MEDICARE/MEDICAID CERTIFICAT	HON AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE	E STATE SURVEY AGENCY

ID: VNGR Facility ID: 00938

MEDICARE/MEDICAID PROVIDER (L1) 245052 2.STATE VENDOR OR MEDICAID NO. (L2) 154578700 SEFFECTIVE DATE CHANGE OF OW (L9) 02/01/2017 6. DATE OF SURVEY 09/05. 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/NERSHIP	3. NAME AND AD (L3) MOORHEA (L4) 2810 SECON (L5) MOORHEA 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	D REHABILITA ND AVENUE NO D, MN	ATION & I	(L6) 56560 (L6) 56560 (D2 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	78 (L18) 78 (L17)	Compliand1.		am	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNR 5. Life Safety Code * Code: A	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 78 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS	19 SNF (L39)	ICF (L42) E SHOW LTC CANCE	IID (L43) ELLATION DATE)	:	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE Beth Nowling, HFE - N			09/12/2018	(L19)	18. STATE SURVEY AGENCY	rcement Specialist 09/12/2018 (L20)
19. DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Pacific Section 2. Facility is not Eligible	Y articipate	20. COM	BY HCFA RE MPLIANCE WITH G GHTS ACT:			ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 03/01/1979 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind Sus	DATE VE SANCTIONS of Admissions:	4. LTC AGREEM ENDING DATI (L25) (L44) (L45)		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMARKS	
	(L28)	01111		(L31)		

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VNGR Facility ID: 00938

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

IJ was cited at F 689 -- IJ removed March 13, 2018 but remained at the lower s/s of G IJ of K cited at F812 - IJ removed March 9, 2018 but remained at the lower s/s of E 3 G's cited at F 676, F 686 and F 697

On June 1, 2018, the Minnesota Department of Health and Office of the Centers for Medicare & Medicaid Services (CMS) completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 13, 2018 and April 13, 2018. Based on our visit, we have determined that this facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 13, 2018. The deficiencies not corrected are as follows:

F0607 -- S/S: C -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies

F0636 -- S/S: E -- 483.20(b)(1)(2)(i)(iii) -- Comprehensive Assessments & Timing

F0656 -- S/S: D -- 483.21(b)(1) -- Develop/implement Comprehensive Care Plan

F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer

F0812 -- S/S: F -- 483.60(i)(1)(2) -- Food Procurement, store/prepare/serve-Sanitary

In addition, at the time of this revisit, we identified the following deficiencies:

F0655 -- S/S: D -- 483.21(a)(1)-(3) -- Baseline Care Plan

F0698 -- S/S: D -- 483.25(1) -- Dialysis

F0726 -- S/S: D -- 483.35(a)(3)(4)(c) -- Competent Nursing Staff

F0865 -- S/S: F -- 483.75(a)(2)(h)(i) -- Qapi Prgm/plan, Disclosure/good Faith Attmpt

The most serious deficiencies in this facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required.

Also on June 1, 2018 the Office of Health Facility Complaints completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 23, 2018. Based on our visit, we have determined that this facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 23, 2018. The deficiencies not corrected are as follows:

F0686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer F0697 -- S/S: G -- 483.25 (k) -- Pain Management

The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

On August 1, 2018, the Minnesota Department of Health and CMS completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 1, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our PCR, completed on June 1, 2018.

Also August 2, 2018 the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 1, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on June 1, 2018.

As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

On August 28, 2018, the CMS Region V Office notified you of the following actions:

• Mandatory termination effective September 13, 2018.

In addition, the following previously imposed remedies will remain in effect:

- State monitoring effective April 4, 2018.
- Discretionary denial of payment for new admissions effective June 1, 2018.
- Federal Civil Money Penalty.

On September 5, 2018, the Minnesota Departments of Health, OHFC and CMS completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 1, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on August 1, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 5, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of August 28, 2018:

- Mandatory termination effective September 13, 2018 be rescinded effective September 5, 2018.
- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 1, 2018 be discontinued effective September 5, 2018. (42 CFR 488.417 (b))
- Federal Civil money penalty.

This facility is now in compliance.

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00938



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2018

CMS Certification Number (CCN): 245052

Administrator Moorhead Rehabilitation & Healthcare Center 2810 Second Avenue North Moorhead, MN 56560

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 5, 2018 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2018

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

RE: Project Number S5052027, H5052064, H5052065, and H5052066

Dear Administrator:

On March 30, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 4, 2018. (42 CFR 488.422)

On April 26, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- State monitoring effective April 4, 2018
- Discretionary denial of payment for new admissions effective June 1, 2018
- Federal Civil Money Penalty

Also, the CMS Region V Office notified you in their letter of April 26, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 13, 2018.

This was based on the deficiencies cited by this Department during an extended survey completed on March 13, 2018 and by Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on March 13, 2018 that included an investigation of complaint numbers H5052064, H5052065, and H5052066. The most serious deficiencies were found to be a pattern

of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On June 1, 2018, the Minnesota Department of Health and Office of the Centers for Medicare & Medicaid Services (CMS), The Department of Health and Department Office of Health Facilities Complaints (OHFC) completed a post certification revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 13, 2018 and April 13, 2018. Based on our visit, we have determined that

Moorhead Rehabilitation & Healthcare Center September 12, 2018 Page 2

your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 13, 2018. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition you were notified of the following actions in our letter dated June 27, 2018:

- Civil money penalty would remain in effect. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for new admissions effective June 1, 2018 will remain in effect.

On August 1, 2018, the Minnesota Department of Health and CMS completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 1, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our PCR, completed on June 1, 2018.

Also August 2, 2018 the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an PCR, completed on June 1, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on June 1, 2018.

As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

On August 28, 2018, the CMS Region V Office notified you of the following actions:

• Mandatory termination effective September 13, 2018.

In addition, the following previously imposed remedies will remain in effect:

- State monitoring effective April 4, 2018.
- Discretionary denial of payment for new admissions effective June 1, 2018.
- Federal Civil Money Penalty.

On September 5, 2018, the Minnesota Departments of Health, OHFC and CMS completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 1, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on August 1, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state

Moorhead Rehabilitation & Healthcare Center September 12, 2018 Page 3

monitoring effective September 5, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of August 28, 2018:

- Mandatory termination effective September 13, 2018 be rescinded effective September 5, 2018
- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 1, 2018 be discontinued effective September 5, 2018. (42 CFR 488.417 (b))
- Federal Civil money penalty.

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

As we notified you in our letter of March 30, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 13, 2018.

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

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

MEDICARE/MEDICALD CERTIFICATION AND TRANSMIT	IAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGE	ENCY

ID: VNGR Facility ID: 00938

MEDICARE/MEDICAID PROVIDER (L1)	/NERSHIP	(L4) 2810 SECON (L5) MOORHEA 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	D REHABILIT. ND AVENUE NO D, MN PPLIER CATEGOR 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ATION & DRTH RY 09 ESRD 10 NF 11 ICF/IID 12 RHC	(L6) 56560 (L6) 56560 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	78 (L18) 78 (L17)	Compliance1.		ram	And/Or Approved Waivers Of TI 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code * Code: B *	6. Scope of Services Limit7. Medical Director
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 78 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS	19 SNF (L39)	ICF (L42) E SHOW LTC CANCE	IID (L43) ELLATION DATE	:	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE Jonathan Anderson, H			06/01/2018	(L19)	Joanne Simon, Enfo	rcement Specialist 06/27/2018 (L20)
19. DETERMINATION OF ELIGIBILIT			BY HCFA RE	EGIONAL	L OFFICE OR SINGLE ST	ATE AGENCY
1. Facility is Eligible to Pace	articipate		MPLIANCE WITH GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) :
	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI	ENT 2. DATE VE SANCTIONS a of Admissions:		ENT	Ownership/Control	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety of the state of the
22. ORIGINAL DATE OF PARTICIPATION 03/01/1979 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI' A. Suspension B. Rescind Sus	ENT 2. DATE VE SANCTIONS a of Admissions:	4. LTC AGREEM ENDING DAT (L25) (L44) (L45) CARRIER NO.	ENT E	2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety ent OTHER 07-Provider Status Change

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00938

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

IJ was cited at F 689 -- IJ removed March 13, 2018 but remained at the lower s/s of G IJ of K cited at F812 - IJ removed March 9, 2018 but remained at the lower s/s of E 3 G's cited at F 676, F 686 and F 697

On June 1, 2018, the Minnesota Department of Health and Office of the Centers for Medicare & Medicaid Services (CMS) completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 13, 2018 and April 13, 2018. Based on our visit, we have determined that this facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 13, 2018. The deficiencies not corrected are as follows:

```
F0607 -- S/S: C -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies F0636 -- S/S: E -- 483.20(b)(1)(2)(i)(iii) -- Comprehensive Assessments & Timing F0656 -- S/S: D -- 483.21(b)(1) -- Develop/implement Comprehensive Care Plan F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer F0812 -- S/S: F -- 483.60(i)(1)(2) -- Food Procurement,store/prepare/serve-Sanitary
```

In addition, at the time of this revisit, we identified the following deficiencies:

```
F0655 -- S/S: D -- 483.21(a)(1)-(3) -- Baseline Care Plan
F0698 -- S/S: D -- 483.25(l) -- Dialysis
F0726 -- S/S: D -- 483.35(a)(3)(4)(c) -- Competent Nursing Staff
F0865 -- S/S: F -- 483.75(a)(2)(h)(i) -- Qapi Prgm/plan, Disclosure/good Faith Attmpt
```

The most serious deficiencies in this facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required.

Also on June 1, 2018 the Office of Health Facility Complaints completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 23, 2018. Based on our visit, we have determined that this facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 23, 2018. The deficiencies not corrected are as follows:

```
F0686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer F0697 -- S/S: G -- 483.25 (k) -- Pain Management
```

The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).



Protecting, Maintaining and Improving the Health of All Minnesotans

Revised Letter

Electronically delivered July 18, 2018

Mr. Jesse Doschadis, Administrator Moorhead Rehabilitation & Healthcare Center 2810 Second Avenue North Moorhead, MN 56560

RE: Project Number S5052027, H5052064, H5052065, H5052066

Dear Mr. Doschadis:

This letter is to replace the letter dated June 27, 2018. The following tags were not listed as additional deficiencies cited:

F0585 -- S/S: D -- 483.10(j)(1)-(4) -- Grievances

F0623 -- S/S: B -- 483.15(c)(3)-(6)(8) -- Notice Requirements Before Transfer/discharge

F0625 -- S/S: B -- 483.15(d)(1)(2) -- Notice of Bed Hold Policy Before/upon Trnsfr

F0657 -- S/S: D -- 483.21(b)(2)(i)-(iii) - - Care Plan Timing And Revision F0761 -- S/S: F -- 483.45(g)(h)(1)(2) -- Label/store Drugs And Biologicals

On March 30, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 4, 2018. (42 CFR 488.422)

On April 26, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- State Monitoring effective April 4, 2018.
- Discretionary denial of payment for new admissions effective June 1, 2018
- Federal Civil Money Penalty

Also, the CMS Region V Office notified you in their letter of April 26, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 13, 2018.

This was based on the deficiencies cited by this Department during an extended survey completed on March 13, 2018 and by Minnesota Department of Health, Office of Health Facility Complaints for an

Moorhead Rehabilitation & Healthcare Center July 18, 2018 Page 2

abbreviated standard survey completed on March 13, 2018 that included an investigation of complaint number H5052064, H5052065, H5052066. The most serious deficiencies were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On June 1, 2018, the Minnesota Department of Health and Office of the Centers for Medicare & Medicaid Services (CMS) completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 13, 2018 and April 13, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 13, 2018. The deficiencies not corrected are as follows:

```
F0607 -- S/S: C -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies
F0636 -- S/S: E -- 483.20(b)(1)(2)(i)(iii) -- Comprehensive Assessments & Timing
F0656 -- S/S: D -- 483.21(b)(1) -- Develop/implement Comprehensive Care Plan
F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0812 -- S/S: F -- 483.60(i)(1)(2) -- Food Procurement, store/prepare/serve-Sanitary
```

In addition, at the time of this revisit, we identified the following deficiencies:

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F0726 -- S/S: D -- 483.35(a)(3)(4)(c) -- Competent Nursing Staff

F0865 -- S/S: F -- 483.75(a)(2)(h)(i) -- Qapi Prgm/plan, Disclosure/good Faith Attmpt

F0585 -- S/S: D -- 483.10(j)(1)-(4) -- Grievances

F0623 -- S/S: B -- 483.15(c)(3)-(6)(8) -- Notice Requirements Before Transfer/discharge

F0625 -- S/S: B -- 483.15(d)(1)(2) -- Notice of Bed Hold Policy Before/upon Trnsfr

F0657 -- S/S: D -- 483.21(b)(2)(i)-(iii) - - Care Plan Timing And Revision

F0761 -- S/S: F -- 483.45(g)(h)(1)(2) -- Label/store Drugs And Biologicals
```

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

Also on June 1, 2018 the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 23, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 23, 2018. The deficiencies not corrected are as follows:

