from the nendation was made for the if Isosorbide 60 mg. should be or not. The form lacked any ure from the physician. Nendation was made for the luate prescribing Quetiapine c medications have the et drug interaction for someone of Disease. The form lacked gnature from the physician. mendation was made for the if Isosorbide mono 60 mg. ormulation or not. The form se or signature from the se or signature from the tet drug interaction for someone is Disease. The form lacked gnature from the physician. mendation was made for the if Isosorbide mono 60 mg. ormulation or not. The form se or signature from the the form titled Patient Summary 12/22/21, revealed the ties identified- see report.				
	- 7/19/21, irregulari	ties identified- see report.				
	- 8/26/21, irregulari	ties identified- see report.				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00938	B. WING		C 12/22/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MOORH	EAD RESTORATIVE (	CARE CENTER	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	age 65	21530			
	- 9/22/21, irregularities identified- see report.					
	- 10/29/21, irregula	rities identified- see report.				
	- 11/29/21, no irregularities identified.					
	- 12/17/21, irregularities identified- see report.					
	R9					
	identified R9 had c included hypertens (DM), renal insuffic MDS identified R9 dressing and had u transfers and walki received antianxiet	even of seven days during the				
		rent physician orders signed R9 received the following				
	to fight infections c	on (antifungal medication used aused by fungus) 100,000 ve 5 ml by as needed (PRN)	I			
	tablet extended rel milligrams (mg) by	hloride (HCL) (antidepressant) ease (ER) 24 hour give 150 mouth at bedtime for r single episode. Revision date				
	to treat imbalance tablet 15 mg tablet	r) (antianxiety medication used of chemicals in the brain) HCL give 15 mg by mouth three pressive major single episode.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		00938	B. WING		C 12/22/2021	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORHI	EAD RESTORATIVE		COND AVENUE			
		MOORH	EAD, MN 5656		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 66	21530			
	Revision date 5/25	/21.				
	used to treat imbal HCL ER capsule 2	tor) (antidepressant medication ance of chemicals in the brain 4 hour 75 mg give 1 capsule b ing for depression. Revision	)			
	-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.					
		ased blood glucose/sugar 500 mg give my mouth two I.				
		narmacist's (CP) Medication 21 through 12/2021, identified				
	-6/28/21, No irregu	larities identified.				
	-7/19/2021, No irre	gularities identified.				
	-8/26/21, No irregu	larities identified.				
	PRN. Identified the frequency of use o record (MAR). Stat provider and updat	n on 12/17/21, Nystatin 5 ml e medication did not include the n the medication administratio ff were directed to contact the re the MAR with the intended as possible but no later than				
	-10/29/21, No irreg	ularities identified.				
		on, Effexor, Depakote, and en reduced recently.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		С	
		00938	B. WING		12/	22/2021
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S			
MOORHE	EAD RESTORATIVE O	CARE CENTER	OND AVENUI AD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ige 67	21530			
	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.					
		ntified 6/9/20, had been the C that was drawn with results				
	1:50 p.m. identified	rsician visit dated 12/22/21, at R9 had been in need of blood obin A1C was then ordered.				
		d lacked documentation R9's vas updated or followed up on lations.				
	R12					
	identified R12 had of extensive assitance walking, dressing, t The MDS indicated coronary heart dise pneumonia, arthritis post traumatic stress	ange MDS dated 11/13/21, cognition intact and required e needed with bed mobility, colleting, and personal hygiene. R12's diagnoses included case (CAD), HTN, DM, s, anxiety, depression, and ss syndrome (PTSD). The				
		ereceived insulin and even of seven days during the				