```
F0686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer F0697 -- S/S: G -- 483.25 (k) -- Pain Management
```

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

Moorhead Rehabilitation & Healthcare Center July 18, 2018 Page 3

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of April 26, 2018:

- Civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for new admissions effective June 1, 2018

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

• Civil money penalty effective June 1, 2018. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of March 30, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 13, 2018.

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.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196 An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

Moorhead Rehabilitation & Healthcare Center July 18, 2018 Page 5

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the fourth revisit.

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 September 13, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

Moorhead Rehabilitation & Healthcare Center July 18, 2018 Page 6

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

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

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

PRINTED: 07/22/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245052	B. WING			R
NAME OF I	PROVIDER OR SUPPLIER	243032	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/	01/2018
MOORHI	EAD REHABILITATION	N & HEALTHCARE 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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 00	00}		
{F 000}	compliance with CN Preparedness Requin compliance with A Preparedness Requinities Requinities Requinities Required to the complete of the comp		{F 00	00}		
	completed on 5/29/ certification tags the found on the CMS2 were not found corr	18, and 6/1/18. The at were corrected can be 1567B. Also there are tags that rected at the time of onsite ated on the CMS2567.				
	signature is not req					
{F 607} SS=C	on-site revisit of you validate that substa regulations has bee your verification. Develop/Implement	acceptable electronic POC, an ur facility will be conducted to ntial compliance with the en attained in accordance with Abuse/Neglect Policies 1)-(3)	{F 60	07}		7/23/18
		ility must develop and olicies and procedures that:				
		ibit and prevent abuse, ation of residents and resident property,				
	to investigate any s	olish policies and procedures uch allegations, and				
LABORATOR'	Y DIBECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	VALUEL	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 07/02/2018

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	` '	SURVEY PLETED
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{F 607}	Continued From pa	age 1	{F 607}			
	paragraph §483.95 This REQUIREME by: Based on interview facility failed to dev all alleged violation exploitation or mist unknown source a resident property a within the required results of all invest state agency within incident. In addition staff received abus and existing staff in practice had the por residing in the facili reviewed 5/10/18, I evaluated and care susceptibility to aborisk for abusing oth be taken to minimis listed the assessm admission, and rev The policy did not a investigation, prote violations of abuse mistreatment, injur	v and document review the relop an abuse policy to ensure involving abuse, neglect, reatment, including injuries of and misappropriation of the reported to the state agency timeframe's and ensure the regations are reported to the state agency timeframe's and ensure the reported to the state agency timeframe's and ensure the reported to the state agency timeframe's and ensure the reported to the state agency timeframe's and ensure the reported to the state agency timeframe's and ensure the reported to the state agency timeframe's and ensure to ensure the prevention training for new in the facility. This deficient reported to affect all 54 residents reported to affect all 54 residents reported to the resident would be replanned for their individual reported to the risk of abuse. The policy report would be done upon riewed quarterly and annually. Address identification, ction and reporting of alleged, neglect, exploitation, resident would be done upon riewed quarterly and annually.		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility to repincidents and do timely follow up or incident that result in injury. All incident and accidents are to be reviewed immediately for any potential abuse neglect. In this case the review determined the actual policy was not complete and lacked the following elements: The policy failed to include training abuse prevention upon hire and an for all employees. The policy failed to include that all a violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident proper reported immediately, but not later hours after the allegation is made, events that cause the allegation invabuse or result in serious bodily inj	or the ssion or that of and oort all n any dents e or ot on nually alleged ling rty, are than 2 if the volve ury, or	
		f resident property and did not r new and existing employees on.		not later than 24 hours if the events cause the allegation do not involve and do not result in serious bodily i to the State Survey Agency The po	abuse njury,	

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{F 607}	Continued From pa	ge 2	{F 60	07}			
	Review of the facilit Protection Manual I	y policy titled Resident Program statement, updated ne program listed the	·	,	failed state that results of the investigations would be reported to State Agency within 5 working days incident The findings also conclude based on vulnerable adult policy th	of the	
	abuse are substant financial exploitation neglect, or if a thera a call must be made	plainable, if the findings of iated(physical, verbal, sexual, n), if there is caregiver apeutic error resulted in injury e to the facility designated iin 2 hours of the initial			facility did not have system in place address identification, investigation protection and reporting of alleged violations of abuse, neglect, exploit mistreatment, injuries of unknown and misappropriation of resident prand did not address training for nevexisting employees on abuse preventions.	e to cation, source operty w and	
	Administrator, Direct	days of the original report, ctor of Nursing and Director of meet to make the final the outcome of the			2.Because all residents receiving of the facility are determined to be vulnerable adults, all are potentially affected by the cited deficiency. Sir survey the policy has been revised include training implementation, the	are in	
	employee orientation	e will be assigned to new on, and attendance at a yearly esident Safety and Resident y for all employee			hours vs. 24-hour notification rule, when the conclusion of investigatio be completed and timeframe of wh must be submitted. The vulnerable policy has been reviewed and a	and n will ich it	
	violations involving mistreatment, inclusionree and misapp are reported immed hours after the alleg that cause the alleg in serious bodily injuif the events that cainvolve abuse and cinjury, to the State S				vulnerable adult assessment has be completed on high risk residents we educated on proper re-assessment well as education for new and exist employees on abuse prevention. No other residents were affected. 3.To enhance currently compliant operations and under the direction director of nurses, on 7/12/2018 all received in-service training regardicupdated policy and assessing vulnerables. All new and existing staff we	ith staff t as ting lo of the staff ng erable	
	investigations would	include the results of the d be reported to the State rking days of the incident.			continue to have initial and yearly education of abuse prevention and of policy. Amended policy is being	review	

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{F 607}	prevention upon his employees. On 6/1/18, at 4:31 confirmed the current he had understood	include training on abuse re and annually for all p.m. the administrator ent facility policies and stated the corporate nurse sed the abuse policies to	{F 60	monitored weekly with random's audited on VA, reporting and pri updates with goal of auditing all within next month and intermitted thereafter for next 2 months. 4. Effective 7/16/2018, a quality-program was implemented unde supervision of the administrator the abuse prevention compliance ensure along with SW vulnerable assessments completed and reall incidents will be immediately to the Administrator and if injury is noted, the administrator or dereport a VA to common entry pohours of the incident. If no injury noted, this will then be reported hours and reviewed daily at star Incident occurs after business have weekend, the Administrator collaborate with the DON and retimely manner. Once the report submitted, the Administrator or will report the investigation finding 5 business days of report. Any deficiencies will be corrected on and the findings of the quality-aschecks will be documented and at the monthly quality-assurance committee meeting for further recorrective action. 5. Administrator/SW/DON will be responsible for this POC.	racy staff intly assurance r the to monitor e and e adult riewed. reported or abuse signee will nt within 2 or abuse within 24 d up. If burs or on vill port in a nas been lesignee gs within the spot, surance submitted	
{F 636} SS=E	Comprehensive As CFR(s): 483.20(b)(sessments & Timing 1)(2)(i)(iii)	{F 63	•		7/23/18
	§483.20 Resident A	Assessment onduct initially and periodically				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	СОМ	E SURVEY IPLETED
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{F 636}	reproducible asses functional capacity. §483.20(b) Compre §483.20(b)(1) Res A facility must make assessment of a regoals, life history arresident assessme by CMS. The asset the following: (i) Identification and (ii) Customary routi (iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and behat (vii) Psychological (viii) Physical functi (ix) Continence. (x) Disease diagnos (xi) Dental and nutr (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications. (xv) Special treatme (xvi) Discharge plan (xvii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation assessment. The a include direct observith the resident, as	chensive Assessments ident Assessment Instrument. e a comprehensive sident's needs, strengths, and preferences, using the nt instrument (RAI) specified ssment must include at least demographic information nee. This. In the instrument of the instr	{F 63	6}		

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{F 636}	timeframes prescrichapter, a facility massessment of a retimeframes specific through (iii) of this prescribed in §413 apply to CAHs. (i) Within 14 calence excluding readmissing significant change mental condition. ("readmission" measure following a tempora or therapeutic leav (iii) Not less than or This REQUIREME by: Based on interview facility failed to ensure Assessments (CAA analysis of a reside history and prefere reviewed for dialys Findings include: R37's admission May 1/30/18, indicated cognition, and had end-stage renal distant malnutrition. Trequired extensive personal hygiene a independently after R37's MDS further loss, received a measure of the same preserved a measure of the sa	en required. Subject to the bed in §413.343(b) of this nust conduct a comprehensive esident in accordance with the ed in paragraphs (b)(2)(i) section. The timeframes .343(b) of this chapter do not dar days after admission, sions in which there is no in the resident's physical or For purposes of this section, as a return to the facility ary absence for hospitalization e.) Ince every 12 months. In is not met as evidenced and document review the sure resident Care Area A) included a comprehensive ent's needs, strengths, goals, noces for 1 of 3 resident (R37)	F 63	86}	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility to entresidents are assessed correctly viassessments and MDS to coordinate appropriate care plans. R37 had marea in which the CAA had triggere actual problem but had not been preassessed to ensure actual intervent were in place. In this case, after the surveyor reported R37 assessment inaccurate based on documentation MDS regional team met with dietars.	the ssion or that of and sure all a te nultiple d operly tions e s were n and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	` '	SURVEY PLETED
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{F 636}	dated 5/3/18, identi triggered from the crequiring analysis, triggered; Cognitive Functional/Rehabili Incontinence and In Nutritional Status, EUIcer. -Cognitive Loss/De area was an actual active diagnosis of disturbances and cl (CIHD). The CAA ic treated for CIHD wi active diagnoses ar moderate cognitive revealed multiple properties areas (from data er included; neurologic requiring additional cognition and its reland functional statuc comprehensive and pre-populated chec R37's cognitive functional statuc comprehensive and pre-populated chec R37's cognitive functions and rescare planning consions objective and the in resident or the ratio	therapeutic diet. Area Assessment (CAA) fied seven care areas had data entered into the MDS he following areas were Loss/Dementia, ADL tation Potential, Urinary adwelling Catheter, Falls, Dental Care and Pressure mentia CAA, revealed the care problem for R37, related to an dementia without behavioral pronic ischemic heart disease dentified R37 was being the medications and that these relikely contributors to a impairment. The CAA re-populated check marked attered on the MDS) which cal factors and ADL function, assessment/analysis of R37's ationship to medical problems as. The CAA lacked a alysis of the aforementioned kmarks, which impacted ctioning. The CAA further ansiderations that could affect ctioning from resident sident and/or family input for derations, the overall apact of these needs on the nal for the care plan decision.	{F 63	36}	manager and dietician to review who CAA entails. R37 was reviewed and he is end stage renal, has cognitive issues, has poor dental status and areas were revisited and corrected assess the resident needs. All care have been reviewed and updated, training has been reviewed and updated, training has been reviewed and updocument on CAA's. 2.Because all residents are assess determine their appropriate plan of based on their assessments all are potentially affected by the cited definon 7/2/2018, the MDS nurse review accuracy of CAA's and MDS on R3 other resident CAA's will be review timeliness and accuracy. Furthermore, CAA's being created as of 7/2/2018 double checked by regional reimbursement coordinator prior to submission to ensure compliance, department also trained on CAA procedure. Policy on MDS/CAA was reviewed. No other residents were affected. 3.To enhance currently compliant operations and under the direction director of nurses, on 7/12/2018 all received in-service training regarding state and federal requirements for documentation, assessments and procedure clear and correct care plans training also emphasized the import of the MDS nurse to follow up on ite	d noted all to all to a plans CAA dated ed to care diciency, all ed for ore, all a will be Dietary s of the staffing proper to s. The tance ems	
	was an actual probl	CAA, revealed the care area em for R37, however the CAA nature of the problem, it only			that are not being addressed during assessment period and ensuring caareas are complete.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	COM	E SURVEY PLETED
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{F 636}	admission, R37 hallabs were available pre-populated checentered on the MD mental status and hinterfere with eating diseases and condor nutritional needs lacked a comprehe aforementioned prowhich impacted R3 further lacked any affect R37's nutrition observation and recare planning conservation and recare planning conservational Status Company affect R37 did deny swallowing difficulting CAA revealed multimarked areas (from which included; cog to oral/dental problet that may be related CAA lacked a compaforementioned prowhich impacted R3 CAA further lacked could affect R37's or resident observation input for care planning Cn 6/1/18, at 10:54	been eating very well since d no teeth and that no current and that no current are the case of the CAA revealed multiple between the case of the case	{F 636	4.Effective 7/16/2018, a quality program was implemented un supervision of the MDS nurse residents will be reviewed at the admission, annually and if significant change occurs to ensure CAA completed thoroughly and contriggers will be care planned a communicated to staff via care and communication book if not interventions in place. Audits and significant changes will be for accuracy and timeliness; the completed by MDS nurse 2 at week x 4 weeks then 1 audit of months to ensure compliance All MDS's will be reviewed for and necessary changes as deaudits. Any deficiencies will be on the spot, and the findings of quality-assurance checks will documented and submitted at quality-assurance committee further review or corrective acts. MDS nurse will be responsit POC.	e that all ime of nificant A's are being mpletely. All and e sheets ew of CAA's, e completed hey will be udits per weekly x 2 in this area. accuracy etermined by e corrected of the be t the monthly meeting for ction.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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{F 636}	5/3/18. However, M Nutritional Status w manager. MDSC-A stated the Nutrition comprehensive and information". On 6/1/18, at 3:38 p confirmed completi for R37, dated 5/3/1 for completion after the DM-A stated the CA comprehensive ass On 6/1/18, at 3:43 p stated R37's CAAs and stated R37's CAAs and stated R37's C comprehensive ass A facility policy titled 4/20/18, indicated the comprehensive sys problem identification for care planning. On the basis for the cashould include: cauthe nature of the condition, facility the cashould include: cauthe nature of the condition, resource decision-making, condition cannot be called the condition of the condition of the condition, resource decision-making, condition cannot be called the condition of the con	B7 including the CAAs dated IDSC-A stated the CAA for as completed by the dietary reviewed R37's CAAs and Status CAA was not d'lacking significant D.m. dietary manager (DM)-A and the Nutritional Status CAA IB. DM-A stated her education IAA was that if it triggered for the MDS, and then fill it out. IAA would not be a sessment. D.m. director of nursing (DON) had "nothing in the boxes" AA would not be considered a	{F 63	36}		
F 655 SS=D	MDS. Baseline Care Plan CFR(s): 483.21(a)(F6	655		7/23/18

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F 655	Planning §483.21(a) Baseline §483.21(a)(1) The fimplement a baseline that includes the inseffective and person that meet professio The baseline care p(i) Be developed with admission. (ii) Include the minimal necessary to propeincluding, but not lir (A) Initial goals bas (B) Physician orders (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recom §483.21(a)(2) The fromprehensive care plan if the com (i) Is developed with admission. (ii) Meets the require (b) of this section (ethics section). §483.21(a)(3) The resident and their resid	nsive Person-Centered Care e Care Plans facility must develop and fine care plan for each resident structions needed to provide in-centered care of the resident final standards of quality care. Folan must- thin 48 hours of a resident's mum healthcare information find to- fined on admission orders. final standards of quality care. Folan must- thin 48 hours of a resident's mum healthcare information find to- fined on admission orders. final standards of a resident's mum healthcare information fined to- fined on admission orders. final standards of a resident's fine on admission orders. final standards of a resident's fine plan in place of the baseline fine plan in place of the baseline fine plan in place of the resident's fine ments set forth in paragraph fine paragraph (b)(2)(i) of facility must provide the final summary final plant includes but is not of the resident. fine resident's medications and		55		

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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	00/01	72010
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F 655	administered by the on behalf of the fa (iv) Any updated ir of the comprehens. This REQUIREME by: Based on intervier facility failed to endeveloped and impadmission to addression admitted. Findings include: R306 was admitted diagnoses includir (HTN), hyperlipide schizophrenia, marmyalgia, Gastro-Eand weakness, acadmission record in R306's admission record in R306's admission record in R306's admission identified the follow and reason was at risk of fall related injuriencourage and refor assistance, mare be well lit and free prevent slipping. * R306 likes to visitattend some group independence. R3 entertainment/soc	and treatments to be le facility and personnel acting cility. Information based on the details sive care plan, as necessary. ENT is not met as evidenced w, and document review, the sure a baseline care plan was blemented within 48 hours of less the individualized needs for 1306, R503, R501) recently Individualized needs for 1306, R503, R501) recen	F 655	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1.It is the policy of this facility to probase line plans. R306, R503, and did not have base line care plans completed as required within 48 ho admission. The survey noted the la information and it was apparent stastill not familiar with the form nor the policy of base line care plans nor we responsible for gathering the datare to formulate care plan for resident. base line care plan has been revised corrected and staff have copy in admission packet and are educated expectations of nurse admitting patcomplete the base line care plan. 2. Because all residents have changlevels of care upon admission all aid potentially affected by the cited deficient of 7/2/2018, the MDS nurse review process of ensuring baseline care plans.	the ssion or that of and ovide R501 urs of ck of and the sed and t	
	independence. R3 entertainment/soc in the dining room Interventions inclu	06's goal to attend bingo and		on 7/2/2018, the MDS nurse review	ved plans d e copy	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245052	B. WING		R 06/01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	00/01/2010
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F 655	and men's group. TV (television). He friendly social and * R306's care plan quality of life and of Review of R306's medical record idecare plan. Review of 306's pr 5/31/18, lacked ev completion. On 5/30/18, at 3:00 (DON) verified R30 The DON indicated responsible to con residents. The DO admission the care standup meeting, a (minimum data se with the resident a residents chart. Af and paper chart, the have a base line of Conselion on the floor at the reviewed R306's pline care plan was indicated she would resident and residents chart.	He likes a variety of shows on a likes country music. He is likes to visit. lacked all other areas of quality of care. electronic and hard copy entified it lacked a base line rogress notes 5/24/18, through idence of a base line care plan 3 p.m. the director of nursing of was admitted on 5/24/18. In the floor nurse on duty was applete the paperwork for new on indicated the day following a plan is reviewed at the land then is given to the MDSC at coordinator) nurse to review it and then place it into the ter review of R306's electronic are plan. 8 p.m. the MDSC indicated she apprehensive assessments for sidents within 13 days of DSC indicated the 48 hour and was completed by the nurse time of admission. The MDSC apper chart and verified a base not in the chart. The MDSC and need to check with the floor ere was not a base line care	F 655	process will be reviewed with all flourses and admission team as well ensure staff understand expectation other resident care plans have beer reviewed and updated for accuracy nurse has been educated on necessimplementing base line care plans importance of discussing with reside POA. The policy on base line care has been reviewed and updated. 3. To enhance currently compliant operations and under the direction director of nurses, on 7/12/2018 all nursing staff received in-service traregarding base line care plans. The training emphasized the importance monitoring ADL's, and treatment information on care sheet follows the actual care performed. MDS nurse visualize residents and ask staff the interview to confirm data. The educincludes development of care plan assessment of resident individual in The residents will also incorporate importance of reviewing base line or plan with residents. 4. Effective 7/16/2018, a quality-ass program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure accurate and correct. The MDS nurse representative will perform the following base line care plan base individual resident needs and all bacare plans. They will be completed MDS nurse 2 audits per week x 4 withen 1 audit weekly x 2 months to the total surfer and the process of the months to the plans and the surfer plans. They will be completed MDS nurse 2 audits per week x 4 withen 1 audit weekly x 2 months to the plans and the process and the process and the plans and	I to ns. All n y, MDS ssity of and dent or plans of the tining e e of ne to rough cation after needs. care surance he o e data urse or owing sed on ase line by veeks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING			R 01/2018	
NAME OF	PROVIDER OR SUPPLIE	 R		STREET ADDRESS, CITY, STATE, ZIP	•	01/2010	
MOORH	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 655	(LPN)-C describe admissions. LPN-plan was not part nurse and was the managers. R503's admission was admitted to the diagnosis information chronic obstructive hypertension (HT (CHF). Review of R503's medical record late line care plan. Review of R503's medical record late line care plan. Review of R503's medical record late line care plan. Review of R503's medical record late line care plan. Review of R503's proposition of the line care plan lacked and quality of care line care plan lacked and quality of care line c	I2 p.m. licensed practical nurse d her responsibilities with new C indicated the base line care of her duties as the admitting e responsibility of the clinical record form identified R503 he facility on 5/23/18. R503's ation included diagnoses of re pulmonary disease (COPD), N) and congestive heart failure electronic and hard copy acked documentation of a base care plan identified one area 8. The care plan included a R503 was quite independent, but way for him to meet people. d R503 would attend bingo, h, and possibly chapel service, and the facility. Interventions invite the resident to scheduled those listed in his goals. The all other areas of quality of life	F 6	compliance in this area. Ar will be corrected on the sp findings of the quality-assumill be documented and sumonthly quality-assurance meeting for further review action. 5.MDS nurse will be resported.	ot, and the irance checks ibmitted at the committee or corrective		

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		245052	B. WING				R 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ODE	00/1	5172010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 E	3E	(X5) COMPLETION DATE
F 655	reviewed R503's pa and RN-A confirme line care plan. On 5/31/18, at 1:30 had spoken to him specific goals for ca R503 indicated he is someone came and cares. On 5/31/18, at 1:39 was admitted on 5/3 facility practice was address the base line complete the form, base line care plan the chart. DON ind be for the base line the nurse who adm	p.m. R503 indicated no one about a care plan or his ares when he first arrived. nad been here a week, and d spoke to him today about his p.m. DON confirmed R503 23/18. DON stated the usual for the admitting nurse to ne care plan with the resident, then provide a copy of the to the resident and place it in licated her expectation would care plan to be completed by	F 6	55			
	indicated R501 was 5/27/18. R501's dia bilateral artificial kn depressive disorder						
		lectronic and hard copy ted a baseline care plan.					
	Review of R501's c	are plan identified one area					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	243032	B. Willa	STREET ADDRESS, CITY, STATE, ZIP (CODE	06/0	01/2018
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 655	initiated on 5/30/18 focus identifying R5 with family and som goal for R501 was the lunch, socials and ractivities. Interventi R501 to scheduled goal. The care plan quality of life and life an	The care plan included a formal like independent activities are group activities as well. The content attending atte	F6	555			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		` '	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	CODE	00/	01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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
F 655	stated paper baseli the minimum data s nursing staff. On 5/30/18, at 3:50 care plan, or baseli the paper chart, as stated the admitting care plan and return care plan would the interdisciplinary tea stand up. They wou resident, and if they be filled in the chart paper chart and corcare plan. On 5/30/18, at 3:58 admitting nurse wor plan and then send then bring the care discuss the resident meeting, MDSC wor plan to the resident sign it. DON review confirmed no basel DON stated she wor plan to be complete. On 5/30/18, at 4:05 admitted to the facino one had spoken plan, or her specific stated that a nurse do some admission. Review of the facilities.	p.m. social worker (SW) ne care plans are given out by set coordinator (MDSC) to the p.m. MDSC stated a 48 hour ne care plan, would be kept in it was a paper form. MDSC gnurse completed the baseline ns it to MDSC. The baseline en be discussed at an m (IDT) meeting, or morning ald then go over it with the vare agreeable with it, it would to MDSC reviewed R501's infirmed there was no baseline p.m. DON stated the uld fill out the baseline care to MDSC. The MDSC would plan to IDT where they t's care. After the IDT uld bring the baseline care to discuss it and have them ed R501's paper chart and ine care plan was present. buld expect the baseline care ed. p.m. R501 stated she lity on 5/27/18. R501 indicated to her about a baseline care e goals for her care. R501 was meeting with her now, to	F6	55			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 656} SS=D	Continued From parblank. The facility policy tit Plans-Comprehens all new admits to ha admission packet a upon admit. Once within 48 hours, it wresident for review and the original to be Develop/Implement CFR(s): 483.21(b)(§483.21(b) Compres §483.21(b)(1) The fimplement a compresident rights set ff §483.10(c)(3), that objectives and time medical, nursing, an needs that are iden assessment. The codescribe the followi (i) The services tha or maintain the resiphysical, mental, ar required under §48. (ii) Any services tha under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized	ge 16 cled, Care ive, reviewed 4/4/18, identified ave a baseline care plan in the and to be started by staff nurse completed and reviewed vill then be copied and given to or POA (power of attorney) be put in the resident's chart. comprehensive Care Plan 1) chensive Care Plans facility must develop and ehensive person-centered resident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive comprehensive care plan must ang t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and att would otherwise be required as 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will	F 6	DEFICIENCY) 55	NATE.	7/23/18
		If a facility disagrees with the ARR, it must indicate its				

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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	00/01/2010
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{F 656}	(iv)In consultation resident's represer (A) The resident's desired outcomes. (B) The resident's future discharge. Future discharge. Future discharge. Future discharge in whether the reside community was as local contact agenentities, for this pu (C) Discharge plar plan, as appropriate requirements set future	with the resident and the ntative(s)-goals for admission and preference and potential for facilities must document ent's desire to return to the seessed and any referrals to cies and/or other appropriate rpose. In the comprehensive care te, in accordance with the orth in paragraph (c) of this entition, interview and document failed to ensure a re plan was developed for esident (R410) who received and for 1 of 1 resident (R107) eostomy (a surgically created are vindpipe [trachea] that eative airway for breathing) care.	{F 656	This Plan of Correction constitutes written allegation of compliance for t deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet requirements established by state at federal law. 1. It is the policy of this facility to provice consistent quality care to ensure reshave comprehensive care plans. Rawas noted to have central line and in dialysis however the care plan did not address these issues nor did the care sheets, so staff were aware how to monitor IV site or provide cares. R10 a trach and the care plan did not add the trach, the expectations of care to and during care it was noted the stareded further education on trach call in this case, after the survey determ	the sion that f nd vide sidents 410 seed of re 07 had dress of trach ff ares.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		LE CONSTRUCTION		SURVEY PLETED
		245052	B. WING				R 01/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	00/0	71/2010
10 10 1	THO VIDEN ON OUT FIELD				810 SECOND AVENUE NORTH		
MOORHI	EAD REHABILITATION	N & HEALTHCARE CENTER			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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 656}	Continued From pa	ge 18	{F 65	56}			
	bilateral lower extre extensive assistance bed mobility, require transfer with a mechanism with a mechanism visual physician physician visual physician physician visual physician p	orientated X (times) 4, had emity amputations, required se with dressing, grooming and ed total staff assistance to hanical lift. sit dated 4/24/18, identified chronic kidney injury which			these residents care plans were mi important information, both were re and updated including care sheets staff. Staff education on trach cares also provided. 2.Because all residents are have changing levels of care all are pote affected by the cited deficiency, on	vised for s was	
	required dialysis. R410's care plan rehad an alteration in hemodialysis, 1 X a	evised 4/26/18, identified R410 kidney function evidenced by week, with a goal to reduce ations associated with			7/2/2018, the MDS nurse reviewed process of ensuring accurate MDS formulate comprehensive care plar other resident care plans have bee reviewed and updated for accuracy MDS nurse is aware of how to prop	ns. All n r, and	
	impaired renal functions symptoms of infections R410's care plan list medications as order physician and/or	tion and will have no signs or on or bleeding at fistula site. sted interventions to administer ered collaborating with armacist for optimal nes, assessment of skin			document on CAA's as well as ens assessments completed during loo period are completed, and correct information is gathered, and all asp care is care planned appropriately. 3.To enhance currently compliant	ure all k back	
	moisturizer as need consult as ordered nutritional, social se	,			operations and under the direction director of nurses, on 7/12/2018 all nursing staff received in-service tra regarding patients with dialysis and to ensure they are understanding to	ining trachs	
	central venous cath had a fistula (a surgartery) in place, and or care of the cathe draws/blood pressukeep site dry, no tul when showering. In direction for what posite developed leak	d not identify R410 had a leter, incorrectly listed R410 gical connection of a vein to an did did not include precautions ter such as no blood lives or flushing of catheter, to baths, and covering site addition the care plan lacked rocedures to follow if catheter ling, bleeding, or signs of the property precedures staff should			resident needs, cares and how to p basic checks to ensure trach site a sites are clean dry and intact and w do if there is an emergency. MDS r visualize residents and ask staff thr interview to confirm data. The educincluded development of care plan assessment of resident individual n 4.Effective 7/16/2018, a quality-ass program was implemented under the supervision of the MDS and DON to	nd IV what to nurse to rough eation after needs. urance	
	implement or whom	gency procedures staff should in the facility should contact in incy involving the dialysis			supervision of the MDS and DON to monitor residents MDS and ensure accurate and correct. The MDS no designated quality-assurance	data	

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		245052	B. WING			R 01/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	•	01/2010
MOORHI	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{F 656}	identified R410 red with ADLs (activitie assistance of two sutilized a power whorientated, directed stocking for the low pressure relief memeal; however did dialysis needs or the Indicated R410's constant of the Indicated R410 indicated he Indicated he Indicated he Indicated H410 indicated he Indicate	ed nursing assistant care sheet quired extensive assistance es of daily living), required staff for transfers and toileting, neelchair, was alert and d care for use of a shrinker wer extremity amputations and asures to lay down between not direct care pertaining to he dialysis catheter site. O nursing assistant (NA)-F atheter was not to get wet and baths as R410 allowed. NA-F es managed all other care eter site. 4 p.m. R 410 stated the er left chest area was used for cated he chose to receive bed e catheter could not get wet. was not restricted on fluids; to add salt to things and was to 0 p.m. the director of nursing 10's computerized care plan or R410's daily and dialysis of the care plan the DON re plan was not comprehensive care, did not include specifics dialysis care, catheter or	{F 65	representative will perform systematic audits of asset formulating care plan base resident needs. They will MDS nurse 4 audits per withen 2 audit weekly x 2 m compliance in this area by diagnoses with assessments of an accurate care plan based on the resident speck. Trach care, hospice, and the findings of the quality-asset committee meeting for furcorrective action. 5.MDS nurse will be respect.	essments sed on individual be completed by week x 4 weeks nonths to ensure y matching ents and CAA's is developed ecific care areas, dialysis. Any cted on the spot, uality-assurance ed and submitted surance rther review or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
		245052					R 06/01/2018
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER				28	REET ADDRESS, CITY, STATE, ZIP CODE 10 SECOND AVENUE NORTH DORHEAD, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	Continued From page 20		{F 6	56}			
	dated 2/20/18, indice was not completed which included attention artificial ocancer. The MDS in extensive assistant which he required to	Minimum Data Set (MDS) cated a cognition assessment , and R107 had diagnoses ention to tracheostomy, pening of digestive tract, and ndicated R107 required ce for all cares except eating, total care. R107's MDS further f oxygen, tracheostomy care					
	independent cognit making and diagnot cell carcinoma of s pain, attention to tr MDS indicated R10 with eating, extens and hygiene, limite was independent w	DS dated 5/1/18, indicated tive skills for daily decision uses which included squamous kin of scalp and neck, chronic acheostomy and anxiety. The D7 required total assistance ive assistance with dressing d assistance with toileting and with all other ADLs. R107's ted tracheostomy care and					
		2/28/18, indicated R107 had a ace due to oral pharyngeal					
	4/3/18, revealed th	current care plan last revised at there was no care plan ed to R107's tracheostomy.					
	updated 5/29/18, ir	rovided Group 3 care sheets, adicated under "Care Notes" ", but there was no instruction or monitoring.					

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		245052	B. WING			R / 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, 2810 SECOND AVENUE NORTI MOORHEAD, MN 56560	ZIP CODE	01/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 656}	bed with the head of completing a nebul his tracheostomy. For device positioned of tubing beside him in the inner cannula dremoved. LPN-B th finished the tracheostomy. The core plan lacke of the care plan lacke of the care plan lacke of the facility, reviewed R107's cuthe care plan lacke.	a.m. R107 was lying on the of bed elevated. R107 was ized medication treatment via R107 had a oral suctioning in the nightstand and had the eady for use. 5 a.m. licensed practical nurse 107's room and set up supplies are. LPN-A washed her hands gloves from the tracheostomy e gloves donned, LPN-A had to working height and eze R107's tracheostomy's gently pulling at the inner inner cannula not disengaging to keep the inner cannula in the wasto cough), LPN-A then velcro collar. LPN-A again and inner cannulas, one with did to disengage the lock and sated she had not provided or cares prior and stated, it someone who knows how to the room. At 11:29 a.m. R107's room with LPN-B. hands and donned gloves, uter cannula with one hand er cannula with the other and isengaged and was able to be en left the room and LPN-A	{F 6	56}		

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	, 33/	
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{F 686} SS=D	On 5/31/18, at 2:15 comprehensive car guideline for reside current care plan at lacked information tracheostomy and s R107's current care. A facility policy titled Comprehensive, recomprehensive car assessment that indicate the MDS; 3. Each replan is designed to problem areas; b. It associated with ide professional service each element of car recognized standar areas and condition are triggered during evaluated using specific light interventions are accomplianted in the second in the second interventions are accomplianted in the second in the secon	p.m. the DON stated e plans were an overall nt care. DON reviewed R107's nd confirmed R107's care plan regarding R107's stated she would not consider e plan to be comprehensive. d, Care Plans - viewed 4/28/18, indicated the e plan is based on a thorough cludes, but is not limited to, esident's comprehensive care a. Incorporate identified incorporate risk factors intified problemsf. Identify the est that are responsible for rei. Reflect currently ds of practice for problem is4. Areas of concern that g the resident assessment are ecific assessment tools a Assessments) before dded to the care plan; 5. Care are designed after careful e relationship between the areas and their causes. Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. brehensive assessment of a	{F 686			7/23/18

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{F 686}	ulcers unless the ir demonstrates that (ii) A resident with professional st promote healing, promote healing, promote healing, promote healing, promote healing are review, the facility from the healing arresident (R56) review pressure ulcers on Finding include: R56's quarterly Mir 4/10/18, identified from the healing arresident (R56) review pressure ulcers on Finding include: R56's quarterly Mir 4/10/18, identified from the healing arresident (R56) review pressure ulcers on Finding include: R56's quarterly Mir 4/10/18, identified from the healing arresident (R56) review pressure ulcers, but did not contain the healed pressure ulcers and the healed pressure ulcers are the healed pressure ulcers and the healed pressure ulcers are the healed pressure the healed pr	d does not develop pressure advidual's clinical condition they were unavoidable; and pressure ulcers receives and services, consistent transport and services, consistent transport infection and prevent eveloping. Note in the service and document ailed to comprehensively to implement interventions to ad prevent worsening for 1 of 2 ewed with current, stage 2 left buttocks.	{F 68		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1.It is the policy of the facility to protreatment and services to prevent pressure ulcers. One of the many withat this has been achieved for resifue this has been achieved for resifue this by completing assessments current documentation of wounds to ensure healing appropriately. R56 who noted to have stage 2 pressure are area now developed another area who previous wound now developing interesting and repositioning and resident non-compliance of offloading OT an urising have changed resident to corepositioning schedule and staff are ensure even while up resident is of either in room or using rail in hallway stand with staff assist. It was also not staff needed education on roho custions.	the ssion or that of and wide ways ident and with so and ay to anoted	

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{F 686}	reduce or relive presidentified altered modiagnoses and compre-populated check hemiplegia/hemiparenal disease, deprand other factors in readmitted and fun motion. R56's CAA be addressed in cardiagnoses at risk for presintegrity, history of decreased mobility completion of Bradiassessment) per penot to massage over encourage regular during the day for a further instructed support, pressure rand mattress and rassement to be contreatments as order identified she had probable to self care impairmodiations to left ar Interventions included to illeting and transferom. R56 indicate hip, and the physical after independently room. R56 indicate hip, and the physical after independently room. R56 indicate hip, and the physical results after independently room. R56 indicate hip, and the physical results after independently room. R56 indicate hip, and the physical results after independently room. R56 indicate hip, and the physical results after independently room. R56 indicate hip, and the physical results after independently room.	al mattress or seat cushion to essure. Intrinsic risk factors ental status and cognitive loss. Inditions identified by	{F 68	staff were educated. Physician updated and resident skin has improving. 2.Because all residents have d which could lead to alteration ir integrity or due to illness have p skin breakdown all are potential by the cited deficiency, wound documentation has been review interventions for prevention are and documented clearly on car Weekly skin audits are complestaff update DON on any new a immediately including reporting bruises, skin tears, skin breakd rashes. All current resident with ulcers were assessed for compassessment along with approprinterventions. Implementation of interventions is reviewed on row weekly. Staff to alert DON is rerefuses otherwise. Staff educating importance of offloading, repostare plan updated, care sheets Weekly skin audits completed day, dietary and therapy involve interventions as needed to thos No other residents were affected policy on wound care has been 3. To enhance currently compliated operations and under the direction of nurses, on 7/12/2013 received in-service training for skin and pressure areas, to enalways use best pressure reducand understand differences in cand understand differences in and understand offloading to put further alterations in skin integrationing emphasizes the import	agnoses skin potential for agnoses skin potential for ally affected wed, in place esheets. ed, and reas noted of any own or pressure rehensive iate of those ands sident ted on attioning, updated. In bath ed in e at risk. d. The reviewed. Into the sall staff monitoring sure staff etion tolls sushions event ty. The	

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MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		MOORHEAD,				
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{F 686}	dressing change. On 5/31/18, at 6:45 her room sitting on shirt, pants and sh (NA)-B was in room morning cares. NA assisted R56 to sta while holding her h R56 to pull her pan a large 2 x 6 inch to buttocks. The surroclor. R56's had a relieving cushion w When surveyor put was easily pushed to sit in the w/c, whapplied a jacket an NA-B. NA-B transp the front nursing depropelled herself to R56 remained in the coffee, water and a propelled herself be the activity room w At 7:47 a.m. R56 b her room, when sh member if she wan R56 returned to he teeth independently refilled a bag on he her bedside table to doing a word search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m. when chilled a bag on the search 9:52 a.m.	r surveyor to view during a.m. R56 was observed in the edge of the bed with her oes on. Nursing assistant and assisted her with a poplied a gait belt and and then walk to the bathroom, emi walker. NA-B assisted ts down and revealed R56 had an dressing in place on her left ounding skin was normal in Roho cushion (pressure ith air cells) in her wheelchair. Ther hand on the cushion, it down flat. NA-B assisted R56 ere R56 combed her hair and d scarf with assistance from ported her in her wheelchair to esk near the dining room. R56 the dining room at 7:10 a.m., to be deed to be each to her room at 7:40 a.m. to here she read the newspaper. The egan to propel herself back to be was asked by a staff the aride which she agreed. The room where she brushed her wat the sink. At 7:58 a.m. R56 or wheelchair with candy from the propelled herself back to 56 remained at the dining window, drinking water and the book from 8:01 a.m. until turch service began.	{F 68	following a maintenant skin condimportant assessme implement intervention 4. Effective program was supervision monitor reintegrity applans with appropriat of nurses represent systemati will ensure pressure diagnosis x 4 weeks 4 weeks to residents deficiencial and the finch checks with at the mocommittee corrective	e 7/16/2018, a quality-ass was implemented under the proof of the director of nurse esidents with impaired skilling and any changes to ensure the follow through. The director or designated quality-assistative will perform the followic changes: the DON or do a changes: th	surance he s to n nd care rector surance wing esignee with per weekly kly for n 2 e spot, rance bmitted ew or		

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{F 686}	the day, did word se active room. NA-B express her needs would put her call lip bathroom. NA-B in bathroom about twin usually reminded R around lunch time to indicated she was a bottom. NA-B indicated she was a bottom. NA-B indicated she the last survey. NA provided a copy of them. When survey related to pressure discussed reposition R56's repositioning be checked every 2 nursing assistant can assist Q2 HRS (eveneed, for skin care. On 5/31/18, at 10:5 room at the same sof the window. R56 dining room for the leave during it. At 1 director of nursing (repositioned since a would assist R56, a permission, for repwound assessment agreed and left the	g out in the dining room during earch books and went to the indicated R56 was able to by going back to her room and ght on if she wanted to use the dicated she took R56 to the ce a day, and indicated she 56 to use the bathroom o see if she would go. NA-B aware R56 had a sore on her eated as nursing assistants hing with resident cushions. was provided education after and deficiencies and reviewed yor asked her about education ulcers, she indicated they ning. When asked about and the hours and confirmed her are sheet instructed 1 staff to early 2 hours), resident can state of a.m. R56 was in the dining pot, sitting at the table in front indicated she was in the church activity, and did not 10:56 a.m. surveyor notified (DON) that R56 had not been 7:05 a.m. DON indicated she after she asked her ositioning and complete her and dressing change. R56	{F 6	86}			
		. She indicated R56 had a					

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{F 686}	was using a low prinches. OT-A joint indicated she had joushion yesterday indicated she had sitting on it. OT-A cushion to assure out of the wheelchars and she confirment of the wheelchars and she confirment in the hall straight arm to pull herse propelling herself to the hall. OT-A indicent arm to pull on the hall of the properties of the properties are the confirmed in a return appropriate because of the bathroom with the cushion using a R56 to remove her was normal color and dressing was removed.	er wheelchair prior, but now ofile Roho cushion that was 2 and R56 in the hallway and she just checked R56's Roho to assure it was full, but checked it while R56 was indicated she would check the it was inflated when R56 got air. DON also in hallway near remed R56 should be 2 hours. OT-A indicated she ioning techniques, and taught drails in the hallway for estructed R56 to show surveyor esition herself with the rails. Turned towards the hand rail in rright hand on the rail, but was self up. R56 then began owards her room using her the handrail as she went down cated she had requested RN Director of Quality (RDQ) to assistant care sheets for R56 every 2 hours, but was ne-mail that it was not	{F 68	6}			

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{F 686}	drainage. R56 had one in the center of DON indicated had areas measured 1 or area, and applied a (foam dressing for Review of R56's tree (TAR) identified a tile was completed on Ulcer precaution even Ulcer precaution eve	three superficial open areas, the excoriated area, which bled, and two below this. All cm by 0.5 cm. DON cleansed 4 inch by 4 inch Mepilex wounds) to the area. Tatment administration record saue tolerance assessment 5/10/18, and 5/28/18. Pressure very shift began on 5/29/18. To a.m. DON and surveyor ctronic record. DON and indicated they 5/10/18, and 5/28/18, but she them. DON indicated they 5/10/18, and 5/28/18, but she them. DON confirmed R56 to tolerance completed. DON ency of R56's repositioning termined by the the tissue N indicated she would expect oned every 2 hours, her Roho and the tissue tolerance completed. Tring assistant care sheet, or R56 identified; skin, 1 assist can state need and care notes intated, resident able to direct and elevated; lotion at hand sident repo (reposition) PRN	F 68	36}			

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{F 686}	Pressure Sore Risk score of 16, low risl Review of R56's we 5/30/18 identified th -5/2/18, skin dry, or open 2 X 1 cm, me monitor. Site: left gl X 1 cm5/9/18, skin dry, or open 2 X 1 cm, me monitor. Site: left gl X 1 cm5/16/18, skin dry, or open 2 X 1 cm, me monitor. Site: left gl X 1 cm5/16/18, skin dry, or open 2 X 1 cm, me tissue color pink an monitor. Site: left gl X 1 cm5/23/18, open area left buttocks. No further the series of R56's W Multiple weeks-V 4 identified the follow -5/4/18, Wound ide vascular 2 length, 1 wound type; pressur completed, granula defined, current trea (left) buttocks q (ev	aden Scale for Predicting and dated 5/4/18, identified a sc. bekly skin review 5/1/18, to be following; ben area, left buttock check pilex in place, will continue to uteal fold, existing open are 2 ben area, left buttock cheek pilex in place, will continue to uteal fold, existing open are 2 ben area, left buttock cheek pilex in place, will continue to uteal fold, existing open are 2 ben area, left buttock cheek pilex in place, almost resolved, d part scab, will continue to luteal fold, existing open are 2 a, resident has an open area to orther description. bound Evaluation Flow Sheet from 5/4/18, to 5/22/18		36}			

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{F 686}	cushion. Wound hat change to care pland a change in cereived a change in cevery) 3 days and treatment ordered a contract interventions: press w/c cushion. No direviewed, wound hat contract in cereived, wound hat contract in cereived a cereived a contract in cereived a contract in cereived a c	ion mattress, w/c (wheelchair) ad not been debrided and not been debrided. I was reviewed. I was reviewed. I all all all all all all all all all al	F 68	36}			

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Review of R56's Od and plan of treatmed pressure ulcer of le 5/2/18, revealed the 5/2/18, rev	essment. ccupational therapy evaluation ent, dated 5/21/18, identified fit buttock stage 2 onset of e following: ccluded: pt (patient)/staff to elieve pressure while seated in pervised and 25% verbal cues target date 6/3/18. Pt/staff will ssful use of new/adapted indicated by vement of L (left) buttocks mc day of eval, for skin unagement). Pt/staff will to manage incontinence apted methods with % cues to prevent worsening cerns. Sted included; Pt/staff will to manage pressure relief and echniques/equipment to kin integrity with no cues a prevent worsening of a prevent worsening of a prevent worsening facility). tes good rehab potential as portive caregivers/staff and coarticipated in establishing	{F 68	36}			
-Pt has not had pre	ssure ulcers in the past, has					
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa pressure ulcer asse Review of R56's Oc and plan of treatme pressure ulcer of le 5/2/18, revealed the -Short term goals ir increase ability to re wheelchair with sup for schedule/form, the demonstrate succe seating systems as maintenance/impro wound 2 X 1 X 0.2 integrity mgmt. (mademonstrate ability mgmt schedule/ada supervision and 25' of skin integrity con -Long term goals list demonstrate ability incontinent mgmt te maintain/improve s required. -Pt/caregiver goals; pressure ulcer, hea function in SNF (sk -Patient demonstrate evidenced by support recent onset. -Patient/Caregiver poort POT (plan of treatment)	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 pressure ulcer assessment. 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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		70172313	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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) COMPLETION DATE	
{F 686}	-cognition; follows to (assistance); safety learning capacity = -Summary of evaluation cognitive and psych summary also idented and interpersonal holimitations and/or possible properties of the company	wo-step w/o (without) (A) wavereness = impaired, new impaired. ation identified physical, nosocial deficits. The tified impairments in mobility habits, which resulted in articipation restrictions. cumentation 5/21/18, to he following; diareas of deficit and ents to positioning. Educated rocess and goals. Ited narrower wheelchair to dialow profile Roho cushion Fixed broken left elevating dia comfort and visibly was not sessment. 66 in incontinence prevention schedule and use of call light to kin integrity. Educated R56 on night and R56 reported I education. Trained patient in iques and w/c pull-ups using pressure relief. R56 required dia 50% cues. Communicated hedule and repositioning to	{F 68	6}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	01/2010
MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER			310 SECOND AVENUE NORTH OORHEAD, 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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 686}	indicated understood on in report that day staff to use or alert. Review of R56's ord 5/29/18, included of change mepilex to if soiled or falls off, every 3 days, for word word and all the soiled or falls off, every 3 days, for word their act. one time at 5/21/18. -Weekly skin check every Wed, order downward completed assessing DON indicated R56 the excoriation and DON confirmed R5 areas to her buttool not completed a conformed R56's pressure ulcoordered an air pressure if R56 currently relieving mattress of and report if it was.	and cares to desired level. NA and Roho cares and would pass by. Pump left in R56's room for therapy with questions. Der summary report signed rders: L) buttocks q 3 days and PRN as needed, every day shift bund care, order date 12/6/17. Tal (evaluate) and tx (treat) 10 common many many many many many many many man	{F 68	36}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			E SURVEY PLETED
		245052	B. WING	i			R 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	P CODE	1 00/0	71/2010
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{F 686}	primary physician hulcer on 5/29/19. Iulcer began on 5/4/R56 would need as reposition herself, a was needed to lift hand herself updated sheets on 5/25/18. considered a part of the considered and	ved. DON confirmed R56's ad examined R56's pressure DON indicated R56's pressure 18. DON indicated she felt sistance to off load and and confirmed staff assistance er up. DON indicated RDQ d the nursing assistant care DON confirmed they were f R56's care plan. p.m. a voice message was ry physician, but a return received. Dund audits for R56 on 8 revealed that dietary notes be wound. No follow up noted. Dicy titled Prevention of skin ed 4/20/18, instructed esident assessment we assessment in factors. Evaluate turning and als or initiate tissue tolerance licy. Pressure ulcer treatment d re-evaluation of turning and als or initiate tissue tolerance es Braden and comprehensive aily wound monitoring should ment sheet. Procedure for	{F 68	86}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION ((X3) DATE SURVEY COMPLETED
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{F 686}	bed and wheelchai The policy also insi provide ongoing eculcer care and prev	re pressure reducing devises in r sitting surface as ordered. tructed in bold lettering to lucation to all staff on pressure	{F 686		7/02/19
F 698 SS=D	require dialysis rec with professional si comprehensive per the residents' goals This REQUIREME by: Based on observareview, the facility of care and community of care and nutritional interest of community of care and malnutrition. The community of care and malnutrition of care and malnutrition. The community of care and care and malnutrition of care and care	resure that residents who eive such services, consistent tandards of practice, the reson-centered care plan, and and preferences. NT is not met as evidenced tion, interview and document railed to to ensure coordination unication related to potassium levels in the blood) eventions for 1 of 3 residents modialysis. Inimum Data Set (MDS) dated R37 had moderately impaired diagnoses which included sease (ESRD), hyperkalemia the MDS indicated R37 assistance for dressing, and toilet use, but could eat rest up assistance from staff. Indicated no weight gain or echanically altered diet and sis. R37's MDS indicated he	F 69	This Plan of Correction constitutes written allegation of compliance for t deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of the facility to providialysis care to all residents based of appropriate diagnosis and assessment and staresident had no interventions in place the appropriate diet had not been determined based on dialysis diagnor. The dialysis company noted high potassium and yet resident still got bananas. The diet slip had been charton state no bananas and no orange.	the sion r that of nd ride on ent. a and o care of the eand osis.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
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					810 SECOND AVENUE NORTH		
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER			OORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	R37's Care Area A 5/3/18, indicated F diagnoses of ESR dependent on rena The CAA indicated resistive to cares. indicated R37 had had no teeth and t available for review status lacked infor ESRD or hyperkaldialysis. R37's care plan las R37 required hemorequired a therape various intervention ordered by the phy and social services monitor any signs (difficulty swallowing supplements as or be provided as neoffer healthy snack work as ordered. Haddress R37's diaground or chopped R37's physician or information regard. Review of R37's A dated 4/30/18, indiculding ESRD, his including ESRD, his including ESRD, his indicated R3/3/18, indiculding ESRD, his including ESRD, his including ESRD, his indiculding ESRD, his indiculd	ssessment (CAA) dated R37 was admitted with D and dementia and was all dialysis three times per week. I R37 was forgetful and at times R37's nutritional status been eating well since admit, here was no current labs w. However, R37's nutritional mation regarding diagnoses of emia and being dependent on st revised 5/21/18, indicated odialysis due to ESRD and utic diet. R37's care plan listed ns which included: consults as visician (nephrology, nutritional s), diet per physician order, or symptoms of dysphagiang), provide snacks, diet and dered, nutritional education will eded and at resident request, as and obtain and monitor lab dowever, the care plan did not gnosis of hyperkalemia or what le on hemodialysis. gned physician orders dated 37 was ordered a regular diet oft texture, regular consistency, dimeat into quarter pieces. ders lacked any further	F 6	988	a new nutritional assessment had no been completed. When the informat was reviewed it was noted no recent were in chart either. A potassium was ordered, the nutritional assessment revised, diet reviewed, and care platupdated. Staff educated on renal dieta. Because many residents are on restrictions related to care needs and diagnosis, many are potentially affect by the cited deficiency. Dietician rewith MD along with dialysis team the order, clarified the diet resident show have based on diagnosis and instrustaff to follow care sheets and entercommunication book. All current reson restrictions due to dialysis were reviewed and ensured information matched and staff were aware. Diet were updated, diet choices for dialy diets were posted to ensure staff parappropriate lunches. No other residivere affected. The policy on hemotomas been reviewed. 3. To enhance currently compliant operations and under the direction of director of nurses, on 7/12/2018 all (nursing and dietary) will receive in-service training monitoring diets a describing diets based on diagnose training emphasizes the importance following a plan of care, reviewing diagnosis, and appropriate monitoring 4. Effective 7/16/2018, a quality-assignorial program was implemented under the supervision of the dietician to monitor resident's diets in relation to their diagnosis. Dietician will review nutrassessments monthly and as needs as needs.	tion It labs as In It labs as It	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
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F 698	loss, skin was intacted dehydration of age edentulous, ate 75 potassium level (all and refer to nutrition). Review of R37's clinutrition assessment on 5/31/18, at 8:14 back in bed with his table was next to the Mt. Dew 12 oz can table. On 6/1/18, at 8:45 ticket, dated 6/1/18 indicated R37 had mechanical soft an Under "Special Nota a note for oatmeal ticket lacked identificated R37 had mechanical soft an Under "Special Nota a note for oatmeal ticket lacked identificated R37 had mechanical soft an Under "Special Nota a note for oatmeal ticket lacked identificated R37 had mechanical soft an Under "Special Nota a note for oatmeal ticket lacked identificated R37." Special Nota a note for oatmeal ticket lacked identificated R37. Special R37's special R3	ct, had risk factors for and decreased mobility, was % of meals, had a normal though no value was given)	F 698	monitor and update intervention Dietician will contact dialysis coreview labs monthly and as need dietician or designated quality-arepresentative will perform the systematic changes: audit 2 results 3 weeks than 1 resident for 5 wensure appropriate diet is giver dialysis center has made no diet changes, that lunches are appreciate and resident not in compliate waiver on file will be reviewed weeks by dietician with dialysis no other concerns or issues are non-compliance then monthly finext 2 months. Any deficiencies corrected on the spot, and the standard the quality-assurance checks we documented and submitted at 1 quality-assurance committee methods for the pool.	enter and eded. The assurance following sidents for reeks to a, the etary opriate for ance with weekly for 3 to ensure se due to collow up for s will be findings of rill be he monthly leeting for on.	

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F 698	level of 6.9 miliequi 3.4 - 5.1) on 5/22/18 R37's facility and up lab and to limit the a oranges/orange juic stated R37 also had level on 5/24/18. Dit the facility to comm low potassium need On 6/1/18, at 10:16 was regular, mechadialysis. CK-C state responsible to pack residents. She state a mechanical soft to sandwich without of celery, apple sauce apple cranberry juic some aids would us bananas or mandar was not aware of R On 6/1/18, at 10:28 stated she was the stated the dialysis of ago and updated he and it was decided orange juice due to day and a couple gistated the only way information was to juice" on his tray tic current tray ticket frostated she changed DD-A. She pulled usystem MenuMatrix information was additional control of the stated she changed DD-A. She pulled usystem MenuMatrix information was additional control of the stated she changed DD-A. She pulled usystem MenuMatrix information was additional control of the stated she changed DD-A. She pulled usystem MenuMatrix information was additional control of the stated she changed DD-A. She pulled usystem MenuMatrix information was additional control of the stated she changed DD-A. She pulled usystem MenuMatrix information was additional control of the stated she changed DD-A. She pulled usystem MenuMatrix information was additional control of the stated she changed DD-A. She pulled usystem MenuMatrix information was additional control of the stated she changed DD-A.	valents per liter (normal range 8. DD-A stated she called odated a staff RN on the high amount of bananas and ce R37 consumed. DD-A d a critically high potassium D-A stated she would expect unicate the dietary needs of ds of R37 in some manner. cook (CK)-C stated R37's diet anical soft and he required de dietary staff was a sack lunches for dialysis ed R37 would typically receive urkey, ham, egg or tuna salad neese, lettuce, carrots or and hard boiled eggs with the supplement. CK-C stated se other fruits such as grapes, rin orange. CK-C stated she 37's high potassium levels. a.m. dietary manager (DM)-A dietician called her 2-3 days er about R37's hyperkalemia to eliminate bananas and R37 eating 2-3 bananas a lasses of orange juice. DM-A she communicated that place "No bananas, no orange ket. DM-A reviewed R37's om that days breakfast. DM-A if it the day she spoke with p the tray ticket computer	F6	98		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 698	CK-A will at times pahead of time and printed out on ticked information should care plan as well. I dietician completed assessment. On 6/1/18, at 10:50 responsible for printed the facility etc.) that she wou time. CK-A stated of Saturday, Sunday print out Tuesdays Tuesday and Thurs Wednesdays. On 6/1/18, at 10:54 (MDSC)-A stated shutrition assessment was in MDSC-A	e for printing off the tray tickets print the tickets out a few days the new order has not been ets yet. DM-A stated the have been added to R37's DM-A stated the corporate d R37's admission nutrition O a.m. CK-A confirmed she was atting out the tray tickets for K-A stated at times, if she would by (weekend off, appointments do print out the ticket ahead of the print out the ticket and then on Mondays tickets and then on Monday, Wednesdays on saday and Fridays on the would expect to see a new tent since the new admission on confirmed no new nutrition in R37's clinical record. The would have expected to see or orange juice on the care	F 69	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 698	admission nutrition completed. On 6/1/18, at 11:28 stated she thought morning and R37 w potassium. On 6/1/18, at 11:40 sure if R37 was to having teeth, she w plan. NA-F stated seducation regarding. On 6/1/18, at 2:39 consultant dietician with R37 and discuaround R37's admit thought it was miss or DM-A) was going nutrition assessme record lacked an amost recent admission address R37's	a.m. nursing assistant (NA)-H R37 had a banana this vas supposed to have extra a.m. NA-F stated she was not nave bananas due to not vould have to check his care the had not received any	F 69	,		
	reviewed 4/28/18, i conduct and coordi through appropriate information should dialysis provider to care. Dietary initial the dietary director dietician was responding the discontinuous responding the dietary director dietician was responding the dietary director dietician was responding the dietary director dietician was responding the dietary director dietary	olicy titled Hemodialysis Policy indicated the facility must mate the MDS/RAI process assessments. The be coordinated with the develop a coordinated plan of assessment and care plan, in consultation with the insible for completing the initial int and plan of care. The completes a monthly nutrition				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 698	Continued From pa	ge 41	F 6	898			
	assessments are ba	re plan review. These ased upon food/fluid intake, t adherence, and laboratory					
F 726 SS=D	Competent Nursing CFR(s): 483.35(a)(F 7	'26			7/23/18
	the appropriate comprovide nursing and resident safety and practicable physical well-being of each resident assessment and considering the diagnoses of the factors.	ervices ve sufficient nursing staff with npetencies and skills sets to d related services to assure attain or maintain the highest l, mental, and psychosocial resident, as determined by nts and individual plans of care e number, acuity and cility's resident population in e facility assessment required					
	licensed nurses have and skill sets necess needs, as identified	acility must ensure that the specific competencies sary to care for residents' through resident described in the plan of care.					
	limited to assessing	ding care includes but is not g, evaluating, planning and ent care plans and responding					
	to demonstrate com techniques necessa needs, as identified assessments, and o	sure that nurse aides are able npetency in skills and ary to care for residents'					

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MOORHI	EAD REHABILITATIO	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560		
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F 726	review, the facility received and dem related to tracheo (R107) reviewed for created hole (ston that provides an acare. Findings include: R107's admission dated 2/20/18, individed attatention artificial cancer. The MDS extensive assistar which he required indicated the use and suctioning. R107's quarterly findependent cognimaking and diagnical carcinoma of pain, attention to the MDS indicated R1 with eating, extensional material for the modern cognimation of the modern cognition cognition of the modern cognition cogniti	ation, interview and document failed to ensure nursing staff onstrated competency skills stomy care for 1 of 1 resident or tracheostomy (a surgically na) in your windpipe (trachea) Iternative airway for breathing) Minimum Data Set (MDS) licated a cognition assessment d, and R107 had diagnoses ention to tracheostomy, opening of digestive tract, and indicated R107 required nee for all cares except eating, total care. R107's MDS further of oxygen, tracheostomy care MDS dated 5/1/18 indicated itive skills for daily decision oses, which included squamous skin of scalp and neck, chronic racheostomy and anxiety. The 07 required total assistance sive assistance with dressing ed assistance with dressing ed assistance with toileting and with all other ADLs. R107's ated tracheostomy care and Assessment (CAA) dated R107 had a tracheostomy in oharyngeal cancer.	F 72	This Plan of Correction cowritten allegation of complideficiencies cited. However of this Plan of Correction is admission that a deficiency one was cited correctly. To Correction is submitted to requirements established to federal law. 1. It is the policy of the facil that there are sufficient number the appropriate competent sets to provide nursing and services to assure resident highest practicable physical psychosocial well-being of Since survey findings, all seducated and are competent tracheostomy care. Educated and are competent tracheostomy care. Educated and are competent tracheostomy care. In additional nurses have been given as in nursing skill areas and recompetency testing of all adetermined based on resident their job title, and areas ideasurvey, staff, residents, far quality assurance committed designee immediately begand competency trainings for a staff will be orientated throorientation system. 2. All residents can be affect incompetent nursing staff. files and training records we current orientation for new 7/2/2018 and other individual residents can be affect incompetent nursing staff.	ance for the rr, submission is not an y exists or that his Plan of meet by state and lity to ensure ring staff with cies and skills direlated to safety and al, mental, each resident. It taff have been ent little and displayed a leaning and licensed diditional training leeded proper literas as lent population, entified through milies and the lee. DON and lan proper little staff and new little	

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MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER			MOORHEAD, MN 56560		
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F 726	Continued From pa	age 43	F 7	'26			
	Review of R107's	current care plan last revised			education provided since survey. T	he	
		nat there was no care plan			DON along with staffing and ED		
	related to R107's to				determined a series of trainings,		
		•			in-services, 1:1 trainings, return		
	Review of facility p	provided Group 3 care sheets,			demonstrations, packets for review	for all	
		ndicated under "Care Notes"			staff based on their individualized tr		