Minnesota Department of Health STATE FORM

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LZD411

If continuation sheet 68 of 73

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		C 12/22/2021	
	00938		B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORHE	EAD RESTORATIVE (		COND AVENUE EAD, MN 5656			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET
21530	Continued From pa	age 68	21530			
	Review of R12's cu 12/28/21, revealed	irrent physician orders signed :				
	-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.					
	insomnia and indic	(sedative used to treat ated for short term use only) 0 mg by mouth as needed at y insomnia.				
	blood flow to the he	d to treat chest pain to increase eart) tablet sublingual give 0.4 ery 5 minutes as needed for	e			
		on Reviews from 6/2021 dentified the following:				
	mg SL tab PRN as the maximum 3 do	n on 10/29/21, Nitroglycerin 0.4 directed. CP recommended ses/episode should be edicaion administration record n 30 days.	1			
	immediate release administered with r increase oral absor	lol Tartrate 25 mg tablets are and should be ideally neals or directly after meals to rption. CP recommended Id have been added to the				
	PRN was used for needed to be reval	n 10 mg every bedtime (HS) a psychological condition and uated within the first 14 days o mended in order to continue	f			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00938	B. WING			22/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MOORHI	EAD RESTORATIVE O		COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ge 69	21530			
		e-evaluation date to reassess added, medication continued, te again in 60 days.				
	-11/29/21, No irregu	ularities identified.				
	-12/17/21, No irregularities identified.					
		s for June, July, and August ed and not provided.				
	R12's primary phys	rd lacked documentation ician had been updated or CP recommendations.				
	interview, the facility indicated she felt in struggle to get the f address her pharm timely manner. She R20 had a review of recommendations a recommendations to September. The ph she expected her p	56 a.m. during a telephone y pharmacy consultant, the past it had been a facility to have the physicians acy recommendations in a indicated she had thought completed in August with no and October she made to address her comments from armacy consultant indicated harmacy recommendations to bon as possible, but no later				
	(DON) stated she s recommendations i indicated she was r prior to that time. D not followed up on t July 2021, Septemb December 2021 an	35 p.m. director of nursing started reviewing the pharmacy n November 2021, and not aware who reviewed them ON confirmed the facility had the recommendations from per 2021, October 2021, and d verified there had been ndations due to the facility's	/			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
			A. BUILDING:			С
	00938		B. WING			22/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHE	EAD RESTORATIVE O	CARE CENTER	COND AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ge 70	21530			
	(DON) indicated sh medications to be r expect pharmacy re addressed in a time indicated the facility pharmacy consulta reviews and their r addressed timely a confirmed R20's re September had not December. A facility policy titled Review, reviewed 4 facility's policy to ha review residents me to ensure all medic discontinued and m the facility would en	47 p.m. the director of nursing e would expect residents eviewed monthly and would ecommendations to be ely manner. The DON / had identified issues with nts completing monthly ecommendations being couple of months ago. She commendations from been not addressed until d, Pharmacy Medication //3/18, identified it was the ave the consultant pharmacist edications for dose reductions ations were properly ordered, nonitored. The policy revealed issure the provider would recommendations in a timely				
	director of nursing of review and revise p pharmacy reviews a of nursing or design educate staff and d ensure pharmacy re irregularities are be assurance committ measures to ensure					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty One	9			
21915	MN St. Statute 144 Residents of HC Fa	.651 Subd. 27 Patients &	21915			2/18/22

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED	
	00938		B. WING		C 12/22/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
IOORHI	EAD RESTORATIVE (	CARE CENTER	OND AVEN			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION					(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
21915	Continued From pa	age 71	21915			
	their families shall maintain, and parti family councils. Ea assistance and spa meetings shall be a visitors attending o invitation. A staff p responsibility of pro responding to writte council meetings.	ry councils. Residents and have the right to organize, cipate in resident advisory and ach facility shall provide ace for meetings. Council afforded privacy, with staff or nly upon the council's berson shall be designated the oviding this assistance and en requests which result from Resident and family councils ed to make recommendations oblicies.				
	by: Based on interview facility failed to atte	ent is not met as evidenced and document review, the empt to organize a family nually. This had the potential to nts in the facility.		<ol> <li>No single resident was identified in deficiency. During the week of 12/20/2 messages were sent to family member for the residents in the facility to give family members a choice to participat family council.</li> <li>This has the potential to affect all</li> </ol>	2021 ers	
	services, identified family council grou services stated prio	:10 a.m. the director of social the facility did not have a p. The director of social or to 12/20/21, families and been notified or information council group.		residents that reside at the facility. Au will ensure that all current and future residents of MRHCC and families will provided the opportunity to participate family council every 12 months. Staff educated on 12/22/21. 3.Audits will be completed by the direct	be in were	
	A family council policy and procedure was requested but was not received.			of social work or designee every six months for one year until 100% compliance is achieved.		
	administrator or de avenues of commu a family council. Th posting, and verba	THOD OF CORRECTION: The signee could utilize several unication in attempt to promote his could include mailing, lly requesting family members g a council. Results could be		<ul> <li>4.Audits will be reviewed by administr or designee and then further discussion will take place at the next QAPI meeting review and recommend any necessar changes.</li> <li>5.02/18/2022</li> </ul>	on ng to	

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00938		B. WING			C 22/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHE	EAD RESTORATIVE (		COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21915	Continued From pa	age 72	21915			
	compiled, and furth persons expressing	ner information provided to g interest.				
	TIME PERIOD FO (21) days	R CORRECTION: Twenty-one				