		n", but there was no instruction			requirements. On 7/2/2018 skills la		
	related to its care of	or monitoring.			form review was held for all nurses		
	On F/04/40 at 44.4	45 - m. lineared avertical assure			3.Upon review and completion of all		
		15 a.m. licensed practical nurse 1107's room and set up supplies			competencies, re-orientation and a	nnuai	
		care. LPN-A washed her hands			training requirements, the DON or designee will complete a 1:1 perfor	manco	
		gloves from the tracheostomy			evaluation with each nursing emplo		
		le gloves donned, LPN-A			ensure competent staff, and review		
		o holding the tracheostomy			other training and education needs		
		er cannula in place and			also be included for quality assuran		
		eeze R107's tracheostomy's			purposes. All new hires will have		
		e gently pulling at the inner			completion of orientation and training		
		inner cannula not disengaging			consistent with facility policy. All ca		
		to keep the inner cannula in			employees unable to complete nec		
		nt was to cough), LPN-A then			training will not be allowed to work		
		Velcro collar more. LPN-A			facility until after completion and 1:		
		outer and inner cannulas, one			review with DON. Staff will be audit	ea	
		ed to disengage the lock, and stated she had not provided			starting 7/16 on the job by nursing management for aspects of care,		
		y cares prior and stated			charting, skills, medications and po	licies	
		et someone who knows how to			related to job expectations. Audits v		
		en stated she was going to get			done on random nurses every weel		
		29 a.m. LPN-A returned to			during different care functions to er		
		LPN-B. LPN-B washed her			nurses per week are reviewed alter		
		gloves, she then held the			shifts over next 3 months.	-	
		one hand and twisted the inner			4.Beginning 7/16/18 the DON, ADC		
		ther hand, and the inner			MDS nurse will provide all nurses w		
		ed and was able to be removed.			above educational training and will	review,	
		inner cannula, which had white			monitor and assist staff to ensure		
		noted to the inner cannula into			completion. Ongoing monthly in-se		
		d with plastic, filled with a			will be provided and tracked by DO	iv (or	
		drogen peroxide and half sterile			designee) to assure continued	vill	

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		245052	B. WING			ີ 01/2018
NAME OF	PROVIDER OR SUPPLIE		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	•	01/2010
		ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 726	LPN-A placed new cotton tipped approarton containing cannula with one of the inner cannucarton. LPN-A the applicator and we and sterile water and cleaned the egrabbed the inner used a small white cannula of small of secretions. She thinner cannula and using an up and or replaced the inner tightened the Velodressing around to the control of the costomy carvideo 2 to 3 month normally worked to the morning and the morning and the morning and the morning and the costomy carchecked off on he tracheostomy carchecked off on he tracheostomy carstaff meeting with watched a video, different tracheotomy carstaff meeting with watched a return completed a return completed a return completed a return control of the costomy carstaff meeting with watched a video, different tracheotomy carchecked of a return completed a return completed a return control of the costomy carchecked a video, different tracheotomy carchecked a video, different tracheotomy carchecked a return completed a return control of the costomy carchecked a video, different tracheotomy carchecked a return completed a return control of the costomy carchecked a video, different tracheotomy carchecked a video, different trachecked a return completed a return control of the costomy carchecked a video, different trachecked a return control of the costomy carchecked a return control of the costomy carchecked a video, different trachecked a return control of the costomy carchecked a video, different trachecked a return control of the costomy carchecked a video, different trachecked a return control of the costomy carchecked a video, different trachecked a return control of the costomy carchecked a video, different trachecked a video, different trachecked a return control of the costomy carchecked a video, different trachecked a vide	w sterile gloves, grabbed a licator, wetted it in the same the inner cannula and held the hand and cleaned the exterior alla and returned it to the same en grabbed a new cotton tipped atted it with a hydrogen peroxide solution from a separate carton exterior cannula. LPN-A then cannula with one hand and e pipe cleaner to clean the inner chunks of the white and tan nen poured sterile water over a shook the excess water off down bobbing motion and then reannula into the outer cannula, cro strap and placed a gauze he exterior cannula. 243 a.m. LPN-A stated her e education included watching a hs ago. LPN-A stated she che night shift, which did not acheostomy cares, as R107's e was done twice a day during evening shift. LPN-A stated she eted a return demonstration after e education and had not been er comprehension of	F 7	identify areas of weakness from performance reviews and areas identified in the reviews. All nursing staff's competencies will be com 7-20-2018. All new hires we completed competencies orientation. Monthly for 6 facility will continue to more assigned annual and deer trainings are completed mediciencies will be immediand findings will be documented at the monthly que committee meeting. 5. The DON will be respon POC.	s, resident needs monthly QAPI s individual pleted by vill have during months the nitor that ned appropriate onthly. Any iately corrected, nented and uality assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING _			R 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		01/2010
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F 726	On 5/31/18 at 1:27 tracheostomy care the last month, whice cannulas, and suctivated she did reserved watching "some" nubut stated she did reserved watched. Dolocare included how and properly clean expect all licensed cannula and clean focused her educat shift nurses, but ha nurses yet. She stanight nurse would have tracheostomy cares. Review of facility do 5/22/18, indicated to tracheostomies. The "Trach care on MAI record) /TAR" (treat "Trach ties intact", often is trach changeroom" and "How are cannula and trach a information for both tracheostomy care; no information for hot cannula and trach a Review of facility processed Nurse-Trace Evaluation dated 5/25/20/20/20/20/20/20/20/20/20/20/20/20/20/	p.m. DON stated education was completed in ch included: cleaning the oning. Education included urses do tracheostomy care, not have a form for those that N confirmed the tracheostomy to remove an inner cannula it. DON stated she would staff to know how to remove a it. DON stated she had ion to the day and evening d not gotten to the night shift ted there was a potential a lave to know how to complete	F 72			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	` '	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	243032	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	06/	01/2018
_		N & HEALTHCARE 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 CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 726		age 46 facility provided education d no training on tracheostomy	F 72	26		
{F 812} SS=F	education, training requirements, but r	none was provided. ,Store/Prepare/Serve-Sanitary	{F 81	2}		7/23/18
	§483.60(i) Food sa The facility must -	fety requirements.				
	approved or considerate or local author (i) This may include from local produced and local laws or refull) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of the constant of the consta	e food items obtained directly rs, subject to applicable State				
	serve food in accor standards for food This REQUIREMED by: Based on observa review, the facility f items were not ava consumption. This	NT is not met as evidenced tion, interview and record ailed to ensure outdated food		This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, submof this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet	or the nission or that	

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NAME OF	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
MOORH	EAD BEHARII ITATIC	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH		
MOOITI	LAD NEHADIEHAHQ	M & HEALINGARE CENTER		MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 812}	refrigerator on 5/29 tray of approximate covered containers of groun clear container of loaf of banana bred dated 5/20/18. Die facilty were throwing and banana bread manager would be On 5/29/18, at 9:40 indicated she had last survey was contained to be entire the food. On 5/29/18, at 9:40 indicated she beverages, and clear indicated she beverages, and clear included making some residents and to do coolers. DA-B indicated the days for outdated the such as cleaning and ishes, use only part of the coverages of the such as cleaning and ishes, use only part of the coverage of the coverag	our of the kitchen of the walk-in 9/18, at 9:18 a.m. revealed a ely 20 apple sauce one cup is dated 5/19/18, a clear d ham dated 5/16/18 and a diced ham dated 5/18/18, a and dated 5/11/18, and a piectician (DN)-A indicated the ing away the apple sauce, piectician (DN-A indicated the dietary in later. Of a.m. dietary aide (DA)-A received education since the exation on many items, including I how to speak with residents. It is washed dishes, set up eaned the coolers, but did not a since the last survey which ure food was warm for ate all foods that go in the icated foods should not be kept nothing should be kept 7 days. By checked the coolers every 3	{F 81	requirements established by federal law. 1.It is the policy of this facilit healthy and safe meal service the many ways that this has ensuring clean environment preparing and serving food a beverages to residents before expiration dates. After the sureported finding expired date items in kitchen it was deternot properly managing expired limmediately the dietary mar out items and updated staff dates. The log sheet that has signed off 2 out of 9 days wand monitored for daily checased all residents recembered by the cited deficient the dietary manager did deed fridge to remove all outdated Cleaning out fridge items the is now done daily with kitches chedule. The staff have revolicy and are aware of propand dating open items. 3. To enhance currently com operations and under the did director of dietary, on 7/2/20 staff reviewed proper storage with dietary manager to ensare safe to serve. 4. Effective 7/16/2018, a quaprogram was implemented usupervision of the director of monitor fridge for expired ited director of dietary or designated in the director of dietary or designated in the director of dietary or designated in the director of dietary or designated ited director of dietary or designated in the directo	ty to ensure ce. Some of been done is and safely and are their urveyor es or undated mined staff red foods. hager threw to monitor ad only been as addressed cks. eive their potentially ncy, 7/2/2018, at are expired en cleaning viewed the per storage pliant rection of the off and dates ure all items. Ality-assurance under the f dietary to ems. The	

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MOORH	EAD REHABILITATIO	ON & HEALTHCARE CENTER		MOC	PRHEAD, MN 56560		
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{F 812}	apple sauce and be initial tour. Ck-A ir check the food day indicated she three ham also, she indipast the date they indicated she did reday. CK-A indicated she did reday. CK-A indicated she did reday. CK-A indicated she was multiple task. On 5/29/18, at 9:5 worked at the faciliprovided staff edurincluding the use of items and cleaning ham, diced ham, it sauce were expired on 5/29/18, at 2:0 indicated she was provided the educated she was not aware expired foods in the may have been to many items they ha	ated she threw away the pie, canana bread at the time of the indicated she has told staff to ites, but "they don't do it." CK-A w away the ground and diced cated they were 2 or 3 days should be used. CK-A not notice the dates of the foods ated if staff do not show up she ity and indicated the facility had cation on various topics, of pasteurized eggs, dating g. DN-A confirmed the ground banana bread, pie and apple	{F 8	po fr po fc di do au cl ar 5.	erform audits to visualize conteridge, dates, and storage to be der week for 4 weeks then 1x per 2 months to ensure compliant etary manager or designee. An eficiencies will be corrected on and the findings of the quality-assumecks will be documented and so the monthly QAPI meeting for eview or corrective action. Dietary manager and maintenate responsible for this POC.	one 2x week be via he spot, surance ubmitted further	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{F 812}	Schedule from 5/2 the area marked "out all outdated for only 2 out of 9 day Review of staff tra 5/3/18, CK-A and I food, and taking doutchen. No specific were provided as a surface of the second of	1/18, to 5/5/29/18, identified Check for label and date, throw ods", was initialed or checked s. Ining provided indicated on DM-A reviewed policy of saving own all temperatures in the fic training objectives or details requested. Cold Food Storage, undated, I potentially hazardous foods; other ingredients "use by date" lacing in refrigerator. Foods in h included opened fruit sauces, 7 days after placing in I USDA (United States iculture) Food Safety and , Storage Times for s, undated, identified ham, fully	F 81	2}			

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		2810 SE	ADDRESS, CITY, STATE, ZIP CODE ECOND AVENUE NORTH HEAD, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 865 SS=F	dated 2011, identific hazardous food ing containers must be "use-by" date. The to store all extra poinches deep), approvinces by" date and ritems not stored in labeled and noted a storage chart, and allowed days. Monexpiration dates or outdated items imm QAPI Prgm/Plan, DCFR(s): 483.75(a)(Section 1988) (2) Pressurvey Agency no I promulgation of this Section 1988 (2) Pressurvey Agency no I promulgation of the compliance of section 1988 (2) Sanction Good faith attempts and correct quality a basis for sanction	tled Storing Prepared Foods, ed food or potentially predients not stored in original ediscarded if not used within a policy further instructed staff ortions in sealed shallow (2 oved containers. Label, note refrigerate immediately. All original container must be with "use by" date according to used or discarded within a policy dates and discard all nediately. Disclosure/Good Faith Attmpt 2)(h)(i) assurance and performance PI) program. ent its QAPI plan to the State later than 1 year after the se regulation; ure of information. etary may not require ecords of such committee such disclosure is related to such committee with the se section. as. s by the committee to identify deficiencies will not be used as	{F 8				7/23/18

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIEF	R		STREET ADDRESS, CITY, STATE, ZIP	CODE	
MOODU	EAD DELIABILITATIO	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH		
MOORE	EAD REHADILITATIO	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 865	Based on intervier failed to maintain assurance (QAA) identifying and rest This deficient practall 54 residents in Findings include: During an interview the nursing consuverified he was the administrator iden regularly attended nursing, director of director, medical of coordinator (MDS). The administrator quarterly meeting The administrator members discussion the facility survey indicated many neplace, staff were edietary and MDSO initiated to review The nurse consult	w and record review, the facility a quality assessment and committee that was effective in ponding to quality deficiencies. Stice had the potential to affect the facility. w on 6/1/18 at 4:31 p.m., with stant present, the administrator is lead for QAA. The tified the following staff the QAA meetings: director of a social services, therapy stirector, Minimum Data Set C) and pharmacy consultant. identified the most recent was conducted on 4/30/18. identified the QAA meeting and many of the tags cited during for 3/13/18. The administrator is protocols were put in to aducated, new staff hired for a position and audits were the progress. ant (NC) identified the nursing	F 8	This Plan of Correction cowritten allegation of complide deficiencies cited. However of this Plan of Correction is admission that a deficiency one was cited correctly. To Correction is submitted to requirements established be federal law. 1. It is the policy of the facilithat the Quality Assurance Improvement committee in develops appropriate action to system failures. The fact have appropriate action plasystem failures including develops and monitoring for addressing the lack of eduto continued problems with Administrator educated even QAPI program, the guideling and how to analyze data, effectively address system improve quality at facility. 2. Lack of appropriate actions system failures can affect the facility. At this meeting for improvement were identification.	onstitutes my itance for the er, submission is not an experience of that his Plan of meet on state and with the state of the er, submission is not an experience of the experi	
	nursing staff had of listening, charting, identified the facili providing informat on practices.	ncy issues. The NC identified demonstrated problems with and documentation. The NC ty had a system failure with ion, orientation and follow-up		and performance improver were initiated, reviewed an be monitored. The items t will continue to be address competencies will also be monitoring. 3.To enhance currently con	nd continue to agged in survey sed and the staff added to the mpliant	
	had been educate	audits the NC indicated staff d on how to perform audits and d with negative findings. The		operations and under the of Administrator, education re elements and goals of the	eviewed the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED	
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			2810 SECOND AVENUE NORTH				
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		MOORHEAD, MN 56560			
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F 865	Continued From particles of the August 1987 NC indicated the august 1987 NC identified the Quant Systems were together to get according to the facility had place problems rather that is what had to now with the audits fixed but the staff is the NC indicated by problems and which with the revisit survivation indicated she was a improvement can be seen improvement.	age 52 udits were not expected to be ere to learn from them. The AA committee had identified not in place and were working buntability. The NC indicated ed a lot of Band-Aid on an fix the problem because be done. The NC indicated it is noted that the problem is a not educated. The indicated seeing aware of the facility he citations were being recited ey. The NC indicated she had in the facility; however, seeing struggles where	F 8	assistance and tools for areview, and proper identificause while assuring goal (specific, measurable, atta and time oriented). All stain-service training regarding program. 4. The QA committee will rediscuss action plans related deficiencies noted during and analyze audits and deappropriate continued mossystem changes in additional ready identified on the Cagenda. The medical direspresent quarterly and phase consultant will be present quarterly; if not present misubmitted to them prior to allow for input during mee reviewed and signed moniting place and reviewed month at all supporting docume each department head is a Administrator the Monday for adequate time to review the minutes and supporting documentation will then be and COO for review. This correction will be monitore QAPI meeting and audits such a time that shows co substantial compliance wit regulations and the facilities.	ccurate da ication of reals are SMA ainable, real aff will recend QAPI meet monthed to survey, revertermine on to other QAPI plan ector will be rmacy at a miniminutes will be rmacy at a miniminutes will be rmacy at a miniminute will be real at the real at the mito continue on sistent the es QAPI	ata oot ART alistic sive hly to view items e num have o will be is are sure om to the eeting API RDCS nonthly e until	
				has been met, as determing representative of the region team. 5. The Administrator or despensible for this POC.	onal execut		

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NAME OF F	ROVIDER OR SUPPLIER	243032	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/01/2018	
NAME OF P	ROVIDER OR SUPPLIER					
MOORHE	EAD REHABILITATION	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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PRINTED: 07/22/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245052	B. WING			R 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	1 00/	01/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 00	00}		
{F 000}	through 6/1/18, to do CMS Appendix Z En Requirements. The with Appendix Z En Requirements. INITIAL COMMENTAL An onsite post cert completed on 5/29/certification tags the found on the CMS2	ification revisit (PCR) was 18, and 6/1/18. The at were corrected can be 567B. Also the tags which ected at the time of onsite	{F 00	00}		
{F 585} SS=D	signature is not req page of the CMS-29 submission of the F verification of computer of an anon-site revisit of you validate that substate regulations has been your verification. Grievances CFR(s): 483.10(j)(1) §483.10(j) Grievance §483.10(j)(1) The regrievances to the fathat hears grievance reprisal and without reprisal. Such griev respect to care and furnished as well as	acceptable electronic POC, an ur facility will be conducted to ntial compliance with the en attained in accordance with	{F 58	TITLE		7/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

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.

07/19/2018

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE COMI	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ODE:	00/0	71/2016
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{F 585}	residents, and other facility stay. §483.10(j)(2) The refacility must make presolve grievances accordance with thi §483.10(j)(3) The facility must of the resident. §483.10(j)(4) The facility of the resident. §483.10(j)(4) The facility of all grievances recontained in this pacing provider must give at the resident. The include: (i) Notifying resident postings in promine facility of the right to (meaning spoken) of grievances anonym of the grievance offican be filed, that is, address (mailing annumber; a reasonal completing the reviet to obtain a written of grievance; and the filed, that is, the Quality Improvement Agency and State Liprogram or protection.	vior of staff and of other r concerns regarding their LTC esident has the right to and the prompt efforts by the facility to the resident may have, in	{F 58	85}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			R	
NAME OF I	PROVIDER OR SUPPLIER	243032	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		/01/2018	
MOORHI	EAD REHABILITATION	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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{F 585}	receiving and trackic conclusions; leading by the facility; maintinformation associal example, the identiting grievances submitted written grievance decoordinating with stancessary in light of (iii) As necessary, to prevent further poteright while the allegginvestigated; (iv) Consistent with reporting all alleged abuse, including injurand/or misappropriation and provider, to the admass required by State (v) Ensuring that all include the date the summary statement the steps taken to insummary of the per regarding the residents to whether the gronfirmed, any corritaken by the facility and the date the writing with the state Survey Agorganization, or local control of the provider of the control of the provider of the provider of the provider of the state Survey Agorganization, or local control of the provider of the provi	rseeing the grievance process, ng grievances through to their g any necessary investigations taining the confidentiality of all ted with grievances, for try of the resident for those ed anonymously, issuing ecisions to the resident; and ate and federal agencies as a specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately I violations involving neglect, uries of unknown source, ation of resident property, by ervices on behalf of the ninistrator of the provider; and	{F 58	35}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		01/2010
MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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{F 585}	(vii) Maintaining everesult of all grievand syears from the is decision. This REQUIREME by: Based on observareview, the facility grievance procedu grievances were acfor 1 of 1 resident (grievances. Findings include: On 5/31/18, at 8:03 morning cares. R4 nursing assistant (Iddress. R410 reque and a tank top from NA-F informed R4 tops in the closet. I pants up for R410 responded that the important because anything but shorts pair of jogging panwear. On 5/31/18, at 8:30 pair of shorts missitank tops. R410 included with his na facility staff in the pant of anything about the important of shorts missitank tops. R410 included with his na facility staff in the pant of anything about the important of shorts missitank tops. R410 included with his na facility staff in the pant of anything about the important of shorts missitank tops. R410 included with his na facility staff in the pant of the important of shorts missitank tops. R410 included with his na facility staff in the pant of the important of shorts missitank tops. R410 included with his na facility staff in the pant of the important of the im	a of responsibility; and idence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced tion, interview and document failed to implement their re and ensure verbal ddressed in a timely manner (R410) reviewed for B a.m. R410 was observed with 10 received assistance from NA)-F and NA-G to wash and sted NA-F to choose shorts in the closet to wear for the day. 10 there were no shorts or tank NA-F held two pair of jogging to choose from. R410 choice of pants was not it was too warm to wear and tank tops. NA-F chose a ts and a T-shirt for R410 to D a.m. R410 indicated he had 9 ing and an unknown number of dicated the clothing items were me, he had reported it to the past; however, the staff had not ut the missing items. R410 ke to wear any clothing other	{F 58	This Plan of Correction constit written allegation of compliance deficiencies cited. However, su of this Plan of Correction is not admission that a deficiency exisone was cited correctly. This PCorrection is submitted to mee requirements established by stifederal law. 1. It is the policy of this facility to residents the right to file a griet they feel they are concerned whithin the facility and it is the post facility to respond to those griet R410 was noted to have missing and the aide reported it to their did not report to SW or fill out of form. No follow up was done remissing clothing. In this case, a surveyor reported the resident the SW went to laundry manage explained concern. After looking laundry room it was determined pairs of shorts and couple tank discovered without a name and staff had not known who to return the seemed happy with outcome. In not ensuring clothes are labele being sent to laundry. 2. Because all residents that residentity calling it their home and	e for the bmission an ets or that lan of t ate and ate	

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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH	1 00/1	31/2010
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 585}	On 6/1/18, at 8:47 services (DSS) stainformed of R410's After review of her no reports of R410 indicated she woul concerns of missin grievance could be The DSS indicated educated regarding provided with the pindicated she woul and with facility ho could be located. On 6/1/18, at 9:01 informed the nurse but was not aware indicated she did in had been missing time off of work an shorts prior to the could inform social as well as nursing duty at the time. The undated facilit Grievance Report, 1. Who completes A. The resident B. The family mor C. The staff per concern. 2. What is done wind the report is gird departmental design assessment can be served.	a.m. the director of social ated she had not been so concern of missing clothing. files, the DSS verified she had its missing items. The DSS dexpect staff to report ag items to her, and stated a reported by a resident or staff. I all staff had recently been go the grievance process and apperwork to do so. The DSS defollow up with the resident usekeeping to see if the items a.m. NA-F indicated she had about R410's missing shorts of the missing shirts. NA-F not know how long the items however, she had taken some do had reported R410's missing time off. NA-F indicated she a services of the missing items but had only told the nurse on the form? If y form titled Resident identified the following: the form? If y form the concern, or the green to the administrator or the green, so the proper	{F 585	have the right to express their or all are potentially affected by the deficiency. On 7/12/2018, curre residents were audited to ensur understand they can file a griev they have concerns, that the fact follow up timely, any outstanding grievances were resolved, and review added to morning stand were also reminded that they she forward all grievances to the SV follow up. No other residents we affected. The Policy and Proced grievances was reviewed. 3. To enhance currently compliad operations and under the direct SW, on 7/18/2018 all staff and received handout with policy and grievance form. The hand out eour policy and resident rights and appropriate time frame for follow also reminded resident to have with labeling items and ensuring that are expensive or sentiment be kept off site or in drawers to loss of property. A reminder was given to staff and protocol hung room, so staff could review the form. 4. Effective 7/18/2018, a quality-program was implemented undesupervision of the SW to monited grievances and resident inventor ensure facility aware of resident The SW or designee will complead udits per week x 4 weeks on reensure no concerns are being uthen 2 audits weekly for 4 week deficiencies will be corrected or	e cited ont e they ance if cility will grievance up. Staff would of or ED for one of the esidents of any items al should prevent a also in break colicy and assurance or the or resident ries to items. Ete 4 esidents to nmet, s. Any	

NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		E SURVEY PLETED
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MOORHEAD REHABILITATION & HEALTHCARE CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (F 585) Continued From page 5 A. Investigation: The administrator will assign an appropriate designee to complete the investigative report. The designee will contact the resident/family if further clarification is needed. 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 (X5) PREFIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTION SHOULD BE COMPLETIC DATE OF THE APPROPRIATE DEFICIENCY) (F 585) A. Investigation: The administrator will assign an appropriate designee to complete the investigative report. The designee will contact the resident/family if further clarification is needed.	NAME OF I		243032	D. WING	CTREET ADDRESS OITY STATE ZID CODE	06/0	01/2018
MOORHEAD, MN 56560 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 585) A. Investigation: The administrator will assign an appropriate designee to complete the investigative report. The designee will contact the resident/family if further clarification is needed. (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE A	NAME OF I	PROVIDER OR SUPPLIER					
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 585) Continued From page 5 A. Investigation: The administrator will assign an appropriate designee to complete the investigative report. The designee will contact the resident/family if further clarification is needed. PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE And the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or	MOORHI	EAD REHABILITATION	N & HEALTHCARE CENTER				
A. Investigation: The administrator will assign an appropriate designee to complete the investigative report. The designee will contact the resident/family if further clarification is needed. and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION
B. Assessment: Using the information gathered through the appropriate staff. C. Planning: From the staff evaluation, an appropriate plan of action will be determined. D. Implementation: An approach for implementing the plan will be determined. 4. What is the resolution? A. The resolution and disposition sections of the report will be completed after the action plan has been implemented. The resident/family will again be contacted upon resolution of the problem. B. The concern report will again be routed to the administrator for final review and signature. C. The report will be filled in the Social Service Department. Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of residents and misappropriation of residents and misappropriation of residents and misappropriation of resident property. §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REOUIREMENT is not met as evidenced by: Based on interview and document review the	{F 607}	A. Investigation: an appropriate desi investigative report. resident/family if fur B. Assessment gathered through the C. Planning: Fr appropriate plan of D. Implementati implementing the plan of D. Implementati implement will be contacted problem. B. The resolution the report will be contacted problem. B. The concern the administrator fo C. The report of C. The report of C. The report of C. The report of Service Department Develop/Implement CFR(s): 483.12(b)(for Service Department CFR(s): 483.12(b)(for Service) The facili implement written plants of Service of Service Department of Service Depa	The administrator will assign gnee to complete the The designee will contact the other clarification is needed. The designee will contact the other clarification is needed. The complete staff. The appropriate staff. The appropriate staff. The staff evaluation, an action will be determined. The interest of the staff evaluation of the staff evaluation sections of the staff evaluation sections of the staff evaluation sections of the staff evaluation of the staff evaluation, and the staff evaluation is needed.		and the findings of the quality-ass checks will be documented and stat the monthly quality-assurance committee meeting for further revicorrective action. 5.SW will be responsible for this F	ubmitted few or POC.	7/23/18

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{F 607}	all alleged violation exploitation or mist unknown source a resident property a within the required results of all investistate agency within incident. In addition staff received abus and existing staff in practice had the poresiding in the facili reviewed 5/10/18, I evaluated and care susceptibility to aborisk for abusing oth be taken to minimiz listed the assessmadmission, and reviewed to a linvestigation, prote violations of abuse mistreatment, injur misappropriation of address training for on abuse prevention. Review of the facili Protection Manual 5/28/18, revealed to following:	relop an abuse policy to ensure s involving abuse, neglect, reatment, including injuries of and misappropriation of re reported to the state agency timeframe's and ensure the igations are reported to the instance of some state agency timeframe's and ensure the igations are reported to the instance of	{F 60	written allegation of compliance deficiencies cited. However, so of this Plan of Correction is not admission that a deficiency expone was cited correctly. This Correction is submitted to me requirements established by seederal law. 1. It is the policy of this facility incidents and do timely follow incident that result in injury. A and accidents are to be review immediately for any potential neglect. In this case the review determined the actual policy wormplete and lacked the follow elements: The policy failed to include the violations involving abuse, new exploitation or mistreatment, injuries of unknown source armisappropriation of resident preported immediately, but not hours after the allegation is mevents that cause the allegation where the cause the allegation do not inform and do not result in serious both to the State Survey Agency The failed state that results of the investigations would be reported that the state survey Agency The failed state that results of the investigations would be reported that the state survey Agency The failed state that results of the investigations would be reported that the state survey Agency The failed state that results of the investigations would be reported that the state survey Agency The failed state that results of the investigations would be reported that the survey Agency The failed state that results of the investigations would be reported to the state survey Agency The failed state that results of the investigations would be reported to the state survey Agency The failed state that results of the investigations would be reported to the state survey Agency The failed state that results of the investigations would be reported to the state survey Agency The failed state that results of the investigations would be reported to the state survey Agency The failed state that results of the investigations would be reported to the state survey Agency The failed state that results of the investigations would be reported to the state survey Agency The failed state that r	ubmission of an cists or that Plan of et ctate and to report all up on any I incidents ved abuse or vas not ving ining on and annually at all alleged glect, ncluding d roperty, are later than 2 ade, if the on involve ily injury, or events that volve abuse odily injury, ne policy ed to the days of the cluded cy that	

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		<i>7.</i> 10
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{F 607}	financial exploitation neglect, or if a ther a call must be made State Agencies with findings -within 5 business Administrator, Dire Social Services wild decision regarding investigation -each new employeemployee orientation-service on the Rights is mandator. The policy failed to violations involving mistreatment, inclusions after the allegin serious bodily in if the events that cause the allegin serious bodily in if the events that can involve abuse and injury, to the State. The policy failed to investigations would agency within 5 would represent the policy failed to prevention upon hiemployees.	tiated(physical, verbal, sexual, on), if there is caregiver apeutic error resulted in injury le to the facility designated hin 2 hours of the initial days of the original report, ctor of Nursing and Director of I meet to make the final the outcome of the ewill be assigned to new on, and attendance at a yearly esident Safety and Resident by for all employee include that all alleged abuse, neglect, exploitation or uding injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result jury, or not later than 24 hours ause the allegation do not do not result in serious bodily	{F 607	address identification, investigation protection and reporting of alleged violations of abuse, neglect, explosmistreatment, injuries of unknown and misappropriation of resident pand did not address training for neexisting employees on abuse preventies abuse all residents receiving the facility are determined to be vulnerable adults, all are potentiall affected by the cited deficiency. Sinclude training implementation, the hours vs. 24-hour notification rule, when the conclusion of investigation be completed and timeframe of whouse the submitted. The vulnerable policy has been reviewed and a vulnerable adult assessment has a completed on high risk residents we educated on proper re-assessment well as education for new and exist employees on abuse prevention. Other residents were affected. 3. To enhance currently compliant operations and under the direction director of nurses, on 7/12/2018 a received in-service training regard updated policy and assessing vulnadults. All new and existing staff we continue to have initial and yearly education of abuse prevention and of policy. Amended policy is being monitored weekly with random standited on VA, reporting and privating updates with goal of auditing all st within next month and intermittent thereafter for next 2 months. 4. Effective 7/16/2018, a quality-as	itation, source property wand ention. care in y nce d to lee 2 and on will nich it e adult lee	

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NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD REHABILITATION	8 HEALTHCARE CENTER			110 SECOND AVENUE NORTH OORHEAD, MN 56560		
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{F 607}	he had understood consultant had revisinclude the required	ont facility policies and stated the corporate nurse sed the abuse policies to I components.	{F 60		program was implemented under the supervision of the administrator to a the abuse prevention compliance a ensure along with SW vulnerable as assessments completed and review. All incidents will be immediately report to the Administrator and if injury or is noted, the administrator or design report a VA to common entry point whours of the incident. If no injury or noted, this will then be reported with hours and reviewed daily at stand a lincident occurs after business hour the weekend, the Administrator will collaborate with the DON and report imely manner. Once the report has submitted, the Administrator or design will report the investigation findings 5 business days of report. Any deficiencies will be corrected on the and the findings of the quality-assurance committee meeting for further review corrective action. 5. Administrator/SW/DON will be responsible for this POC.	monitor nd dult ved. ported abuse nee will within 2 abuse nin 24 up. If as or on at in a seen ignee within e spot, rance omitted	
{F 623} SS=B	Notice Requiremen CFR(s): 483.15(c)(3	ts Before Transfer/Discharge 3)-(6)(8)	{F 62	23}			7/23/18
	resident, the facility (i) Notify the resider representative(s) of the reasons for the language and mann	nsfers or discharges a					

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{F 623}	Long-Term Care Or (ii) Record the reas discharge in the resaccordance with parand (iii) Include in the not paragraph (c)(5) of \$483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be referred transfer or d (A) The safety of ince the endangered und this section; (B) The health of ince the endangered, under paragraph (c) (D) An immediate the required by the resident paragraph (c) (E) A resident has redays. §483.15(c)(5) Contention of the endangered in pure tinclude the fol (i) The reason for to (ii) The effective days.	e Office of the State inbudsman. One for the transfer or cident's medical record in ragraph (c)(2) of this section; of the items described in this section. In go of the notice. Ited in paragraphs (c)(4)(ii) and in the notice of transfer or under this section must be at least 30 days before the ed or discharged. In made as soon as practicable ischarge whendividuals in the facility would der paragraph (c)(1)(i)(C) of individuals in the facility would der paragraph (c)(1)(i)(D) of interest in the section; or interest of the notice. The written the paragraph (c)(3) of this section.	{F 62	23}			

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{F 623}	including the name and telephone num receives such requito obtain an appear completing the form hearing request; (v) The name, add telephone number Long-Term Care O (vi) For nursing fact and developmental disabilities, the mattelephone number the protection and developme	the resident's appeal rights, and the entity which lests; and information on how I form and assistance in and submitting the appeal ress (mailing and email) and of the Office of the State inhudsman; allity residents with intellectual I disabilities or related illing and email address and of the agency responsible for advocacy of individuals with abilities established under Part ental Disabilities Assistance act of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the efor the protection and luals with a mental disorder the Protection and Advocacy viduals Act. Inges to the notice. In the notice changes prior to er or discharge, the facility ecipients of the notice as soon as the updated information	{F 62	23}			

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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		01/2010
				2810 SECOND AVENUE NORTH		
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER		MOORHEAD, MN 56560		
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{F 623}	to the State Survey State Long-Term Cathe facility, and the well as the plan for relocation of the res 483.70(I). This REQUIREMENT by: Based on interview failed to ensure that for transfers were grepresentatives, or residents (R305) revenue Findings include: R305's admission of the result of the second of th	Agency, the Office of the Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at § NT is not met as evidenced and record review the facility the written notifications required given to the residents, resident the ombudsman for 1 of 2 viewed for hospitalization. Minimum Data Set (MDS) tified R503 had diagnoses betes mellitus, benign prostatic and retention of urine. The 5 was cognitively intact, had ter and required extensive	{F 62	This Plan of Correction const written allegation of compliance deficiencies cited. However, so of this Plan of Correction is not admission that a deficiency exone was cited correctly. This Correction is submitted to mer requirements established by sefederal law. 1. It is the policy of this facility transfers and discharges to the ombudsmen. R305 was sent of procedure but due to significate procedure ended up staying in hospital to be admitted and not was not made regarding their the ombudsman office or POA stipulated by regulations. Whe surveyor noted these resident documentation supporting not was noted that this practice has been implemented within facil	te for the submission of an ists or that Plan of et tate and report all eduction transfer to as en the sto have no fication it ad not yet ty especially	
	documentation that or that the Office of (LTC) Ombudsman transfer in writing.	nedical record revealed no the resident's representative the State Long-Term Care had been notified of R35's a.m. director of nursing		regarding residents sent out a admitted. Immediately policy procedure on transfers/dischareviewed, staff were educated sent to nursing stations with prequirements. Staff to ensure documented in chart and POA Ombudsmen notified.	and rges was , reminders olicy and transfer	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	1 00/01/2010	
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{F 623}	(DON) indicated R have a procedure nephrostomy tube sure if he was kep usual practice was representative and hospitalizations. It chart and confirmed documentation this indicated she expeduring transfer, an assure completed. The facility policy to Emergency, revise notify the represermember and to as any temporary transferd all notice needed to be sent notification to office. The facility policy to Emergency, revise notify the represerment of the sent notification to office.	a305 went to the hospital to completed with his. DON indicated she was not to overnight. DON indicated the set to notify a resident's dombudsman for overnight DON reviewed R305's electronic ed she could not find so was completed. DON exted the nurse to complete this id the social worker to review to exitled Transfer or Discharge, and 4/28/18, instructed staff to intative (sponsor) or other family k if they would like bed held for insfers. The policy further is of discharges and transfers written transfer or discharge is of ombudsmen. Titled Transfer or Discharge, and 4/28/18, instructed staff to intative (sponsor) or other family by would like bed held for any ers. The policy identified this inted in a progress note taht they	{F 623	2.Because all residents that reside facility do either discharge or have ER, all are potentially affected by the deficiency. Immediately all resident transferred or discharged were revand update was noted to ombuds. When staff note any resident leave are aware of notification needed a turn make appropriate note in resichart. Current residents were audidirector of nursing to ensure all has appropriate notification in place. Note that the direction in place is not appropriate notification in place. Note that the importance of notifying ombudsman and under the direction social services, on 7/18/2018 all not staff will be re-trained regarding the and the importance of notifying ombudsman and POA and not for those sent out as anticipated returnstay out on leave overnight. The twill emphasize this is to be done as as possible for transfers and up to days prior for discharges and documentation of notification is critically as program was implemented under supervision of the SW to monitor at transfers and discharges to ensurappropriate notification given. The designee will complete 2 audits per x 4 weeks on residents that have transferred or discharged, then 1 aweekly for 4 weeks ensure staff con with current policy. Any deficiencies corrected on the spot, and the find the quality-assurance checks will be documented and submitted at the quality-assurance committee mee	visits to he cited ts being viewed nan. ng they nd in dent ted by d o other of ursing is policy getting n but raining s soon 30 tical. surance the any e SW or er week audit omply es will be ings of oe monthly	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG	COV	E SURVEY MPLETED
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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 623}			F 623		ition. his POC.	
{F 625} SS=B		Policy Before/Upon Trnsfr 1)(2)	rnsfr {F 625}			7/23/18
	§483.15(d) Notice of	of bed-hold policy and return-				
	nursing facility trans the resident goes o nursing facility mus the resident or resid specifies- (i) The duration of t any, during which the return and resume facility; (ii) The reserve become and the second of this section.	specified in paragraph (e)(1)				
	the time of transfer hospitalization or th facility must provide resident representa specifies the duration described in paragrathis REQUIREMENT by: Based on interview failed to ensure that	hold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the attive written notice which on of the bed-hold policy aph (d)(1) of this section. Note it is not met as evidenced and record review the facility to notifications of bed hold esidents that transfer to		This Plan of Correction const written allegation of compliand deficiencies cited. However, s	ce for the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245052	B. WING				R 01/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOODLI	EAD DELIABII ITATIOI	N & HEALTHCARE CENTER		2	810 SECOND AVENUE NORTH		
WOORN	EAD RENABILITATIO	N & REALINCARE CENTER		N	MOORHEAD, 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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 625}	Continued From pa	_	{F 62	25}			
another facility were p (R305) reviewed for h		e provided for 1 of 2 residents r hospitalization			of this Plan of Correction is not an admission that a deficiency exists of the correction is not an admission.		
	Findings include:				one was cited correctly. This Plan Correction is submitted to meet requirements established by state a		
	dated 4/16/18, iden which included diab hyperplasia (BPH) a MDS identified R30 an indwelling cathe assistance with toile Review of R305's p 5/30/18, at 11:39 p. Sanford 5E med su having a procedure be coming back to Friday. Review of R305's n documentation that or that the Office of	view of R305's medical record revealed no cumentation that the resident's representative that the Office of the State Long-Term Care C) Ombudsman had been notified of R35's			federal law. 1.It is the policy of this facility to ensur bed hold consent obtained from POA acopy given to hospital receiving reside and that POA also receives copy. R30 were sent to the hospital and no indicated hold policy was sent to hospital or POA per regulation. When the surveyor reported lack of documentation that the occurred, it was noted that this practice had not yet been reviewed and implemented appropriately within facili Immediately policy and procedure on holds was reviewed, staff were educated reminders sent to nursing stations with policy and requirements. 2.Because all residents that reside in facility make visits to hospitals on occasion or go on therapeutic leaves,		
	Review of R305's n documentation that representative were On 5/31/18, at 9:03 (DON) indicated R3 have a procedure on the complete the bed have the complete the bed have the complete the bed have a procedure on the complete the bed have a procedure on the complete the bed have a procedure to the complete the bed have a procedure the procedur				are potentially affected by the cited deficiency. Immediately all resident transferred or on leave were review updated bed hold policy given out. staff note any resident leaving they aware to get POA consent for bed send bed hold with resident to hosy with resident taking leave and get of POA with note in resident chart. Curesidents were audited by director nursing to ensure all had appropria notification in place. No other resid were affected. 3.To enhance currently compliant operations and under the direction	s being wed and When are hold, bital or copy to arrent of te ents	

			(X3) DATE SURVEY COMPLETED		
		245052	B. WING _		R 06/01/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/01/2010
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
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{F 625}	indicated she expeduring transfer, and assure completed. The facility policy tit Emergency, revised notify the represent	tion this was completed. DON cted the nurse to complete this if the social worker to review to cled Transfer or Discharge, d 4/28/18, instructed staff to ative (sponsor) or other family if they would like bed held for sfers.	{F 62	social services, on 7/18/2018 all nurstaff will be re-trained regarding this and the importance of giving the beand consent from POA if required. training will emphasize this must be with all residents being sent out of figoing out on leave or transferring to hospital. 4. Effective 7/18/2018, a quality-assurogram was implemented under the supervision of the SW to monitor and transfers to ensure appropriate noting given. The SW or designee will coreduced audits per week x 4 weeks on resentant have transferred or left, then 1 weekly for 4 weeks ensure staff con with current policy. Any deficiencies corrected on the spot, and the finding the quality-assurance checks will be documented and submitted at the medial quality-assurance committee meeting further review or corrective action. 5.SW will be responsible for this PC	s policy d hold The e done acility urance ne ny fication mplete idents audit mply s will be ngs of e nonthly ng for
SS=D	Planning §483.21(a) Baselind §483.21(a)(1) The firmplement a baselind that includes the inseffective and personant meet profession. The baseline care profession in Be developed with admission.	nsive Person-Centered Care e Care Plans facility must develop and ne care plan for each resident structions needed to provide n-centered care of the resident nal standards of quality care.			

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	•	
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{F 655}	including, but not li (A) Initial goals bas (B) Physician orde (C) Dietary orders. (D) Therapy service (E) Social services (F) PASARR recor §483.21(a)(2) The comprehensive ca care plan if the cor (i) Is developed w admission. (ii) Meets the requ (b) of this section (this section). §483.21(a)(3) The resident and their of the baseline car limited to: (i) The initial goals (ii) A summary of dietary instructions (iii) Any services a administered by th on behalf of the fac (iv) Any updated ir of the comprehens This REQUIREME by: Based on observa review, the facility plan was develope hours of admission	erly care for a resident mited to- sed on admission orders. rs. es. inmendation, if applicable. facility may develop a re plan in place of the baseline mprehensive care plantithin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of a facility must provide the representative with a summary e plan that includes but is not as of the resident. It is of the resident. It is of the resident to be a facility and personnel acting	{F 65	This Plan of Correction con written allegation of complia deficiencies cited. However of this Plan of Correction is admission that a deficiency one was cited correctly. The Correction is submitted to me the correction of the correction is admission that a deficiency one was cited correctly. The correction is submitted to me the correction of the correc	nce for the , submission not an exists or that is Plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245052	B. WING	_			R 01/ 2018
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MOORHEAD REHABILITATION	& HEALTHCARE CENTER			310 SECOND AVENUE NORTH OORHEAD, MN 56560		
PREFIX (EACH DEFICIENCY	FEMENT 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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
diagnoses including (HTN), hyperlipidem schizophrenia, majo myalgia, Gastro-Esc and weakness, acco admission record fo R306's admission condentified the following *R306 was at risk for fall related injuriest encourage and remit for assistance, main be well lit and free of prevent slipping. * R306 likes to visit attend some groups independence. R300 entertainment/social in the dining room at Interventions included activities such as bit and men's group. Have the friendly social and liter is R306's care plan land quality of life and quality	on 5/24/18, with multiple type II diabetes, hypertension nia, gout, insomnia, or depressive disorder, ophageal reflux (GERD), pain ording to the undated facility rm. are plan dated 5/29/18, ng: or falls, with a goal to be free s. Interventions included: ind R306 to use the call light niain R306's environment to of clutter, non-skid foot wear to and be around others. He will as well as enjoy his 6's goal to attend bingo and I gatherings. He will eat meals nd socialize with others. ed: invite R306 to scheduled ngo, entertainment, socials, e likes a variety of shows on ikes country music. He is kes to visit. acked all other areas of	{F 65	55}	requirements established by state as federal law. 1.It is the policy of this facility to probase line plans. R306, R503, and did not have base line care plans completed as required within 48 ho admission. The survey noted the lainformation and it was apparent stastill not familiar with the form nor the policy of base line care plans nor woresponsible for gathering the data in to formulate care plan for resident. base line care plan has been revise corrected and staff have copy in admission packet and are educated expectations of nurse admitting pactomplete the base line care plan. 2. Because all residents have changlevels of care upon admission all as potentially affected by the cited defined on 7/2/2018, the MDS nurse review process of ensuring baseline care plans are followed up within 48 hours and brought to IDT for team review while in chart and one given to resident. Process will be reviewed with all flourses and admission team as well ensure staff understand expectation other resident care plans have bee reviewed and updated for accuracy nurse has been educated on necessimplementing base line care plans importance of discussing with reside POA. The policy on base line care has been reviewed and updated. 3. To enhance currently compliant operations and under the direction director of nurses, on 7/12/2018 all nursing staff received in-service training	ovide R501 urs of ck of iff were e ho is needed The ed and d on tient to ging re iciency, yed blans ble copy The or I to ns. All n MDS ssity of and lent or plans of the	

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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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{F 655}	(DON) verified R30 The DON indicated responsible to compesidents. The DOD admission the care standup meeting, a (minimum data set with the resident airesidents chart. Aft and paper chart, the have a base line care of the completed the compession. The MI (baseline) care plan on the floor at the treviewed R306's poline care plan was indicated she would nurse as to why the plan completed for On 5/30/18, at 3:12 (LPN)-C described admissions. LPN-C plan was not part on nurse and was the managers.	B p.m. the director of nursing 26 was admitted on 5/24/18. If the floor nurse on duty was plete the paperwork for new 3N indicated the day following a plan is reviewed at the and then is given to the MDSC coordinator) nurse to review it and then place it into the are review of R306's electronic are plan. B p.m. the MDSC indicated she aprehensive assessments for idents within 13 days of DSC indicated the 48 hour in was completed by the nurse ime of admission. The MDSC aper chart and verified a base not in the chart. The MDSC dineed to check with the floor are was not a base line care R306. Dep.m. licensed practical nurse her responsibilities with new condicated the base line care for the duties as the admitting responsibility of the clinical	{F 65	regarding base line care plans training emphasized the impormonitoring ADL's, and treatmer information on care sheet followactual care performed. MDS in visualize residents and ask stainterview to confirm data. The includes development of care assessment of resident individing The residents will also incorposimportance of reviewing base plan with residents. 4. Effective 7/16/2018, a quality program was implemented und supervision of the MDS and D monitor residents MDS and erroresentative will perform the systematic audity-assurance representative will perform the systematic audits of assessment formulating base line care plans. They will be complemented and care plans. They will be complemented and care plans. They will be complemented and submate in this area. Any different will be documented and submate monthly quality-assurance commetting for further review or caction. 5.MDS nurse will be responsible POC.	tance of ent was the urse to aff through education plan after ual needs. rate line care y-assurance der the ON to asure data os nurse or following ents a based on all base line eted by x 4 weeks a to ensure eficiencies and the ce checks atted at the nmittee orrective	
		record form identified R503 e facility on 5/23/18. R503's				

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{F 655}	chronic obstructive hypertension (HTN) (CHF). Review of R503's e medical record laciline care plan. Review of R503's c initiated on 5/25/18 focus identifying R5 groups may be a ware the goal indicated young men's lunch, and socialize aroun instructed staff to in activities such as the care plan lacked all and quality of care. Review of 503's proof a base line care of a base line care. On 5/30/18, at 4:04 indicated the registra admission paperwork indicated she believ (DON) completed the RN-A and surveyor and electronic chardid not have a base. On 5/31/18, at 1:30 had spoken to him specific goals for care.	on included diagnoses of pulmonary disease (COPD), and congestive heart failure dectronic and hard copy ked documentation of a base are plan identified one area. The care plan included a so3 was quite independent, but ay for him to meet people. R503 would attend bingo, and possibly chapel service, defined the resident to scheduled lose listed in his goals. The other areas of quality of life agress notes lacked evidence plan completion. p.m. registered nurse (RN)-A ered nurses completed rk for new residents. RN-A ared the director of nursing the care plans for all residents. reviewed R503's paper chart and RN-A confirmed R503	F 65	55}			

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{F 655}	was admitted on 5/facility practice was address the base li complete the form, base line care plan the chart. DON induction be for the base line the nurse who adm	p.m. DON confirmed R503 23/18. DON stated the usual for the admitting nurse to ne care plan with the resident, then provide a copy of the to the resident and place it in licated her expectation would care plan to be completed by	{F 65	5}		
	R501's Admission I indicated R501 was 5/27/18. R501's dia bilateral artificial kn depressive disorde Review of R501's emedical record lack Review of R501's cinitiated on 5/30/18 focus identifying R with family and som goal for R501 was flunch, socials and ractivities. Interventi R501 to scheduled	ed a baseline care plan. are plan identified one area The care plan included a for like independent activities are group activities as well. The attend bingo, young ladies maintain her independent ons instructed staff to invite activities as outlined in the lacked all other areas of				

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{F 655}	evidence of comple Review of facility fo 5/29/18, indicated F assistance with acti wore glasses, requi belt for transfers, us regular diet, require hours. The form indoriented, could dire- care and was weigh On 5/30/18, at 3:25	rogress notes lacked tion of a baseline care plan. rm titled Group 3, updated R501 required extensive vities of daily living (ADLs), red assist of one with transfer sed a wheelchair, had a d repositioning every two licated R501 was alert and ct own cares, required Polar at bearing as tolerated. p.m. nursing assistant (NA)-E	{F 65	55}				
	staff would ask the NA-E stated if a residays then they would on 5/30/18, at 3:38 stated when a residadmitting nurse work assessment and re NA verbally. RN-B is started at a later timplans existed. RN-E and confirmed no bis stated all care plans knew. On 5/30/18, at 3:45 stated paper baseling the minimum data is nursing staff. On 5/30/18, at 3:50 care plan, or baseling the minimum data is nursing staff.	was new to the facility, then nurse for care instructions. ident had been here for a few ld look at the care sheet. B p.m. registered nurse (RN)-B ent was admitted, the uld complete an admission lay any care instruction to the stated a care plan would be ne and that no paper care B reviewed R501's paper chart aseline care plan. RN-B again are electronic as far as she p.m. social worker (SW) ne care plans are given out by set coordinator (MDSC) to the p.m. MDSC stated a 48 hour ne care plan, would be kept in it was a paper form. MDSC						

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{F 655}	care plan and retucare plan would the interdisciplinary testand up. We then resident, and if the be filled in the charpaper chart and cocare plan. On 5/30/18, at 3:5 (DON) stated the atthe baseline care plan. On 5/30/18, at 3:5 (DON) stated the atthe baseline care plan to the restriction of the resident of the mass of the mass of the mass of the mass of the complete of the mass of the fact of the	In grants completed the baseline rns it to MDSC. The baseline en be discussed at an am (IDT) meeting, or morning a would go over it with the ey are agreeable with it, it would ent. MDSC reviewed R501's confirmed there was no baseline admitting nurse would fill out colan and then send to MDSC. Then bring the care plan to IDT the resident's care. After the CC would bring the baseline sident to discuss it and have reviewed R501's paper chart baseline care plan was present. Ould expect the baseline care etc. 5 p.m. R501 stated she collistify on 5/27/18. R501 indicated in to her about a baseline care are goals for her care. R501 was meeting with her now, to in paperwork. ity baseline CP (care plan) d, provided by the facility was	{F 65	5}		

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{F 655} {F 656} SS=D	and the original to b	or POA (power of attorney) be put in the resident's chart. Comprehensive Care Plan	{F 6			7/23/18
	§483.21(b) Compre §483.21(b)(1) The fimplement a compression care plan for each resident rights set fo §483.10(c)(3), that objectives and time medical, nursing, an needs that are ident assessment. The codescribe the following (i) The services that or maintain the resident physical, mental, arrequired under §483 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclute at ment under §483.10, inclute at me	hensive Care Plans acility must develop and ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive emprehensive care plan must are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and the would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse 33.10(c)(6). services or specialized es the nursing facility will of PASARR aff a facility disagrees with the ARR, it must indicate its dent's medical record.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	245052	B. WING _		R 06/01/20 °	18
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/01/20	
			2810 SECOND AVENUE NORTH		
MOORHEAD REHABILITATION &	HEALTHCARE CENTER		MOORHEAD, MN 56560		
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local contact agencies entities, for this purpos (C) Discharge plans in plan, as appropriate, in requirements set forth section. This REQUIREMENT by: Based on observation, review the facility failed comprehensive care pl dialysis for 1 of 1 reside dialysis services and for reviewed for tracheoste hole (stoma) in your win provides an alternative Findings include: On 5/31/18, at 8:03 a.m morning cares. R410 renursing assistant (NA)-dress. R410 was observenous catheter (a cenvein) on his upper left of R410's care area asset/26/18, identified R410 included diabetes, stag received renal dialysis. R410 was alert and orie bilateral lower extremity extensive assistance where with a mechan R410's physician visit of	sed and any referrals to and/or other appropriate e. the comprehensive care accordance with the in paragraph (c) of this is not met as evidenced, interview and document to ensure a lan was developed for ent (R410) who received or 1 of 1 resident (R107) omy (a surgically created indpipe (trachea) that airway for breathing) care. In. R410 was observed with eceived assistance from F and NA-G to wash and rived to have a central interal line placed in a large chest. The CAA further identified entated X (times) 4, had y amputations, required with dressing, grooming and total staff assistance to	{F 65	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility to proconsistent quality care to ensure rehave comprehensive care plans. It was noted to have central line and dialysis however the care plan did address these issues nor did the casheets, so staff were aware how to monitor IV site or provide cares. But a trach and the care plan did not act the trach, the expectations of care and during care it was noted the staneeded further education on trach on this case, after the survey detern these residents care plans were mit important information, both were reand updated including care sheets staff. Staff education on trach cares also provided. 2. Because all residents are have changing levels of care all are pote affected by the cited deficiency, on	the ssion or that of and ovide sidents 410 need not are 07 had ddress to trach aff cares. nined ssing vised for s was	

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{F 656}	had an alteration in hemodialysis, 1 X short term complice impaired renal functions as ordered and terms of infect R410's care plan limedications as ordered and terms of the condition weekly be moisturizer as need consult as ordered and tritional, social secondary in place, and or care of the catheflushing of cathete and covering site was care plan lacked of follow if catheter sides or signs of infections that in case of a dialysis catheter sidentified R410 red with ADLs (activities assistance of two sutilized a power whorientated, directed stocking for the low	revised 4/26/18, identified R410 in kidney function evidenced by a week, with a goal to reduce ations associated with cition and will have no signs or tion or bleeding at fistula site. It is sted interventions to administer dered collaborating with the harmacist for optimal mes, assessment of skin y licensed nurse, apply skin ded for dry, itchy skin and to by Physician (nephrology, ervices). In the process of the process	{F 65	56}	7/2/2018, the MDS nurse reviewed process of ensuring accurate MDS formulate comprehensive care plar other resident care plans have bee reviewed and updated for accuracy MDS nurse is aware of how to prop document on CAA's as well as ensure assessments completed during loo period are completed, and correct information is gathered, and all aspecare is care planned appropriately. 3. To enhance currently compliant operations and under the direction director of nurses, on 7/12/2018 all nursing staff received in-service tracegarding patients with dialysis and to ensure they are understanding to resident needs, cares and how to pussic checks to ensure trach site a sites are clean dry and intact and with doing the service of	is to ins. All in in, and iv, and iverly ine all ik back bects of of the ining it trachs of trachs of the ining it trachs of the ining i	

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{F 656}	dialysis needs or the On 5/31/18, at 8:20 indicated R410's constant gave sponge indicated the nurse regarding the cath. On 5/31/18, at 2:20 catheter in his upper dialysis. R410 indicated he however, was not eat extra protein. On 6/1/18, at 12:00 (DON) verified R41 The DON indicated was all inclusive for care. With review of verified R410's care garding dialysis of emergency contact.	not direct care pertaining to the dialysis catheter site. O nursing assistant (NA)-F atheter was not to get wet and baths as R410 allowed. NA-F as managed all other care eter site. 4 p.m. R 410 stated the er left chest area was used for cated he chose to receive bed catheter could not get wet. was not restricted on fluids; to add salt to things and was to the computerized care plan or R410's daily and dialysis of the care plan the DON re plan was not comprehensive care, did not include specifics dialysis care, catheter or ts.	{F 656	so an accurate care plan is de based on the resident specific ex. Trach care, hospice, dialys deficiencies will be corrected of and the findings of the quality-checks will be documented and at the monthly quality-assurance committee meeting for further corrective action. 5.MDS nurse will be responsib POC.	care areas, is. Any n the spot, assurance d submitted ce review or	
	dated 2/20/18, indi was not completed which included atte attention artificial of	Minimum Data Set (MDS) cated a cognition assessment d, and R107 had diagnoses ention to tracheostomy, opening of digestive tract, and indicated R107 required				

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{F 656}	which he required to indicated the use of and suctioning. R107's quarterly Mindependent cognition making and diagnor cell carcinoma of spain, attention to transport to the MDS indicated R10 with eating, extensionand hygiene, limite was independent with MDS further indicated suctioning. R107's Care Area A 2/28/18, indicated I place due to oral place d	ce for all cares except eating, total care. R107's MDS further of oxygen, tracheostomy care DS dated 5/1/18, indicated tive skills for daily decision oses which included squamous kin of scalp and neck, chronic acheostomy and anxiety. The D7 required total assistance ive assistance with dressing dassistance with toileting and with all other ADLs. R107's ted tracheostomy care and Assessment (CAA) dated R107 had a tracheostomy in haryngeal cancer. Current care plan last revised at there was no care planed to R107's tracheostomy. Tovided Group 3 care sheets, indicated under "Care Notes" ", but there was no instruction for monitoring. D a.m. R107 was lying on the of bed elevated. R107 was lized medication treatment via R107 had a oral suctioning on the nightstand and had the	{F 65	66}			

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{F 656}	and placed sterile care kit. With steril R107 raise the bed proceeded to sque outer cannula while cannula. With the ifrom it's lock (used place if the resider tried loosening the grabbed the outer each hand and trie could not. LPN-A s R107 tracheostom "maybe I should go do this" and exited LPN-A returned to LPN-B washed her she then held the cand twisted the inner cannula cremoved. LPN-B th finished the trache On 5/31/18, at 2:06 (MDSC) verified she plans at the facility reviewed R107's control the care plan lacked tracheostomy and consider R107's current care care plan lacked in tracheostomy and care plan lacked in tracheostomy and care plan lacked in tracheostomy and consider R107's current care care plan lacked in tracheostomy and	are. LPN-A washed her hands gloves from the tracheostomy e gloves donned, LPN-A had it to working height and eze R107's tracheostomy's e gently pulling at the inner nner cannula not disengaging to keep the inner cannula in it was to cough), LPN-A then Velcro collar. LPN-A again and inner cannulas, one with d to disengage the lock and tated she had not provided y cares prior and stated et someone who knows how to the room. At 11:29 a.m. R107's room with LPN-B. In hands and donned gloves, outer cannula with one hand er cannula with the other and disengaged and was able to be then left the room and LPN-A	{F 6	56}			

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	A facility policy titled Comprehensive, recomprehensive carassessment that indithe MDS; 3. Each replan is designed to: problem areas; b. In associated with ider professional service each element of carecognized standar areas and condition are triggered during evaluated using specific (including Care Areinterventions are acplan interventions are consideration of the resident's problem as Care Plan Timing a CFR(s): 483.21(b)(2) & 483.21(b)(2) A corbection of the comprehensive (ii) Prepared by an includes but is not Includes but is not Includes but is not Includes but is not Includes aid with resident. (C) A nurse aide with resident.	ge 29 d Care Plans - viewed 4/28/18, indicated the e plan is based on a thorough cludes, but is not limited to, esident's comprehensive care a. Incorporate identified incorporate risk factors intified problemsf. Identify the es that are responsible for rei. Reflect currently ds of practice for problem is4. Areas of concern that if the resident assessment are ecific assessment tools a Assessments) before ided to the care plan; 5. Care are designed after careful e relationship between the areas and their causes. Ind Revision (2)(i)-(iii) Enensive Care Plans Emprehensive care plan must in 7 days after completion of assessment. Interdisciplinary team, that imited to- hysician. Is with responsibility for the eth responsibility for the		CROSS-REFERENCED TO THE APPROPED DEFICIENCY) 56}		
	(E) To the extent pr	od and nutrition services staff. acticable, the participation of e resident's representative(s).				

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{F 657}	medical record if the and their resident is care plan (F) Other appropriate disciplines as deter or as requested by (iii) Reviewed and reteam after each as comprehensive and assessments. This REQUIREMED by: Based on observative review, the facility is plan was updated if reviewed for dialysis. Findings include: R37's admission M 4/30/18, indicated is cognition, and had end-stage renal distand malnutrition. To required extensive personal hygiene as independently after R37's MDS further loss, received a medical was receiving dialy was not receiving at R37's Care Area As 5/3/18, indicated R diagnoses of ESRI dependent on renal care in the side of the side o	st be included in a resident's re participation of the resident epresentative is determined the development of the n. The staff or professionals in rmined by the resident's needs the resident. The revised by the interdisciplinary sessment, including both the diguarterly review. Note that the care of the interview and record tailed to ensure that the care or 1 of 3 residents (R37) s. In the interview and record tailed to ensure that the care or 1 of 3 residents (R37) s. In the interview and record tailed to ensure that the care or 1 of 3 residents (R37) s.	F 6	57}	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility to proconsistent quality care to ensure rehave timely up to date care plans. was noted to need dialysis howeve care plan did not address these iss nor did the care sheets. In this case the survey determined the resident plan was missing important informadietary, dialysis, nursing and MDS reviewed information and updated labs and needs accordingly. 2. Because all residents have changlevels of care all are potentially affect the cited deficiency, on 7/2/2018, the nurse reviewed process of ensuring accurate MDS is to formulate accurate.	the ssion or that of and ovide sidents R37 r the ues e, after s care ation, diet, ging ected by the MDS g	

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{F 657}	indicated R37 had had no teeth and t	age 31 R37's nutritional status been eating well since admit, here was no current labs v. However, R37's nutritional	{F 657	care plans. All other resident care have been reviewed and updated accuracy, and MDS nurse is award to properly document on CAA is a	for e of how	
	status lacked infor ESRD or hyperkale dialysis.	mation regarding diagnoses of emia and being dependent on		as ensure all assessments comple during look back period are compl and correct information is gathered all aspects of care is care planned	eted eted, d, and	
	R37 required hemorequired a therape various intervention ordered by the phy and social services monitor any signs (difficulty swallowing supplements as or be provided as need offer healthy snackwork as ordered. Haddress R37's diagonal intervention of the statement of the statem	st revised 5/21/18, indicated odialysis due to ESRD and utic diet. R37's care plan listed as which included: consults as vician (nephrology, nutritional s), diet per physician order, or symptoms of dysphagia ag), provide snacks, diet and dered, nutritional education will eded and at resident request, as and obtain and monitor lab dowever, the care plan did not gnosis of hyperkalemia or what e on hemodialysis.		appropriately. 3.To enhance currently compliant operations and under the direction director of nurses, on 7/12/2018 nr staff received in-service training repatients with dialysis to ensure the understanding to resident needs, a dietary staff to ensure they review specialized diets. Diet slips update dietician and dialysis dietician contall orders. 4.Effective 7/16/2018, a quality-as program was implemented under supervision of the MDS and DON monitor residents MDS and apparent.	ursing garding y are and ed, and eirmed surance the	
	5/4/18 indicated Riwith mechanical so ground or chopped R37's physician or information regard Review of R37's Adated 4/30/18, indiincluding ESRD, hirenal dialysis. The loss, skin was intaked hydration of age edentulous, ate 75	dmission Nutrition Data V2. 1 cated R37 had diagnoses yperkalemia and dependent on form indicated R37 had weight ct, had risk factors for and decreased mobility, was % of meals, had a normal lthough no value was given)		monitor residents MDS and ensure accurate and correct. The MDS in designated quality-assurance representative will perform the following systematic audits of assessments formulating care plan based on incresident needs. They will be comp MDS nurse 4 audits per week x 4 then 2 audit weekly x 2 months to compliance in this area by matching diagnoses with assessments and so an accurate care plan is developased on the resident specific care ex. hospice, dialysis etc. Any deficit will be corrected on the spot, and findings of the quality-assurance of will be documented and submitted	dividual leted by weeks ensure og CAA s ped e areas, iencies he hecks	

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{F 657}	nutrition assessme On 5/31/18, at 8:14 back in bed with his table was next to th Mt. Dew 12 oz cans table. On 6/1/18, at 8:45 a ticket, dated 6/1/18 indicated R37 had mechanical soft an Under "Special Not a note for oatmeal ticket lacked identif ESRD. On 6/1/18, at 9:10 a with dialysis registe should have diet re high protein and lov their manager had because the facility R37's snack while a issue with hyperkal DRN-A stated he w R37's facility packe the hyperkalemia. On 6/1/18, at 9:55 a with dialysis dieticia DD-A stated R37 h level of 6.9 miliequi 3.4 - 5.1) on 5/22/1 R37's facility and u lab and to limit the	nical record revealed no nt since admission on 4/23/18. a.m. R37 was lying on his seyes closed. An over-the-bed he bed that had three opened is and a 2% milk carton on the a.m. R37's dining room tray, was reviewed. The ticket a regular diet which was diregular texture for liquids. es" section of R37's ticket was with Propass x 2 servings. The ication of a therapeutic diet for a.m. during a phone interview wered nurse (DRN)-A stated R37 strictions for dialysis including with potassium. DRN-A stated to call the facility last week was packing two bananas for at dialysis and R37 just had an emia (high potassioum level). The instructed to keep checking dialysis and R37, and a critically high potassium valents per liter (normal range and a critically high potas	{F 65	monthly quality-assurance of meeting for further review of action. 5.MDS nurse will be respon POC.	r corrective	

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{F 657}	level on 5/24/18. Dithe facility to comm low potassium need On 6/1/18, at 10:16 was regular, mechadialysis. CK-C state responsible to pack residents. She state a mechanical soft to sandwich without cleery, apple sauce apple cranberry juic some aids would us bananas or mandar was not aware of R On 6/1/18, at 10:28 stated she was the stated the dialysis of ago and updated he and it was decided orange juice due to day and a couple grated the only way information was to juice" on his tray tic current tray ticket frostated she changed DD-A. She pulled us system MenuMatrix information was adbananas, no orange person responsible CK-A will at times pahead of time and to printed out on ticke	d a critically high potassium D-A stated she would expect unicate the dietary needs of ds of R37 in some manner. cook (CK)-C stated R37's diet anical soft and he required ed dietary staff was a sack lunches for dialysis ed R37 would typically receive urkey, ham, egg or tuna salad heese, lettuce, carrots or and hard boiled eggs with the supplement. CK-C stated se other fruits such as grapes, rin orange. CK-C stated she 37's high potassium levels. a.m. dietary manager (DM)-A dietician called her 2-3 days er about R37's hyperkalemia to eliminate bananas and R37 eating 2-3 bananas a lasses of orange juice. DM-A she communicated that place "No bananas, no orange ket. DM-A reviewed R37's om that days breakfast. DM-A dietiched that place the day she spoke with p the tray ticket computer	{F 6	57}		

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{F 657}	dietician completed assessment. On 6/1/18, at 10:50 responsible for prir resident meals. Cknot be at the facility etc.) that she would time. CK-A stated of Saturday, Sunday print out Tuesdays Tuesday and Thurs Wednesdays. On 6/1/18, at 10:54 (MDSC)-A stated sonutrition assessment was in MDSC-A stated sh R37's, no bananas plan so all staff had On 6/1/18, at 11:09 (DON) stated R37 fistulagram (is a tein your dialysis gramay be causing prohyperkalemia. DOI and confirmed no in hyperkalemia, or the bananas or drink on the state of the	DM-A stated the corporate d R37's admission nutrition D a.m. CK-A confirmed she was ating out the tray tickets for K-A stated at times, if she would y (weekend off, appointments d print out the ticket ahead of on Fridays she would print off and Mondays tickets and then on Monday, Wednesdays on saday and Fridays on A a.m. MDS coordinator the would expect to see a new ent since the new admission on confirmed no new nutrition in R37's clinical record. The would have expected to see or orange juice on the care	{F 6!	57}	DEFICIENCY)		
	admission nutrition completed.	e plan, as well as a new assessment to have been as a.m. nursing assistant (NA)-H					

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{F 686} SS=D	morning and R37 w potassium. On 6/1/18, at 11:40 aware if R37 was to having teeth she sh care plan. NA-F sta education regarding. A facility policy titled Comprehensive, recomprehensive care assessment that ind the MDS; 3. Each replan is designed to: problem areas; b. In associated with iderprofessional service each element of carecognized standar areas and condition are triggered during evaluated using specific luding Care Are interventions are acplan interventions are acplan interventions are consideration of the resident's problem areas and condition of the resident's problem are acplan interventions are acplan interventions. Treatment/Svcs to ICFR(s): 483.25(b) Skin Interventions are acplantation of the resident's problem are acplantation.	R37 had a banana this ras supposed to have extra a.m. NA-F stated she was not a have bananas due to not e would have to check his ted she had not received any gray lately. If Care Plans - viewed 4/28/18, indicated the eplan is based on a thorough cludes, but is not limited to, esident's comprehensive care a. Incorporate identified incorporate risk factors intified problemsf. Identify the est hat are responsible for reci. Reflect currently do of practice for problem is4. Areas of concern that in the resident assessment are exific assessment tools a Assessments) before lided to the care plan; 5. Care re designed after careful erelationship between the areas and their causes. Prevent/Heal Pressure Ulcer 1)(i)(ii)	{F 68	57}		7/23/18
	resident, the facility (i) A resident receiv					

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{F 686}		age 36 nd does not develop pressure ndividual's clinical condition	{F 686	}	
	(ii) A resident with necessary treatme	they were unavoidable; and pressure ulcers receives ent and services, consistent standards of practice, to			
	promote healing, p new ulcers from de This REQUIREME	prevent infection and prevent			
	review, the facility assess and failed to promote healing an resident (R56) revi	ation, interview and document failed to comprehensively to implement interventions to nd prevent worsening for 1 of 2 iewed with current, stage 2		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists of	the ssion or that
	pressure ulcers on Finding include:	left buttocks.		one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law.	
	4/10/18, identified had diagnoses white (paralysis on one shemiparesis (slight side of the body), rechronic kidney dise MDS identified R5 ulcers, but did not healed pressure ultreatments were prechair and bed and	nimum Data Set (MDS) dated R56 was cognitively intact and ich included hemiplegia side of the body) or t paralysis or weakness on one muscle weakness, stage 3 ease and depression. R56's 6 was at risk for pressure currently have one, and had no licers. Skin and ulcer ressure reducing device for application of nonsurgical an to feet. R56's MDS further		1.It is the policy of the facility to pro treatment and services to prevent pressure ulcers. One of the many with this has been achieved for resi #56 is by completing assessments current documentation of wounds to ensure healing appropriately. R56 with noted to have stage 2 pressure are area now developed another area with previous wound now developing intimatage 3. After survey noted the inconsistency in R56 turning and repositioning and resident	vays dent and o vas a and vith
	identified she required bed mobility, trans R56's pressure uld (CAA) dated 2/14/2 problem/need. Pre	ired extensive assistance with fer, toileting and did not walk. cer care area assessment 18, identified R56 had an actual e-populated check marks risk factors included pressure		non-compliance of offloading OT are nursing have changed resident to or repositioning schedule and staff are ensure even while up resident is off either in room or using rail in hallway stand with staff assist. It was also not staff needed education on roho customers.	2h e to floaded ay to noted

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	` /	E SURVEY PLETED
		245052	B. WING			R 01/2018
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	01/2010
				2810 SECOND AVENUE NORTH		
MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER		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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 686}	reduce or relive presidentified altered modiagnoses and compre-populated check hemiplegia/hemiparenal disease, depand other factors in readmitted and fur motion. R56's CAA be addressed in car R56's pressure uld was warranted. R56's care plan rewas at risk for presintegrity, history of decreased mobility completion of Bradassessment) per prot to massage ovencourage regular	al mattress or seat cushion to essure. Intrinsic risk factors nental status and cognitive loss. Inditions identified by the marks included presis, chronic or end-stage ression and pain. Treatments included newly admitted or included newly admitted or included newly admitted or included pressure ulcer will are plan to minimize risks. For CAA indicated no referral vised on 2/21/18, identified R56 issure ulcers due to altered skin pressure ulcers and interventions included len Scale (pressure ulcer risk olicy, weekly skin inspections, er bony prominences and offloading when up for a while	{F 686	staff were educated. Physician has updated and resident skin has be improving. 2.Because all residents have diag which could lead to alteration in sintegrity or due to illness have pot skin breakdown all are potentially by the cited deficiency, wound documentation has been reviewed interventions for prevention are in and documented clearly on care sinterventions for prevention are in and documented clearly on care sinterventions are in and documented clearly on care sinterventions for prevention are in and documented clearly on care sinterventions including reporting of bruises, skin tears, skin breakdow rashes. All current resident with pulcers were assessed for compresion assessment along with appropriation interventions. Implementation of tinterventions is reviewed on round weekly. Staff to alert DON is resident sets of the staff educated.	en inoses kin ential for affected d, place sheets. I, and as noted any m or ressure hensive te hose ds lent d on	
	further instructed s support, pressure and mattress and in assement to be contreatments as order identified she had a to self care impaired limitations to left as Interventions include toileting and transform on 5/30/18, at 12:3 after independently room. R56 indicated hip, and the physical	activities. R56's interventions taff for nutritional and hydration reduction wheelchair cushion referral to therapy. Skin impleted per policy and ired. R56's care plan also ohysical function deficit related ment, ROM (range of motion) im and balance impaired. If ded extensive assistance with er assist of 1 staff and gait belt. If you propelling self from dining the ded sore on her ian had looked at it yesterday, thought it was healing, and		importance of offloading, repositic care plan updated, care sheets up Weekly skin audits completed on day, dietary and therapy involved interventions as needed to those. No other residents were affected. policy on wound care has been re 3. To enhance currently compliant operations and under the direction director of nurses, on 7/12/2018 a received in-service training for moskin and pressure areas, to ensur always use best pressure reduction and understand differences in cus and understand offloading to preve further alterations in skin integrity.	odated. bath in at risk. The viewed. n of the all staff onitoring e staff on tolls shions ent The	

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NAME OF I		243032	B. 1110		-	01/2018
	PROVIDER OR SUPPLIER EAD REHABILITATIO	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH	DE	
				MOORHEAD, MN 56560		
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{F 686}	dressing change. On 5/31/18, at 6:45 her room sitting on shirt, pants and sh (NA)-B was in room morning cares. NA assisted R56 to stawhile holding her h R56 to pull her pana a large 2 x 6 inch to buttocks. The surrocolor. R56's had a relieving cushion w When surveyor put was easily pushed to sit in the w/c, whapplied a jacket an NA-B. NA-B transp the front nursing depropelled herself to R56 remained in the coffee, water and a propelled herself to R56 remained in the coffee, water and a propelled herself to R56 remained in the coffee, water and a propelled herself to the activity room w At 7:47 a.m. R56 b her room, when sh member if she war R56 returned to he teeth independently refilled a bag on he her bedside table to the dining room. Froom table by the voling a word search 9:52 a.m. when children is shown and search 9:52 a.m. when children is shown and search 9:52 a.m. when children is shown as a search of the	age 38 or surveyor to view during of a.m. R56 was observed in the edge of the bed with her loes on. Nursing assistant in and assisted her with A-B applied a gait belt and and then walk to the bathroom, emi walker. NA-B assisted its down and revealed R56 had an dressing in place on her left ounding skin was normal in Roho cushion (pressure ith air cells) in her wheelchair. There hand on the cushion, it down flat. NA-B assisted R56 ere R56 combed her hair and discarf with assistance from corted her in her wheelchair to esk near the dining room. R56 of the dining room at 7:10 a.m., the dining room at 7:40 a.m. to here she read the newspaper, egan to propel herself back to be was asked by a staff at the dining with she agreed. The room where she brushed her year the sink. At 7:58 a.m. R56 are wheelchair with candy from then propelled herself back to the sink. At 7:58 a.m. R56 are wheelchair with candy from then propelled herself back to the sink. At 7:58 a.m. R56 are wheelchair with candy from then propelled herself back to the sink. At 7:58 a.m. R56 are wheelchair with candy from then propelled herself back to the sink. At 7:58 a.m. R56 are wheelchair with candy from then propelled herself back to the sook from 8:01 a.m. until the book from 8:01 a.m. until the service began.	{F 68	following all interventions for maintenance and reporting of skin conditions. Education do importance of comprehensive assessment of skin, pressure implementation of appropriate interventions. 4. Effective 7/16/2018, a quality program was implemented us supervision of the director of monitor residents with impair integrity and updating MD, far plans with any changes to enappropriate follow through. To finurses or designated quality representative will perform the systematic changes: the DOI will ensure audits on all residing pressure ulcers and those at diagnosis, Braden or CAA trigically a weeks then on 6 resident 4 weeks to ensure compliance residents weekly x 2 months. In deficiencies will be corrected and the findings of the quality checks will be documented at the monthly quality-assural committee meeting for further corrective action. DON will be responsible for the corrective action.	f changes in one on e e ulcers and e e ity-assurance nder the nurses to red skin mily and care isure. The director ity-assurance e following N or designee ents with risk per gger weekly s weekly for ce than 2. Any on the spot, y-assurance and submitted nce er review or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245052	B. WING			R / 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ZIP CODE	/01/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
{F 686}	the day, did word so active room. NA-B express her needs would put her call libathroom. NA-B in bathroom about twi usually reminded R around lunch time to indicated she was a bottom. NA-B indicated she was a bottom. NA-B indicated she the last survey. NA-B indicated she the last survey. NA-B indicated she was a bottom. When survey related to pressure discussed reposition R56's repositioning be checked every a nursing assistant care.	g out in the dining room during earch books and went to the indicated R56 was able to by going back to her room and ght on if she wanted to use the dicated she took R56 to the ce a day, and indicated she 56 to use the bathroom o see if she would go. NA-B aware R56 had a sore on her eated as nursing assistants hing with resident cushions. It was provided education after the deficiencies and reviewed yor asked her about education ulcers, she indicated they ning. When asked about thours and confirmed her are sheet instructed 1 staff to ery 2 hours), resident can state	{F 6	36}		
	room at the same sof the window. R56 dining room for the leave during it. At director of nursing repositioned since would assist R56, a permission, for repwound assessment agreed and left the On 5/31/18, at 11:0 (OT)-A indicated R5	ositioning and complete her and dressing change. R56				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUAND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			COM	TE SURVEY MPLETED		
		245052	B. WING _			R / 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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) COMPLETION DATE
{F 686}	was using a low proinches. OT-A joine indicated she had joushion yesterday indicated she had ositting on it. OT-A icushion to assure irout of the wheelchars and she confirment of the wheelchars and she could repositioned every taught R56 repositioned every taught R56 repositioned and the hallway, put her unable to pull herse propelling herself to right arm to pull on the hall. OT-A indice (registered nurse) update the nursing to be repositioned of informed in a return appropriate because On 5/31/18, at 11:1 entered R56's roon gait belt to transfer to the bathroom with checked R56's Rohand confirmed it was the cushion using a R56 to remove her was normal color a dressing was remoon (damaged, abraded).	r wheelchair prior, but now offile Roho cushion that was 2 d R56 in the hallway and she ust checked R56's Roho to assure it was full, but checked it while R56 was indicated she would check the towas inflated when R56 got air. DON also in hallway near med R56 should be 2 hours. OT-A indicated she oning techniques, and taught it rails in the hallway for instructed R56 to show surveyor osition herself with the rails. The understand the properties of the properties of the hand rail in the hand on the rail, but was self up. R56 then began owards her room using her the handrail as she went down cated she had requested RN Director of Quality (RDQ) to assistant care sheets for R56 every 2 hours, but was in e-mail that it was not	{F 686	6}		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
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{F 686}	drainage. R56 had one in the center of DON indicated had areas measured 1 of area, and applied a (foam dressing for Meview of R56's tree (TAR) identified a tile was completed on Ulcer precaution even Ulcer precaution eve	scant amount of red three superficial open areas, the excoriated area, which bled, and two below this. All cm by 0.5 cm. DON cleansed 4 inch by 4 inch Mepilex wounds) to the area. atment administration record saue tolerance assessment 5/10/18, and 5/28/18. Pressure ery shift began on 5/29/18. 0 a.m. DON and surveyor ctronic record. DON and indicated they 5/10/18, and 5/28/18, but she e them. DON indicated the ewas to complete them in crecord. DON confirmed R56 e tolerance completed. DON ency of R56's repositioning termined by the the tissue N indicated she would expect oned every 2 hours, her Roho and the tissue tolerance completed. rsing assistant care sheet, r R56 identified; skin, 1 assist can state need and care notes stated, resident able to direct and elevated; lotion at hand sident repo (reposition) PRN	{F 68	36}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION JING	(X	3) DATE SURVEY COMPLETED
		245052	B. WING			R 06/01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZII 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	P CODE	00/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIA	
{F 686}	Pressure Sore Risk score of 16, low risl Review of R56's we 5/30/18 identified th -5/2/18, skin dry, or open 2 X 1 cm, me monitor. Site: left gl X 1 cm5/9/18, skin dry, or open 2 X 1 cm, me monitor. Site: left gl X 1 cm5/16/18, skin dry, or open 2 X 1 cm, me monitor. Site: left gl X 1 cm5/16/18, skin dry, or open 2 X 1 cm, me tissue color pink an monitor. Site: left gl X 1 cm5/23/18, open area left buttocks. No further the series of R56's W Multiple weeks-V 4 identified the follow -5/4/18, Wound ide vascular 2 length, 1 wound type; pressur completed, granula defined, current trea (left) buttocks q (ev	aden Scale for Predicting a dated 5/4/18, identified a k. bekly skin review 5/1/18, to be following; ben area, left buttock check pilex in place, will continue to uteal fold, existing open are 2 ben area, left buttock cheek pilex in place, will continue to uteal fold, existing open are 2 ben area, left buttock cheek pilex in place, will continue to uteal fold, existing open are 2 ben area, left buttock cheek pilex in place, almost resolved d part scab, will continue to pluteal fold, existing open are 2 a, resident has an open area to out ther description. ound Evaluation Flow Sheet, from 5/4/18, to 5/22/18		86}		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER			28	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH OORHEAD, MN 56560	1 00/	01/2010
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{F 686}	cushion. Wound h change to care pla -5/12/18, Wound e cm: 108 (probable depth in cm: 0.2, S 0, 100% granulatio treatment; change (every) 3 days and treatment ordered interventions: pres: w/c cushion. No creviewed, wound h -5/22/18, Wound e 1.8, width in cm: 1, exudate, pain scale periwound not deschange mepilex to days and PRN, curpressure redistribute debridement, care not healed. -5/22/18, Wound e 0.5, width in cm: 0. exudate, pain scale margins defined, cmepilex to L) (left) PRN if soiled or fal 12/7/18, current propressure redistribute debridement, care had not healed.	tion mattress, w/c (wheelchair) ad not been debrided and n was reviewed. valuation week 2: length in clerical error), width in cm: 1, tage II, no exudate, Pain scale n, periwound defined, current mepilex to L) (left) buttocks q PRN if soiled or falls off, date 12/7/17. Current preventative sure redistribution mattress, debridement, care plan	{F 6	36}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
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{F 686}	and plan of treatme pressure ulcer of le 5/2/18, revealed the 5/2/18, revealed the -Short term goals in increase ability to rewheelchair with supfor schedule/form, to demonstrate succeseating systems as maintenance/improwound 2 X 1 X 0.2 integrity mgmt. (mademonstrate ability mgmt schedule/ada supervision and 25 of skin integrity con-Long term goals listed demonstrate ability incontinent mgmt to maintain/improve strequired. -Pt/caregiver goals; pressure ulcer, heafunction in SNF (skin evidenced by support on set. -Patient/Caregiver potentials.	essment. ccupational therapy evaluation ont, dated 5/21/18, identified ft buttock stage 2 onset of e following: ccluded: pt (patient)/staff to elieve pressure while seated in pervised and 25% verbal cues arget date 6/3/18. Pt/staff will seful use of new/adapted indicated by verment of L (left) buttocks mc day of eval, for skin nagement). Pt/staff will to manage incontinence apted methods with % cues to prevent worsening cerns. Sted included; Pt/staff will to manage pressure relief and echniques/equipment to kin integrity with no cues prevent worsening of I if possible, and maximize illed nursing facility). tes good rehab potential as preticipated in establishing participated in establishing	{F 68	36}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
{F 686}	years. -cognition; follows to (assistance); safety learning capacity = -Summary of evaluations and psych summary also identions and/or particular properties of the company of the compa	wo-step w/o (without) (A) wo-step w/o (without) (A) wavereness = impaired, new impaired. ation identified physical, nosocial deficits. The tified impairments in mobility abits, which resulted in articipation restrictions. cumentation 5/21/18, to he following; diareas of deficit and ents to positioning. Educated rocess and goals. ted narrower wheelchair to dialow profile Roho cushion Fixed broken left elevating diacomfort and visibly was not sessment. 66 in incontinence prevention schedule and use of call light to kin integrity. Educated R56 on night and R56 reported lieducation. Trained patient in ques and w/c pull-ups using pressure relief. R56 required disconsideration of the pressure relief. R56 required	{F 68	36}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245052	B. WING				R 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE
{F 686}	indicated understood on in report that day staff to use or alert. Review of R56's ord 5/29/18, included on change mepilex to if soiled or falls off, every 3 days, for word word and a staff to use or alert. OT clarification, even X in 30 days for word their act. one time a 5/21/18. -Weekly skin check every Wed, order downward was requested. On 5/31/18, at 1:41 completed assessin DON indicated R56 the excoriation and DON confirmed R5 areas to her buttood not completed a conformed R56's pressure ulcoordered an air pression pressure relief. Sure if R56 currently relieving mattress of and report if it was.	nd cares to desired level. NA and Roho cares and would pass y. Pump left in R56's room for therapy with questions. der summary report signed orders: L) buttocks q 3 days and PRN as needed, every day shift bund care, order date 12/6/17. al (evaluate) and tx (treat) 10 mgmt, self care training, and a day until 6/24/18, order state (Wed PM) every evening shift ate 7/14/17. cautions, order date 5/29/18.	{F 68	36}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING				R 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		00/	31/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
{F 686}	primary physician hulcer on 5/29/19. Iulcer began on 5/4/R56 would need as reposition herself, a was needed to lift hand herself updated sheets on 5/25/18. considered a part of the considered and the consider	ved. DON confirmed R56's ad examined R56's pressure DON indicated R56's pressure 18. DON indicated she felt sistance to off load and and confirmed staff assistance er up. DON indicated RDQ of the nursing assistant care DON confirmed they were f R56's care plan. p.m. a voice message was by physician, but a return received. Dought and audits for R56 on the received. Dought are the received and also rinitiate tissue tolerance and also rinitiate tissue tolerance and re-evaluation of turning and also rinitiate tissue tolerance and research and comprehensive and ment sheet. Procedure for	{F 68	36}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		R 06/01/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLÉTIO	NC
{F 698}	bed and wheelcha The policy also ins	re pressure reducing devises in r sitting surface as ordered. tructed in bold lettering to ducation to all staff on pressure	{F 68		7/23/18	
SS=D	S483.25(I) Dialysis The facility must errequire dialysis recomprehensive pethe residents' goals. This REQUIREMED by: Based on observative review, the facility of care and common hyperkalemia (high and nutritional inte (R37) receiving he Findings include: R37's admission M4/30/18, indicated cognition, and had end-stage renal dialend and malnutrition. Trequired extensive personal hygiene as independently afte R37's MDS further loss, received a metallity must be supposed to the same and the same a	nsure that residents who eive such services, consistent tandards of practice, the rson-centered care plan, and is and preferences. NT is not met as evidenced tion, interview and document failed to to ensure coordination funcation related to a potassium levels in the blood) rventions for 1 of 3 residents modialysis. In the moderately impaired diagnoses which included sease (ESRD), hyperkalemia the MDS indicated R37 assistance for dressing, and toilet use, but could eat reset up assistance from staff. Indicated no weight gain or echanically altered diet and resis. R37's MDS indicated he		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. It is the policy of the facility to prodialysis care to all residents based appropriate diagnosis and assess R37 was noted to have hyperkalen no specific dialysis diet. According plan, nutritional assessment and stresident had no interventions in plathe appropriate diet had not been determined based on dialysis diagnosis company noted high potassium and yet resident still got bananas. The diet slip had been che to state no bananas and no orange.	r the ission or that of and ovide on ment. nia and to care taff the ace and nosis.	

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
{F 698}	R37's Care Area A 5/3/18, indicated F diagnoses of ESR dependent on rena The CAA indicated resistive to cares. indicated R37 had had no teeth and t available for review status lacked infor ESRD or hyperkaldialysis. R37's care plan laterage various intervention ordered by the phy and social services monitor any signs (difficulty swallowing supplements as on be provided as neroffer healthy snack work as ordered. Haddress R37's diagnods to avoid while Review of R37's signound or chopped R37's physician or information regard. Review of R37's A dated 4/30/18, indiculding ESRD, his including ESRD, his care and so signound regard.	Assessment (CAA) dated R37 was admitted with D and dementia and was all dialysis three times per week. If R37 was forgetful and at times R37's nutritional status been eating well since admit, here was no current labs w. However, R37's nutritional mation regarding diagnoses of emia and being dependent on st revised 5/21/18, indicated odialysis due to ESRD and rutic diet. R37's care plan listed ns which included: consults as vician (nephrology, nutritional s), diet per physician order, or symptoms of dysphagiang), provide snacks, diet and redered, nutritional education will eded and at resident request, as and obtain and monitor labellowever, the care plan did not gnosis of hyperkalemia or what le on hemodialysis.	{F 69	a new nutritional asse been completed. Whe was reviewed it was n were in chart either. A ordered, the nutritional revised, diet reviewed updated. Staff educate 2.Because many resides restrictions related to diagnosis, many are posted to diagnosis, many are posted to end diagnosis, many are posted to end diagnosis, many are posted to end diagnosis and ensured matched and staff were updated, diet che diets were updated, diet che diets were posted to end appropriate lunches. If were affected. The posted to end appropriate lunches and under director of nurses, on (nursing and dietary) vin-service training more describing diets based training emphasizes the following a plan of car diagnosis, and approp 4.Effective 7/16/2018, program was implementations. Dietician wassessments monthly	en the information of the noted no recent labs potassium was a lassessment, and care plan ed on renal diets. Idents are on care needs and of tentially affected a Dietician reviewed alysis team the tresident should esis and instructed eets and entered in All current residents dialysis were a information re aware. Diet slips of the residents licy on hemodialysis insure staff pack sho other residents licy on hemodialysis by compliant the direction of the 7/12/2018 all staff will receive nitoring diets and don diagnoses. The ne importance of e, reviewing or a quality-assurance ented under the ician to monitor tion to their vill review nutritional	

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TO WILL OF THE VIBER OF COURT EIGHT			2810 SECOND AVENUE NORTH	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
MOORHEAD REHABILITATION & HE	ALTHCARE CENTER		MOORHEAD, MN 56560		
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(F 698) Continued From page 50 loss, skin was intact, had dehydration of age and de edentulous, ate 75% of m potassium level (although and refer to nutrition assessment since the continuation of the potassium level (although and refer to nutrition assessment since the page of the potassium level (although and refer to nutrition assessment since the page of the potassium level (although and refer to nutrition assessment since the page of the potassium level (although and refer to nutrition assessment since the page of the potassium level (although and refer to nutrition assessment since the page of t	ecreased mobility, was eals, had a normal no value was given) ssment. ecord revealed no e admission on 4/23/18. R37 was lying on his closed. An over-the-bed that had three opened a 2% milk carton on the 37's dining room tray eviewed. The ticket ar diet which was ar texture for liquids. Ction of R37's ticket was opass x 2 servings. The of a therapeutic diet for uring a phone interview rse (DRN)-A stated R37 ns for dialysis including sium. DRN-A stated the facility last week acking two bananas for sis and R37 just had an high potassium level). ructed to keep checking eks for bananas due to uring a phone interview	{F 69	monitor and update intervent Dietician will contact dialysis review labs monthly and as redietician or designated qualit representative will perform the systematic changes: audit 2 3 weeks than 1 resident for 5 ensure appropriate diet is give dialysis center has made not changes, that lunches are applied and resident not in complexity will be reviewed weeks by dietician with dialysing no other concerns or issues non-compliance then monthly next 2 months. Any deficient corrected on the spot, and the quality-assurance checks documented and submitted applied quality-assurance committee further review or corrective a 5. Dietician will be responsible POC.	center and needed. The cy-assurance ine following residents for the dietary oppropriate fooliance with d weekly for sis to ensure arise due to be follow up to be significant of the meeting for the meeting for the meeting for the sistematical for the meeting for the meeting for the sistematical forms.	r r 3 e or f

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{F 698}	3.4 - 5.1) on 5/22/18 R37's facility and up lab and to limit the a oranges/orange juic stated R37 also had level on 5/24/18. Di the facility to comm low potassium need On 6/1/18, at 10:16 was regular, mecha dialysis. CK-C state responsible to pack residents. She state a mechanical soft to sandwich without cl celery, apple sauce apple cranberry juic some aids would us bananas or mandar was not aware of R On 6/1/18, at 10:28 stated she was the stated the dialysis of ago and updated he and it was decided orange juice due to day and a couple gi stated the only way information was to juice" on his tray tic current tray ticket for stated she changed DD-A. She pulled u system MenuMatrix information was add	valents per liter (normal range B. DD-A stated she called odated a staff RN on the high amount of bananas and ce R37 consumed. DD-A d a critically high potassium D-A stated she would expect unicate the dietary needs of ds of R37 in some manner. cook (CK)-C stated R37's diet unical soft and he required dietary staff was sack lunches for dialysis ed R37 would typically receive urkey, ham, egg or tuna salad neese, lettuce, carrots or and hard boiled eggs with the supplement. CK-C stated se other fruits such as grapes, in orange. CK-C stated she 37's high potassium levels. a.m. dietary manager (DM)-A dietician called her 2-3 days er about R37's hyperkalemia to eliminate bananas and R37 eating 2-3 bananas a asses of orange juice. DM-A she communicated that blace "No bananas, no orange ket. DM-A reviewed R37's om that days breakfast. DM-A it the day she spoke with p the tray ticket computer	{F 69	98}			

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{F 698}	CK-A will at times ahead of time and printed out on tick information should care plan as well. dietician complete assessment. On 6/1/18, at 10:5 responsible for pri resident meals. Ch not be at the facilit etc.) that she wout time. CK-A stated Saturday, Sunday print out Tuesdays Tuesday and Thur Wednesdays. On 6/1/18, at 10:5 (MDSC)-A stated sh nutrition assessment was in MDSC-A stated sh R37's, no bananas plan so all staff ha On 6/1/18, at 11:0 (DON) stated R37 fistulagram (is a trin your dialysis gramay be causing proper hyperkalemia. DO and confirmed no hyperkalemia, or tibananas or drink of the care in your dialysis gramay be causing proper the care in	e for printing off the tray tickets print the tickets out a few days the new order has not been ets yet. DM-A stated the I have been added to R37's DM-A stated the corporate d R37's admission nutrition O a.m. CK-A confirmed she was nting out the tray tickets for K-A stated at times, if she would y (weekend off, appointments Id print out the ticket ahead of on Fridays she would print off and Mondays tickets and then on Monday, Wednesdays on sday and Fridays on 4 a.m. MDS coordinator she would expect to see a new ent since the new admission on confirmed no new nutrition in R37's clinical record. He would have expected to see so or orange juice on the care	{F 69	8}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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{F 698}	admission nutrition completed. On 6/1/18, at 11:28 stated she thought morning and R37 w potassium. On 6/1/18, at 11:40 sure if R37 was to having teeth, she w plan. NA-F stated seducation regarding. On 6/1/18, at 2:39 p consultant dietician with R37 and discuaround R37's admist thought it was miss or DM-A) was going nutrition assessment record lacked an accord lacked an accord lacked an accord address R37's becare plan, but would note. Review of facility por reviewed 4/28/18, in conduct and coordithrough appropriate information should dialysis provider to care. Dietary initial the dietary director dietician was responutrition assessment.	a.m. nursing assistant (NA)-H R37 had a banana this ras supposed to have extra a.m. NA-F stated she was not nave bananas due to not ould have to check his care he had not received any g R37 lately. b.m. during a phone interview, (CD)-A stated she had met assed dialysis with DM-A sion date. CD-A stated she ed as to which person (CD-A g to put in the admission assessment from a tion. CD-A stated she would history of hyperkalemia in the d maybe place it in a progress olicy titled Hemodialysis Policy andicated the facility must nate the MDS/RAI process	{F 69	98}				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245052	B. WING				31/2018
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{F 698}	assessments are baweight patterns, die	ge 54 re plan review. These ased upon food/fluid intake, t adherence, and laboratory	{F 69	8}			
{F 761} SS=F	values. Label/Store Drugs a CFR(s): 483.45(g)(l		{F 76	:1}			7/23/18
	Drugs and biological labeled in accordant professional principappropriate access	g of Drugs and Biologicals als used in the facility must be ce with currently accepted les, and include the ory and cautionary e expiration date when					
	§483.45(h) Storage	of Drugs and Biologicals					
	Federal laws, the fabiologicals in locked	cordance with State and scility must store all drugs and drompartments under proper ls, and permit only authorized access to the keys.					
	locked, permanently storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distril quantity stored is more readily detected. This REQUIREMENT by: Based on observator review, the facility falabeling and storage.	acility must provide separately affixed compartments for d drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can all is not met as evidenced ion, interview, and document ailed to ensure appropriate of medications for 3 of 3 on carts. The facility also failed		written allegation deficiencies cite	correction constitutes on of compliance for red. However, submi Correction is not an	the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		PLETED
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{F 761}	were stored with a emergency kits for storage rooms. The potential to affect at the facility. Findings include; On 5/29/18, at 4:20 observed with lice and was found to here. R208's insulin per (pharmacy label in name, prescribing proute and instruction. R800's Levemir was route and instruction. R800's Humalog opened. LPN-E in LPN-E stated shere. 14 days, but indicated indicated she would sure of expiration of medication, she were expiration date. R14's Lantus per when opened. R4's Novolog flex opened. R4's Atrovent inhamondate when opened.	acy kit controlled medications double lock system in 1 of 1 of 1 facility medication is deficient practice had the all 54 residents who resided in 50 p.m. medication cart 1 was ensed practical nurse (LPN)-Enave the following; and had no pharmacy label cludes; resident ohysician, medication, dosage, ons), opened on 5/28/18 wital had no pharmacy label. Kwik pen had no date when adicated pen used a few times. Soelieved the pen was good for the dates, and if no date found on ould use manufacturer. In long lasting, had no date when aller had no pharmacy label and aller had no pharmacy label and	{F 76	51}	admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of the facility to follosafely store and appropriately discarmedications of discharged resident Multiple medications were noted to unlabeled, not dated when opened have no resident name. The Ekit wore resident name. The Ekit wore resident name in the Ekit wore not stored correctly. This was reviewed with staff immediately; medications must belong to the residents never to be left unlocked and unattended, medications must be all insulin pens or dosed containers be dated, and medications must be always stored in secured cart prior giving. The Ekit should be re-seale prior seal is removed and seal numlogged. 2. Because all resident rely on facility ensure proper medication administ and right to their own medications work removed from medications work removed from medication. Residents medications work removed from medication. The policy medication storage was reviewed. Other residents were affected. 3. To enhance currently complian operations and under the direction director of nurses, on 7/17/2018 all	of and ow ard s. be and/or as not ations ident med abeled, a must be to donce aber by to ration his liere ged all er y on No to of the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF F	DOVIDED OD CLIDDLIED	243032	B. Willa		TREET ADDRESS, CITY, STATE, ZIP CODE	06/0	01/2018
NAME OF I	PROVIDER OR SUPPLIER						
MOORH	EAD REHABILITATION	N & HEALTHCARE 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 761}	Continued From pare no box found and no box found and no and no and no box found and no and no box found and no and no box found and no and no and no box found inhaler or box. No and n	ge 56 o date when opened. Iler had no pharmacy label on date when opened. Ihaler had no name or o date when opened. LPN-E no current order for Ventolin discontinued 5/23/18. LPN-E lin inhaler to the bottom of the from the cart later. LPN-E ation is not ordered when cospital, the admitting nurse he medication. LPN-E ing staff were responsible to edications from the Sitories were stored with armacy labels. LPN-E suppositories were stored in I should not be stored with ral and rectal medications ld cause contamination.	{F 76	61}		se of ed on well as surance heck es. The ned cart audit iance. cation ek x 4 ths to y e spot, rance omitted ew or	
	Medications sent fro often have no label, date. LPN-e indicate but the insulin pens and open date. LPI staff were responsite medications, and the medication pass also	resident's name on it. om hospital with a resident and sometimes no open ted they were used anyway, should have pharmacy label N-E indicated night nursing ole for checking expired ey should be checked during so. LPN-E indicated she was would send label when it fell					

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{F 761}	observed with train and was found to here and was found to here. - Calcitonin medical date when opened who's medication it are a separation date. - Albuterol inhaler, resident's name and are are albuterol inhaler, no opened. - R10's Alphagan of date. - Spiriva inhaler, no opened. - R410's Levemir violated seposting for expired indicated if she was or ask a nurse. The separation of the sepost of the s	28 a.m. medication cart 2 was ned medication aide (TMA)-A nave the following; ation had no pharmacy label or . TMA-A unable to identify t belonged to. Ins with no pharmacy labels or no pharmacy label, no no date when opened.	{F 76	31}			
	indicated if she wa or ask a nurse. Th to discard expired	s unsure, she would Google it MA-A indicated it was important medications, because if used date the properties change,					

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{F 761}	Continued From pa	ige 58	{F 70	61]	}		
		5 a.m. medication cart 3 was -J, and found to have the					
	LPN-J indicated it vindicated she open	ad no date when opened. vas good for 28 days. LPN-J ed it on Monday, and if she was opened, she would have er policy.					
	remaining in a 250 label on it. Pen tak kit. LPN-J indicate policy for labeling p	, which had 220 units unit pen, had no pharmacy en from Omnicare emergency d she was not aware of the ens taken from emergency kit. en for R52 had no pharmacy					
	- R804's Levemir vi 5/8/18 but remaine	ial, dated 4/18/18, expired d on cart.					
		p.m. observation of ith LPN-I revealed the					
	-multiple discontinu bags on the counte	ned medications were stored in er.					
	tag. No documenta controlled substance lock was removed. unlocked, and that on the controlled su the box was access with a red numbere	s not double locked with zip tie ation was recorded on the ze log to indicate when the red LPN-J confirmed the box was no documentation was present ubstance log to indicate when sed. LPN-J secured the box ad zip tie, and reported her or of nursing (DON).					

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{F 761}	emergency kit had and no one had ver emergency kit. She to document remove emergency kit, contauthorization and vindicated night nurscheck for expired mindicated the DON carts for expired memonthly. LPN-J incomedication carts last On 6/1/18, at 10:26 (CP)-A during phone medications should names and dose to open dates need to the medication was amount of days. Clawas to contact pharmedication order changed to the medication order changed to the medication box. Clawas to contact pharmedication box. Clawas to contact pharmedication order changed to facility of medications with correct procedure. Emergency kit need medicaiton remove authorization from procedure.	a.m. LPN-J stated the not been verified unlocked, ified the medications in the endicated the procedure was all of narcotics from the fact pharmacy for erify it was removed. LPN-J sing staff were responsible to nedications weekly. LPN-J also checked the medication edications either weekly or licated DON had checked the st week. a.m. consultant pharmacist enterview indicated have labels with resident be given. CP-A indicated be on opened vials, because only good for a certain P-A indicated usual protocol macy to request a label if nanged, and pharmacy would for the medication. CP-A armacy should always include cation, as well as the P-A indicated hospital should needed on medications when y. CP-A stated administration out labels by nursing is not the	 F 76	51}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	CODE	00/	01/2010
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{F 761}	medications were in provided a list of mp.m. that identified proper labels and in reviewed the medications were in removed from the cindicated nursing state opened date and sticker on the medication was open expectation was for sticker on medication expectation was for sticker on medication order changes. DO pharmacy had perform the past. DON in to be locked at all tinarcotic medication procedure was for pemergency kit med nurse to record the controlled substance pharmacy. After reformed tag, which would controlled substance expectation was for checked every shift medication count. The facility policy tit Containers, reviewed medications maintain properly labeled in and federal regulationstructed staff to reform the provided staff to reform the properly labeled in and federal regulationstructed staff to reform the provided staff to reform the p	errors, and ensure that not expired. DON was edications on 5/31/18, at 4:30 medications found without hissing opened dates. DON eation list and confirmed the improperly labeled, and were earts and reordered. DON taff were expected to record and expiration date on the label cation container when the ened to prevent administering is. DON indicated her in nursing staff to place a consist to notify nursing staff of N indicated Omnicare formed training for nursing staff indicated emergency kit needed times to prevent diversion of ins. DON indicated the facility coharmacy to be notified if ication was needed, and the authorization code on the elog received from moving the medication the re-locked with a numbered along along the controlled the data of the emergency kit to be a during the controlled the data of the facility shall be accordance with current state forms. The policy further enturn to the issuing pharmacy exaging or containers that are	{F 76	51}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED	
		245052	B. WING			R 01/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	<u> U6/1</u>	01/2018	
(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) BE	(X5) COMPLETION DATE	
{F 761}	inadequately or impinclude all necessaresident's name, proname of the issuing and quantity of the directions for use. can label or alter the container or packaginstructed nursing any changes in phy No medications carresident's medication. The facility policy tit Policy created 12/2 facility shall comply other requirements medications in e-kit medications available kept in an e-kit in the	properly labeled. Labels shall ry information including escribing physican's name, pharmacy, name, strength drug, expiration date, Only the dispensing pharmacy e label on medication ge. The policy further staff to inform the pharmacy of sician orders for a mediation. In the shared or used if not on. Ited Medication Reconciliation 7/18, (12/17/17?) identified the with all laws, regulations, and related to reconciling all it. The policy indicated one medication room in locked	{F 76	,			
{F 812} SS=F	is called and a required completed, faxed to with authorization or instructs staff to relessecurity tie with a spand document on colocked. Food Procurement, CFR(s): 483.60(i)(1) §483.60(i) Food saft The facility must -	fety requirements. Source food from sources ered satisfactory by federal,	{F 81	12}		7/23/18	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	COMI	SURVEY PLETED	
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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		00/01/2010	
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{F 812}	from local produce and local laws or r (ii) This provision of acilities from using gardens, subject to safe growing and f (iii) This provision from consuming for §483.60(i)(2) - Sto serve food in accostandards for food This REQUIREME by: Based on observative review, the facility items were not avaconsumption. This of the 54 residents kitchen. Findings Include: During the initial to refrigerator on 5/29 tray of approximate covered containers of groun clear container of groun clear container of groun clear container of ground banana bread manager would be on 5/29/18, at 9:4 indicated she had last survey was container of survey was container of survey was contained to s	ers, subject to applicable State egulations. does not prohibit or prevent g produce grown in facility occompliance with applicable food-handling practices. does not preclude residents oods not procured by the facility. The prepare, distribute and redance with professional service safety. The service safety. The service was evidenced failed to ensure outdated food failed food fai	{F 812	This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, submost this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1.It is the policy of this facility to enhealthy and safe meal service. So the many ways that this has been ensuring clean environment and so preparing and serving food and beverages to residents before the expiration dates. After the surveyor reported finding expired dates or items in kitchen it was determined not properly managing expired for limmediately the dietary manager out items and updated staff to modates. The log sheet that had only signed off 2 out of 9 days was adand monitored for daily checks. 2.Because all residents receive the	or the nission of sor that of sor that of sand one is safely eir or undated of staff ods. threw onitor y been dressed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•	J1/2U16	
IVAIVIL OI	THOUBERTORISOFTEEN			2810 SECOND AVENUE NORTH			
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		MOORHEAD, MN 56560			
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{F 812}	DA-A indicated she beverages, and cle handle the food. On 5/29/18, at 9:4: received education included making s residents and to do coolers. DA-B indicated the days for outdated of the days for outdated of the days for outdated of the such as cleaning a dishes, use only particularly did not discussitems. CK-A indicated the such as cleaning a dishes, use only particularly did not discussitems. CK-A indicated she three they did not discussitems. CK-A indicated she three tham also. She indipast the date they indicated she did recommended to today. CK-A indicated she did recommended to the facility provided staff educincluding the use of items and cleaning items and cleaning the same cleaning items and cleaning the use of items are of items and cleaning the use of items are of items and cleaning the use of items are of items and cleaning the use of items are of items and cleaning the use of items are of items and cleaning the use of items are of items and cleaning the use of items are of items and cleaning the use of items are of i	how to speak with residents. It washed dishes, set up the washed dishes, set up the washed dishes, set up the washed the coolers, but did not as a.m. DA-B indicated she had a since the last survey which we food was warm for the washed that go in the dicated foods should not be kept nothing should be kept 7 days. By checked the coolers every 3 foods. 7 a.m. cook (CK)-A indicated the education to staff. By reviewed multiple areas, and drying appliances and asteurized eggs, use of the cooler or outdated food at the time of the indicated she threw away the pie, anana bread at the time of the indicated she has told staff to the es, but "they don't do it." CK-A way way the ground and diced cated they were 2 or 3 days should be used. CK-A and notice the dates of the foods atted if staff do not show up she is. 2 a.m. DN-A indicated she ity and indicated the facility had cation on various topics, of pasteurized eggs, dating g. DN-A confirmed the ground the want apple.	{F 8	meals here in facility all affected by the cited defithe dietary manager did fridge to remove all outd Cleaning out fridge items is now done daily with ki schedule. The staff have policy and are aware of and dating open items. 3.To enhance currently coperations and under the director of dietary, on 7/2 staff reviewed proper stowith dietary manager to are safe to serve. 4.Effective 7/16/2018, a program was implement supervision of the direct monitor fridge for expiredirector of dietary or designality-assurance representations and storage per week for 4 weeks the for 2 months to ensure of dietary manager or designation of the quality-assurance representation of the quality manager or designation of the quality manager and review or corrective actions. Dietary manager and review or corrective actions of the quality manager and review or corrective actions.	iciency, 7/2/2018, deep clean of the lated items. Is that are expired to the cleaning ereviewed the proper storage compliant endirection of the 2/2018 dietary orage and dates ensure all items ensure all items quality-assurance and under the corror of dietary to di		

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245052	B. WING				R 01/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	REET ADDRESS, CITY, STATE, ZIP CODE 10 SECOND AVENUE NORTH DORHEAD, MN 56560	1 00/1	01/2010
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{F 812}	indicated she was provided the educashe was not aware expired foods in the may have been too many items they have been too many items they have checked the deast every other downweekend, the last Friday. DM-A indicated the could be kept 3 day prepared date or ostaff followed the could be kept 3 day prepared date or ostaff followed the could be kept 3 day and indicated choon the facility daily dietary staff used. Review of the facil Schedule from 5/2 the area marked "County 2 out of 9 day Review of staff traits 5/3/18, CK-A and I food, and taking downwere provided as a facility form titled identified prepared foods mixed with county and says after poriginal form, whice	D p.m. dietary manager (DM)-A new to the facility and CK-A ation to staff. DM-A indicated there was a problem with e fridge. DM-A indicated she d, but indicated there were ad reviewed. DM-A indicated ates on refrigerated foods at ay, but due to the holiday time she checked was last cated she believed most items ys after dated, either the pened date. DM-A indicated lirections posted on the cooler e-by dates to be followed. ecking for outdated foods was cleaning schedule task list the lity forms titled Daily Cleaning 1/18, to 5/5/29/18, identified Check for label and date, throw ods", was initialed or checked so. ning provided indicated on DM-A reviewed policy of saving own all temperatures in the ic training objectives or details	{F8	12}			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		R 06/01/2018		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH	1 00/	01/2016	
MOORHE	EAD REHABILITATION	N & HEALTHCARE CENTER		MOORHEAD, MN 56560			
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{F 812}	Continued From pa	ge 65	{F 81	2}			
	Department of Agric Inspection Service,	, undated, identified ham, fully					
	Healthcare Manage from 5/21/18, to 5/2	dit forms titled Superior ement-Moorhead Kitchen Audit 5/18 lacked audit questions storage dates of refrigerated					
	confirmed the audit storage dates of ref indicated he himsel coolers to assure fo storage dates. His	0 p.m. the administrator s did not include checking rigerated foods. Administrator f had gone through the loods were not past their expectation would be that rough and remove foods past					
{F 865}	dated 2011, identific hazardous food ing containers must be "use-by" date. The to store all extra poinches deep), approuse by" date and reitems not stored in labeled and noted vistorage chart, and uallowed days. Mon expiration dates or outdated items imm	led Storing Prepared Foods, ed food or potentially redients not stored in original discarded if not used within policy further instructed staff rtions in sealed shallow (2 oved containers. Label, note efrigerate immediately. All original container must be with "use by" date according to used or discarded within itor all items daily for "use by" dates and discard all rediately. isclosure/Good Faith Attmpt	{F 86	55}		7/23/18	
SS=F			(. 30				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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{F 865}	Continued From pa	age 66	{F 865	5}		
	§483.75(a) Quality improvement (QAF	assurance and performance PI) program.				
		sent its QAPI plan to the State later than 1 year after the s regulation;				
	disclosure of the re except in so far as	retary may not require ecords of such committee such disclosure is related to such committee with the				
	and correct quality a basis for sanction This REQUIREME	s by the committee to identify deficiencies will not be used as				
	failed to maintain a assurance (QAA) o identifying and res	w and record review, the facility a quality assessment and committee that was effective in ponding to quality deficiencies. tice had the potential to affect the facility.		This Plan of Correction constitu written allegation of compliance deficiencies cited. However, sub of this Plan of Correction is not a admission that a deficiency exist one was cited correctly. This Pla Correction is submitted to meet requirements established by stated	for the omission an that an of	
	the nursing consul- verified he was the administrator ident regularly attended nursing, director of director, medical d coordinator (MDSC	v on 6/1/18 at 4:31 p.m., with tant present, the administrator lead for QAA. The ified the following staff the QAA meetings: director of social services, therapy irector, Minimum Data Set C) and pharmacy consultant.		federal law. 1.It is the policy of the facility to a that the Quality Assurance Perform Improvement committee identified develops appropriate action plans to system failures. The facility factor have appropriate action plans resystem failures including doing paudits and monitoring for change addressing the lack of education	ormance es and es related ailed to elated to orevious es but not	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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MOORHI	EAD REHABILITATIO	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560			
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{F 865}	The administrator members discussed the facility survey of indicated many neplace, staff were edietary and MDSC initiated to review at the nurse consults staff had competed nursing staff had collistening, charting, identified the facility providing information practices. With review of the had been educated what was expected NC indicated the aperfect and staff we NC identified the Cowhat systems were together to get accepted the facility had place problems rather that is what had to now with the audit fixed but the staff in the NC indicated problems and whice with the revisit survey seen improvement.	identified the QAA meeting ed many of the tags cited during of 3/13/18. The administrator w protocols were put in to ducated, new staff hired for position and audits were the progress. ant (NC) identified the nursing ncy issues. The NC identified demonstrated problems with and documentation. The NC ty had a system failure with ion, orientation and follow-up audits the NC indicated staff d on how to perform audits and d with negative findings. The audits were not expected to be sere to learn from them. The QAA committee had identified the not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place and were working countability. The NC indicated are not in place are not expected to be are to learn from them. The not indicated are not in place are not expected to be are to learn from them. The not indicated are not in place are not expected to be are to learn from them. The not indicated are not in place are not expected to be are to learn from them. The not indicated are not in place are not in place are not expected to be are to learn from them.	{F 86	to continued problems with Administrator educated even QAPI program, the guidel and how to analyze data, effectively address system improve quality at facility. 2. Lack of appropriate active system failures can affect the facility. At this meeting for improvement were ide prioritized, root cause was and performance improve were initiated, reviewed at be monitored. The items will continue to be address competencies will also be monitoring. 3. To enhance currently comperations and under the Administrator, education relements and goals of the assistance and tools for a review, and proper identifications while assuring goal (specific, measurable, attain-service training regarding program. 4. The QA committee will rediscuss action plans related deficiencies noted during and analyze audits and deappropriate continued mon system changes in additional ready identified on the Cagenda. The medical directions of the consultant will be present quarterly; if not present measurement and present measurement and present measurement and present measurement and present medical directions of the consultant will be present measurement and present medical directions of the consultant will be present measurement.	veryone on the ines, processes etc. to begin to nic failures to on plans for all residents at g, opportunities intified, a determined, ement plans and continue to tagged in survey sed and the staff added to the ompliant direction of the reviewed the e QAPI program, accurate data ication of root ls are SMART ainable, realistic aff will receive ing QAPI meet monthly to ed to survey, review etermine on to other items QAPI plan ector will be armacy at a minimum		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED				
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NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HEALTHCARE 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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 865}	Continued From pa The requested facil	ge 68 ity policy was not provided.	{F 80	65}	submitted to them prior to meeting allow for input during meeting, ther reviewed and signed monthly. Aud in place and reviewed monthly to a that all supporting documentation feach department head is submitted. Administrator the Monday prior to refor adequate time to review. After the minutes and supporting documentation will then be sent to and COO for review. This plan of correction will be monitored at the QAPI meeting and audits to continuous a time that shows consistent substantial compliance with the regulations and the facilities' QAPI has been met, as determined by a representative of the regional execteam. 5. The Administrator or designee wiresponsible for this POC.	will be lits are ssure rom d to the neeting QAPI RDCS monthly ue until plan utive	

PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER MOORHEAD REHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, JPP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 55550 PROVIDERS PLAN OF CORRECTION FROM PROVID	-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MOORHEAD REHABILITATION & HEALTHCARE CENTER MOORHEAD, MN 56560 SUMMARY STATEMENT OF DEFICIENCIES 2019 SECOND AVENUE NORTH MOORHEAD, MN 56560 PRIEFRY TAG PROVIDERS PLAN OF CORRECTION (PRIEFR TAG PROVIDERS PLAN OF CORRECTION PRIEFR TAG PROVIDERS PLAN OF CORRECTION PRIE			245052	B. WING		04/13/2018	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFY INFORMATION PREFIX TAG REGUL			N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH		
An Emergency Preparedness Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 4/13/18 following a Minnesota Department of Health survey on 3/13/18. At this Comparative Federal Monitoring Survey, Moorhead Rehabilitation and Healthcare Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73 - Emergency Preparedness. Moorhead Rehabilitation and Healthcare Center has a total of 78 dually certified beds. At the time of the survey, the census was 53. E 007 EP Program Patient Population SS=C CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** "Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FOHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by; Based on interview and record review, the facility failed to develop an emergency preparedness	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE COMPLETION	1
Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 4/13/18 following a Minnesota Department of Health survey on 3/13/18. At this Comparative Federal Monitoring Survey, Moorhead Rehabilitation and Healthcare Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73 - Emergency Preparedness. Moorhead Rehabilitation and Healthcare Center has a total of 78 duality certified beds. At the time of the survey, the census was 53. E 007 EP Program Patient Population SS=C CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FOHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an emergency preparedness	E 000	Initial Comments		E 000			
failed to develop an emergency preparedness written allegation of compliance for the		Federal Monitoring Centers for Medica on 4/13/18 following Health survey on 3/ Federal Monitoring Rehabilitation and Inot to be in substar requirements for pa Medicare/Medicaid Emergency Prepare Moorhead Rehabilithas a total of 78 du of the survey, the conference Program Patien CFR(s): 483.73(a)(3) [(a) Emergency Pla and maintain an emithat must be review annually. The plantal (3) Address patient but not limited to, poservices the [facility an emergency; and including delegation plans.** *Note: ["Persons at hospice, PACE, HHFQHC, or ESRD far This REQUIREMENT."	Survey was conducted by the re & Medicaid Services (CMS) g a Minnesota Department of 13/18. At this Comparative Survey, Moorhead Healthcare Center was found atial compliance with the articipation in at 42 CFR 483.73 - edness. Itation and Healthcare Center ally certified beds. At the time ensus was 53. It Population 3) In. The [facility] must develop nergency preparedness plan red, and updated at least must do the following:] In continuity of operations, as of authority and succession of authority and succession of authority and succession of the following is not met as evidenced.	E 007			
		failed to develop an	emergency preparedness		written allegation of compliance for	the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

05/04/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245052	B. WING _		04/1	3/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD REHABILITATIO	N & HEALTHCARE 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 007	the potential to afferesided in the facility. Findings include: On 4/12/18 at 3:30ppreparedness [EP] Administrator and Monoted that the EP pyould assume specialsence. The Administrator and Monoted that the EP pyould assume specialsence.	age 1 succession planning. This had ct all 53 residents currently by at the time of the survey. The facility's "Emergency of the binder was reviewed with the maintenance Director. It was alan lacked detail of which staff cific roles in another staff's inistrator verified that the EP of the succession planning.	E 00	deficiencies cited. However, submission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. A succession plan has been creathe ED and will go into the Emerger Preparedness Binder. 2. The succession plan will discuss temporary, unplanned absence of the Executive Director: Short-Term & Long-Term. As well as planning for permanent change. 3. It will also discuss an emergency succession plan and will include a light who will be in charge if the person at them on the chain of command is relonger able. 4. This plan will be revised annually needed. 5. Staff were trained on the emerge preparedness binder on 4/24/18 at staff meeting. 6. Staff will be educated/trained on the emergency preparedness binder are and it will become part of our new employee orientation process. 7. The Director of Maintenance (DC Executive Director (ED) are response.	or that of and ted by ncy he a ist of above no and as ncy an all the nnually	
E 015 SS=C		s for Staff and Patients 1)	E 0	for this POC.		5/21/18
	develop and impler	ocedures. [Facilities] must nent emergency preparedness lures, based on the emergency				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		04/	/13/2018	
	PROVIDER OR SUPPLIEF	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 015	assessment at para and the communic this section. The previewed and update minimum, the policia address the follow (1) The provision of and patients wheth place, include, but (i) Food, water, measupplies (ii) Alternate source following: (A) Temperature safety and for the provisions. (B) Emergency (C) Fire detection systems. (D) Sewage and *[For Inpatient Host Policies and proceed in the following: (iii) The following and hospice-operated of the policies and proceed in the provision of the policies and proceed in the provision of the policies and proceed in the provision of the	aragraph (a) of this section, risk ragraph (a)(1) of this section, sation plan at paragraph (c) of solicies and procedures must be ated at least annually.] At a cies and procedures must ing: of subsistence needs for staff her they evacuate or shelter in are not limited to the following: edical and pharmaceutical hes of energy to maintain the est o protect patient health and safe and sanitary storage of lighting. on, extinguishing, and alarm disasted waste disposal. Spice at §418.113(b)(6)(iii):] edures. are additional requirements for inpatient care facilities only, procedures must address the of subsistence needs for s and patients, whether they are in place, include, but are not	EO				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		04/	13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
E 015	of provisions. (2) Emergency (3) Fire detect systems. (C) Sewage and This REQUIREMEN by: Based on interview failed to include in t (EP) plan how the f medical and pharm of a facility evacuat to be sheltered in p affect all 53 residen facility at the time o Findings include: On 4/12/18 at 1:30p titled "Emergency F revealed the EP pla facility was going to pharmaceutical sup emergency. This finding was co	he safe and sanitary storage y lighting. ion, extinguishing, and alarm waste disposal. NT is not met as evidenced y and record review, the facility he emergency preparedness acility was to provide for aceutical supplies in the event ion or if residents were going lace. This had the potential to its currently resided in the	E O	This Plan of Correction constitut written allegation of compliance f deficiencies cited. However, subro of this Plan of Correction is not a admission that a deficiency exists one was cited correctly. This Pla Correction is submitted to meet requirements established by statifederal law. 1. A letter was obtained on 5/1/18 facility's new pharmacy. The letter addresses how the pharmacy will with the facility to provide pharmating in the event of an emergency. 2. An agreement/letter is being act from the facility's Medical Supplier address how they will supply the with the proper medical supplier and the event of an emergency. 3. These will be placed into the empreparedness binders and will reannually and changed if needed. 4. Staff were trained on the emergoreparedness binder on 4/24/18 staff meeting. 5. Staff will be educated/trained of emergency preparedness binder and it will become part of our new employee orientation process. 6. The DOM and ED are responsithis POC.	or the nission of sor that of sor the role and sor to facility one eded on the or to facility one eded one role of sor to facility one eded one of sor to facility one eded one of sor to facility one eded one of sor to facility one eded on the sor to facility on the sor to facility of the sor to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 018 SS=C	CFR(s): 483.73(b)([(b) Policies and proceously policies and the communication of the communication of the receously policies and sheltered patients are relocated an emergency. If compatients are relocated patients are relocated an emergency policies and proceously policies and proceous policies policies and proceous policies policies and proceous policies policies and proceous policies policies policies and proceous policies poli	ocedures. The [facilities] must ment emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least annually.] At a ies and procedures must mg:] ck the location of on-duty staff ents in the [facility's] care during on-duty staff and sheltered ted during the emergency, the ment the specific name and eiving facility or other location. 41.184(b), LTC at §483.73(b), 75(b), PACE at §460.84(b):] dures. (2) A system to track the staff and sheltered residents in ICF/IID or PACE] care during lency. If on-duty staff and are relocated during the RTF's, LTC, ICF/IID or PACE] e specific name and location of y or other location.	E 01	8		5/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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E 018	assistance. (v) A system to trace employees' on-duty hospice's care during on-duty employees relocated during the must document the the receiving facilit. *[For CMHCs at §4 procedures. (2) Sa which includes contreatment needs of responsibilities; tracevacuation location means of communassistance. *[For OPOs at § 48 procedures. (2) As documentation that donor information, potential and actuates and maint. *[For ESRD at § 48 procedures. (2) Sa facility, which incluneeds of the patier This REQUIREME by: Based on interview failed to develop potracking of staff an 42 CFR, Section 4 potential to affect as	ck the location of hospice y and sheltered patients in the ng an emergency. If the sor sheltered patients are e emergency, the hospice especific name and location of y or other location. 185.920(b):] Policies and fe evacuation from the CMHC, isideration of care and fe evacuees; staff insportation; identification of n(s); and primary and alternate ication with external sources of 186.360(b):] Policies and system of medical the protects confidentiality of all donor information, and a lains the availability of records. 194.62(b):] Policies and fe evacuation from the dialysis des staff responsibilities, and	E 018	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submi of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a	the ssion or that of

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY PLETED
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E 018	titled "Emergency F revealed the policie account for tracking event of an emerge This finding was co	om, record review of the binder Preparedness" (no date) s and procedures did not g of staff and patients in the	E 01	federal law. 1. The facility evacuation plan has updated and now includes a tracking procedure to inform staff on the procedures for tracking patients, employees, and volunteers in the an emergency. 2. This will be reviewed annually and changed as needed. 3. Staff were trained on the emergency preparedness binder on 4/24/18 as staff meeting. 4. Staff will be educated/trained on emergency preparedness binder and it will become part of our new employee orientation process. 5. The Director of Maintenance (Do Executive Director (ED) are respondent to the process of this POC.	event of and ency tan all the annually	
E 022 SS=C	CFR(s): 483.73(b)(align=16] [(b) Policies and prodevelop and implementation policies and proceed plan set forth in parassessment at para and the communication this section. The porreviewed and updain minimum, the policies address the following (4) A means to she and volunteers who (2),(3),(5),(6)] A me	ocedures. The [facilities] must nent emergency preparedness lures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least annually. At a es and procedures must	E 02			5/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	E SURVEY PLETED
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E 022	and procedures. (6) The following ar hospice-operated in The policies and profollowing: (i) A means to shoospice employees This REQUIREMEN by: Based on interview failed to develop posheltering in place for volunteers in the face emergency. This has residents currently time of the survey. Findings include: Review of the facility plan revealed that to procedures for shell staff and volunteers emergency. This finding was co	ge 7 Dices at §418.113(b):] Policies e additional requirements for apatient care facilities only. Docedures must address the elter in place for patients, who remain in the hospice. Now and record review, the facility licies and procedures for or residents, staff and cility in the event of an aid the potential to affect all 53 resided in the facility at the event of an are the policies and tering in place for residents, in the facility during an enfirmed by the Administrator director on 4/12/18 at 3:30pm.	E 02	This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, submorthis Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. A shelter in place plan has been developed and includes how the fable to remain in operation for a period while keeping its residents members, volunteers, and hospid employees safe. 2. This will be reviewed annually a changed as needed. 3. Staff were trained on the emerging preparedness binder on 4/24/18 a staff meeting. 4. Staff will be educated/trained on emergency preparedness binder and it will become part of our new employee orientation process. 5. The Director of Maintenance (Director (ED) are responsed.)	or the nission of sor that of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
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E 023 E 023 SS=C	Policies/Procedures CFR(s): 483.73(b)(constitution of the constitution of the constitu	s for Medical Documentation	E 023			5/21/18
	plan set forth in par assessment at para and the communica this section. The po reviewed and upda	ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of policies and procedures must be ted at least annually. At a lies and procedures must				
	preserves patient in confidentiality of pa and maintains avail (3),(4),(6)] A system that preserves patie	dical documentation that information, protects tient information, and secures lability of records. [(5) or in of medical documentation ent information, protects tient information, and secures lability of records.				
	procedures. (5) As that does the follow (i) Preserves patier (ii) Protects confide					
	procedures. (2) As documentation that donor information, potential and actua	6.360(b):] Policies and ystem of medical preserves potential and actual protects confidentiality of I donor information, and ains the availability of records.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY PLETED
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E 023	by: Based on interview failed to develop por documents in accord 483.73(b)(5). This is 53 residents currentime of the survey. Findings include: Review of the facility plan revealed that the place that would proprotect confidentiality secure and maintaitievent of an emerge. This finding was co	NT is not met as evidenced and record review, the facility licy and procedure for medical rdance with 42 CFR, Section and the potential to affect all tly resided in the facility at the y's emergency preparedness he facility had no system in eserve patient information, ty of patient information, and n availability of records in the	E O	This Plan of Correction written allegation of comdeficiencies cited. Howe of this Plan of Correction admission that a deficience one was cited correctly. Correction is submitted requirements established federal law. 1.The facility has obtained Waiver for disasters, who what provisions may be to what entities it applies healthcare information of severe disaster. 2.The facility's evacuation been updated and now information. It discusses carts; emergency drug with charts would be bought evacuation location and TARS would be printed emergency laptop and particularly as needed. 4.Staff were trained on the preparedness binder on staff meeting. 5.Staff will be educated/emergency preparedness and it will become particularly employee orientation profe. The Director of Mainte Executive Director (ED) for this POC.	npliance for the ever, submission is not an ency exists on This Plan of the meet end by state a end a HIPAA nich discussed waived, where the store and how can be shared with the emergent of the emergent of a 4/24/18 at a end of our new ocess.	the ssion r that of r that of and es en and wed in also eation dical and y and ncy an all he inually M) and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION ()	X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
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E 024 E 024 SS=C	Policies/Procedure CFR(s): 483.73(b)([(b) Policies and pr develop and impler	s-Volunteers and Staffing 6) ocedures. The [facilities] must ment emergency preparedness	E 024 E 024		5/21/18
	plan set forth in parassessment at para and the communica this section. The poreviewed and upda	dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of plicies and procedures must be ted at least annually. At a lies and procedures must ng:]			
	volunteers in an en staffing strategies, for integration of St	") as noted above] The use of nergency or other emergency including the process and role ate and Federally designated ionals to address surge needs cy.			
	procedures. (6) The emergency and oth strategies to address emergency.	103.748(b):] Policies and e use of volunteers in an user emergency staffing ss surge needs during an			
	Based on record refailed to develop por volunteers in accord 483.73(b)(6). This is 3 residents currentime of the survey.	eview and interview, the facility olicies and procedures for dance with 42 CFR, Section had the potential to affect all other resided in the facility at the		This Plan of Correction constitutes r written allegation of compliance for the deficiencies cited. However, submiss of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet	ne sion that
		om, record review of the binder Preparedness" (no date)		requirements established by state ar federal law. 1.A staffing plan has been developed discusses how the Incident Comman	d and

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
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E 024	revealed the policie account for manage event of an emerge This finding was co and Maintenance D	s and procedures did not ement of volunteers in the	E 02	will designate a staff member to call duty staff and request that they come the facility or relocation site. This designated staff member will then call volunteers and ask for assistance. 2.A memorandum of understanding been signed by three of our sister fall who are willing to send staff to our fain the event of an emergency. The fall evacuation plan has also been updated and now includes a tracking procedulinform staff on the procedures for tracking procedulinform staff on the procedures for tracking procedulinform staff on the procedures for tracking plan will be reviewed annually changed as needed. 4. Staff were trained on the emergen preparedness binder on 4/24/18 at a staff meeting. 5. Staff will be educated/trained on the emergency preparedness binder annual it will become part of our new employee orientation process. 6. The Director of Maintenance (DOM Executive Director (ED) are responsitor this POC.	e to all all has cilities acility acility ted ure to acking in the v and cy un all ne nually
SS=C	CFR(s): 483.73(b)(a [(b) Policies and prodevelop and implentation policies and procedured plantation set forth in parassessment at parasand the communication this section. The poreviewed and update		L 02		3/21/10

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	· ·	(3) DATE SURVEY COMPLETED
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E 026	address the followi (8) [(6), (6)(C)(iv), (facility] under a wain accordance with provision of care at care site identified officials. *[For RNHCIs at §4 procedures. (8) The waiver declared by with section 1135 of at an alternative camanagement official. This REQUIREME by: Based on interview failed to ensure the addressed the role declared by the Sesection 1135 of the and treatment at all by emergency man potential to affect a resided in the facility Findings include: On 4/12/18 at 3:30 preparedness policine reviewed with the Amaintenance Direct that the facility did procedures in its elfacility's role in provalternate care sites	ing:] (7), or (9)] The role of the liver declared by the Secretary, section 1135 of the Act, in the nd treatment at an alternate by emergency management (403.748(b):] Policies and e role of the RNHCI under a the Secretary, in accordance of Act, in the provision of care are site identified by emergency	E 026	This Plan of Correction constitutes in written allegation of compliance for the deficiencies cited. However, submiss of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. The facility has obtained an information sheet on HIPAA Waivers for disasters which discusses how The Secretary HHS may waive certain provisions of rule under the Project Bioshield Act of 2004 (PL 108-276) and Section 1135 of the Social Security Act. 2. The facility's evacuation plan has a been updated and discusses the facing role in providing care and treatment a alternate care sites under an 1135 was 3. Staff were trained on the emergence.	ne sion that that ad ation s, of the of (b)(7) also lity's at aiver.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
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E 026 E 030 SS=C	the regulation.	t Information	E 0		staff meeting. 4.Staff will be educated/trained on the emergency preparedness binder are and it will become part of our new employee orientation process. 5.The Director of Maintenance (DC Executive Director (ED) are respondent for this POC.	nnually M) and	5/21/18
SS=C	[(c) The [facility, exc transplant centers, maintain an emerge communication plan State and local laws updated at least an plan must include a (1) Names and con following: (i) Staff. (ii) Entities providing (iii) Patients' physic (iv) Other [facilities] (v) Volunteers. *[For RNHCls at §4 communication plan following: (1) Names and con following: (i) Staff.	cept RNHCIs, hospices, and HHAs] must develop and ency preparedness in that complies with Federal, is and must be reviewed and mually. The communication II of the following:] tact information for the g services under arrangement. It is an include all of the tact information for the services under arrangement.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 030	plan must include (1) Names and co following: (i) Staff. (ii) Entities providi (iii) Patients' phys (iv) Volunteers. *[For Hospices at communication pl following: (1) Names and co following: (i) Hospice emplo (ii) Entities providi (iii) Patients' phys (iv) Other hospice *[For OPOs at §44 plan must include (1) Names and co following: (i) Staff. (ii) Entities providi (iii) Volunteers. (iv) Other OPOs. (v) Transplant and Donation Service This REQUIREMI by: Based on intervice failed to maintain information in acc 483.73(c)(1). This	6.45(c):] The communication all of the following: ntact information for the ng services under arrangement. cians. §418.113(c):] The an must include all of the ntact information for the yees. ng services under arrangement. cians. s. 36.360(c):] The communication all of the following: ntact information for the ng services under arrangement. I donor hospitals in the OPO's Area (DSA). ENT is not met as evidenced w and record review, the facility a list of names and contact cordance with 42 CFR, Section had the potential to affect all 53 or resided in the facility at the	EO	This Plan of Correction conwritten allegation of compliant deficiencies cited. However, of this Plan of Correction is admission that a deficiency one was cited correctly. This Correction is submitted to make the correction is submitted.	nce for the submission not an exists or that s Plan of eet		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245052	B. WING			04/	13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE B10 SECOND AVENUE NORTH OORHEAD, 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
E 030	lacked documentati physicians', other lo volunteers' contact This finding was co- and Maintenance D	ency preparedness plan on of some of the residents' ing term care facilities' and information. Infirmed by the Administrator irector on 4/12/18 at 3:30pm.	E 0		federal law. 1.The facility's emergency prepared binder has been updated and now includes all patient physician phone numbers as well as phone numbers other local care centers and hospita 2.Phone numbers of all emergency volunteers have also been included 3.Staff were trained on the emergency preparedness binder on 4/24/18 at staff meeting. 4.Staff will be educated/trained on the emergency preparedness binder are and it will become part of our new employee orientation process. 5.The Director of Maintenance (DO Executive Director (ED) are responsion to this POC.	s for als. ncy an all he nnually M) and	
E 033 SS=C	emergency prepare that complies with F and must be review annually.] The com all of the following: (4) A method for shadocumentation for pare, as necessary, maintain the continution of the release patient information (5) A means, in the release patient information of the release patient information of the required for HHAs a complete that the release patient information of the release patient information of the required for HHAs a complete that the release patient information of the release patient i	st develop and maintain an dness communication plan dederal, State and local laws ed and updated at least munication plan must include aring information and medical patients under the [facility's] with other health providers to	ΕO	33			5/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		04/	04/13/2018	
NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE	•	10,2010	
MOORHI	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NOR MOORHEAD, MN 56560	TH		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
E 033	about the general patients under the under 45 CFR 16 *[For RNHCIs at sharing informatic patients under the with care provider care, based on the made by the patients representative. *[For RHCs/FQHO of providing information and location a	eans of providing information condition and location of [facility's] care as permitted 4.510(b)(4). §403.748(c):] (4) A method for on and care documentation for RNHCl's care, as necessary, as to maintain the continuity of e written election statement ent or his or her legal Cs at §491.12(c):] (4) A means mation about the general ation of patients under the permitted under 45 CFR ENT is not met as evidenced ew and record review, the facility a communication plan which dof sharing information and station for residents under the nother health providers to y of care. This had the potential sidents currently resided in the	ΕO	This Plan of Correction written allegation of condeficiencies cited. How of this Plan of Correction admission that a deficience was cited correction is submitted requirements established federal law. 1. A communication play policies and procedure.	ompliance for the wever, submission ion is not an iency exists or that y. This Plan of d to meet ned by state and an as well as		
	plan with the Adm Director on 4/12/1 facility did not dev included methods	ility's emergency preparedness inistrator and the Maintenance 8 at 3:30pm revealed that the relop a communication plan that for sharing information and station for residents under the		created and address t sharing information ar documentation, A mea an evacuation, to relea information as permitt 164.510(b)(1)(ii), A me	he following: nd medial ans, in the event of ase resident ed under 45 CFR		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
		245052	B. WING			04/	13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATION	I & HEALTHCARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 033		other health providers to uity of care. This finding was	EC	033	information about the general cond and location of residents under the facility's care as permitted under 164.510(b)(4) and A method for sha information from the emergency plathe facility has determined is approwith residents and their families or representatives. 2. This plan will be reviewed annual updated as needed. 3. Staff were trained on the emergency preparedness binder on 4/24/18 at staff meeting. 4. Staff will be educated/trained on the emergency preparedness binder are and it will become part of our new employee orientation process. 5. The Director of Maintenance (DO Executive Director (ED) are responsion for this POC.	aring an that priate ly and ncy an all he nnually	
E 035 SS=C	CFR(s): 483.73(c)(8) [(c) The [LTC facility and maintain an emcommunication plar State and local laws updated at least and plan must include at (8) A method for shemergency plan, the is appropriate, with families or represent This REQUIREMENT by: Based on interview	y and ICF/IID] must develop rergency preparedness in that complies with Federal, is and must be reviewed and mually.] The communication II of the following: aring information from the pat the facility has determined residents [or clients] and their	EC	035	This Plan of Correction constitutes written allegation of compliance for		5/21/18

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	245052	B. WING			04/1	3/2018
PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	310 SECOND AVENUE NORTH		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD I	BE	(X5) COMPLETION DATE
included a method the emergency plar determined was ap families or represer to affect all 53 resid facility at the time of Findings include: Review of the "Emewith the Administrate Director revealed the a communication plant for sharing informate that the facility had with residents, their This finding was cound Maintenance Determined the state of the sharing informate that the facility had with residents, their This finding was cound Maintenance Determined the state of the sharing informate that the facility had with residents, their This finding was cound Maintenance Determined the sharing and Test the shari	for sharing information from a that the facility had propriate with residents, their statives. This had the potential lents currently resided in the f the survey. Pergency Preparedness" plant tor and the Maintenance stat the facility did not develop lan which included a method tion from the emergency plant determined was appropriate families or representatives. Infirmed by the Administrator sirector on 4/12/18 at 3:30pm.			of this Plan of Correction is not an admission that a deficiency exists of one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law. 1. A communication plan as well as policies and procedures have been created and address the following: sharing information and medial documentation, A means, in the everant evacuation, to release resident information as permitted under 45 Communication as permitted under 45 Communication of residents under the facility's care as permitted under 164.510(b)(1)(ii), A means of providing and location of residents under the facility's care as permitted under 164.510(b)(4) and A method for share information from the emergency plate facility has determined is appropriately as a staff were trained on the emergency preparedness binder on 4/24/18 at a staff meeting. 4. Staff will be educated/trained on the emergency preparedness binder an and it will become part of our new employee orientation process. 5. The Director of Maintenance (DOI)	r that of nd ent of CFR ing tion ring n that oriate y and ncy an all ne nually M) and sible	5/21/18
CFR(s): 483.73(d)						
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From paincluded a method the emergency plar determined was apfamilies or represer to affect all 53 resid facility at the time of Findings include: Review of the "Emewith the Administrate Director revealed the a communication play for sharing information that the facility had with residents, their This finding was count and Maintenance Description." EP Training and Tester Training an	AD REHABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 included a method for sharing information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: Review of the "Emergency Preparedness" plan with the Administrator and the Maintenance Director revealed that the facility did not develop a communication plan which included a method for sharing information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm.	ROVIDER OR SUPPLIER EAD REHABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 included a method for sharing information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. 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Findings include: Review of the "Emergency Preparedness" plan with the Administrator and the Maintenance Director revealed that the facility did not develop a communication plan which included a method for sharing information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. The facility had determined was appropriate with residents and their families or representatives. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. The facility had determined was appropriate with residents and their families or representatives. 2. This plan will be reviewed annually updated as needed. 3. Staff were trained on the emergency plan the facility has determined is appropriate with residents and their families or representatives. 2. This plan will be reviewed annually updated as needed. 3. Staff well be educated/trained on the emergency plan the facility has determined be endored. 4. Staff will be educated/trained on the emergency plan the facility has determined be endored. 5	A BUILDING 245052 ROVIDER OR SUPPLIER 247052 ROVIDER OR SUPPLIER 247052 STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCIENCY MIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 18 included a method for sharing information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: Review of the "Emergency Preparedness" plan with the Administrator and the Maintenance Director revealed that the facility did not develop a communication plan which included a method for sharing information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm. This plan will be reviewed annually and it will becom

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	` '	TE SURVEY MPLETED
		245052	B. WING		04	/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 036	(d) Training and test develop and maintal preparedness training based on the emergian paragraph (a) of this paragraph (a) of this paragraph (a) of procedures at parathe communication section. The training be reviewed and up *[For ICF/IIDs at §4 testing. The ICF/IID an emergency preparagraph (assessment at parapolicies and procedures and program muleast annually. The requirements for expension and orientation program emergency plan sesection, risk assess this section, policie (b) of this section, policie (b) of this section, program paragraph (c) of this and orientation program that is paragraph (c) of this and orientation program emergency plan sesection, risk assess this section, policie (b) of this section, policie (b) of this section, program that is pro	sting. The [facility] must ain an emergency ing and testing program that is gency plan set forth in s section, risk assessment at this section, policies and graph (b) of this section, and plan at paragraph (c) of this ng and testing program must odated at least annually. 183.475(d):] Training and must develop and maintain paredness training and testing sed on the emergency plan set a) of this section, risk agraph (a)(1) of this section, dures at paragraph (b) of this mmunication plan at s section. The training and ust be reviewed and updated at ICF/IID must meet the vacuation drills and training at es at §494.62(d):] Training, tion. The dialysis facility must ain an emergency ing, testing and patient in that is based on the total forth in paragraph (a) (1) of its and procedures at paragraph and the communication plan at s section. The training, testing gram must be reviewed and	ΕO	36		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		04/13/2018	
	ROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION	
E 036	failed to develop an preparedness (EP) based on the facility assessment. This hassessment assessment time of the survey. Findings include: In an interview with Maintenance Direct Administrator confir documentation to intraining and testing emergency plan and The Administrator for been no education as	ge 20 r and record review, the facility d maintain an emergency training and testing program r's emergency plan and risk ad the potential to affect all 53 resided in the facility at the the Administrator and the or on 4/12/18 at 3:30pm, the med that there was no idicate that the facility had a program based on the d risks identified by the facility. The stated that there had and training provided to staff, g services under arrangement	E 03	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submost this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. On 4/18/18 the facility hosted an Emergency Management Meeting facilities throughout clay county. The meeting was conducted by the Clacounty emergency manager (Bryal Green) and Assistant fire chief (Chestangland). 2. On 4/24/18 the ED and DOM he staff meeting and trained/educated employees on the emergency prepared were handed out to staff and then their files upon completion. 4. Staff will be educated/trained on emergency preparedness binder a and it will become part of our new employee orientation process. 5. The Director of Maintenance (DC Executive Director (ED) are responsible.)	r the ission or that of and for the by and dan all distinct the annually DM) and	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(E 03		5/21/18	
	ASCs, PACE organ	n. The [facility, except CAHs, izations, PRTFs, Hospices, s] must do all of the following:				
	(i) Initial training in 6	emergency preparedness				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	C	X3) DATE S COMPL	
		245052	B. WING			04/13	3/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	CODE		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD B E APPROPRI	_	(X5) COMPLETION DATE
E 037	staff, individuals prarrangement, and vexpected role. (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate si procedures. *[For Hospitals at § at §491.12:] (1) Traor RHC/FQHC] mu (i) Initial training in policies and procedures and procedures. (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate si procedures. *[For Hospices at § hospice must do al (i) Initial training in policies and procedures. *[For Hospices at § hospice must do al (i) Initial training in policies and procedures. (ii) Demonstrate staprocedures. (iii) Demonstrate staprocedures. (iii) Provide emerge least annually. (iv) Periodically revemergency prepare employees (includiced)	dures to all new and existing oviding services under volunteers, consistent with their ency preparedness training at mentation of the training. The fast that the fast to all of the following: emergency preparedness dures to all new and existing oviding on-site services under volunteers, consistent with their ency preparedness training at mentation of the training. The fast fast that the fast training at the fast fast training.	EO	37			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION		E SURVEY MPLETED
		245052	B. WING		04/	/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	•	
(X4) ID PREFIX TAG			ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 037	*[For PRTFs at §44 program. The PRT (i) Initial training in policies and procestaff, individuals prarrangement, and expected roles. (ii) After initial train preparedness train (iii) Demonstrate si procedures. (iv) Maintain documpreparedness train *[For PACE at §46 organization must (i) Initial training in policies and procestaff, individuals prarrangement, contivolunteers, consist (ii) Provide emerge least annually. (iii) Demonstrate si procedures, includ what to do, where case of an emerge (iv) Maintain docum *[For CORFs at §4 CORF must do all (i) Provide initial trapreparedness policiand existing staff, in the procedures of the provide initial trapreparedness policiand existing staff, in the procedure of the provide initial trapreparedness policiand existing staff, in the procedure of the provide initial trapreparedness policiant existing staff, in the procedure of the provide initial trapreparedness policiant existing staff, in the procedure of the provide initial trapreparedness policiant existing staff, in the procedure of the provide initial trapreparedness policiant existing staff, in the provide initial traprep	sary to protect patients and 41.184(d):] (1) Training F must do all of the following: emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their ing, provide emergency ing at least annually. taff knowledge of emergency mentation of all emergency ing. 0.84(d):] (1) The PACE do all of the following: emergency preparedness dures to all new and existing oviding on-site services under ractors, participants, and ent with their expected roles. ency preparedness training at taff knowledge of emergency ing informing participants of to go, and whom to contact in incy. nentation of all training. 85.68(d):](1) Training. The	EC	37		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		04/	/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 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 CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 037	least annually. (iii) Maintain docum (iv) Demonstrate st procedures. All new and assigned specithe CORF's emerge their first workday. include instruction i alarm systems and equipment. *[For CAHs at §485] The CAH must do at (i) Initial training in a policies and procedure reporting and exting and where necessal personnel, and gue cooperation with firm authorities, to all neindividuals providing and volunteers, con roles. (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate st procedures. *[For CMHCs at §4 CMHC must providing preparedness policing and existing staff, in under arrangement with their expected	roles. ncy preparedness training at mentation of the training. aff knowledge of emergency w personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must n the location and use of signals and firefighting 5.625(d):] (1) Training program.	ΕO	37		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		04/13/2018	
	ROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
E 037	procedures. Therea emergency prepare annually. This REQUIREMEN by: Based on interview failed to develop an training program in Section 483.73 (d)(affect all 53 residen facility at the time of Findings include: Record review of the Preparedness" (no no emergency prepulace for staff, individually at the time of the Preparedness of the Preparedn	nowledge of emergency after, the CMHC must provide adness training at least. NT is not met as evidenced and record review, the facility emergency preparedness accordance with 42 CFR, 1). This had the potential to atts currently resided in the finite the survey. e binder titled "Emergency date) revealed that there was aredness training program in iduals providing services and volunteers. rified by the Administrator on and The Administrator further as no documentation to a dining related to emergency been done.	E 03	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists o one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law. 1. On 4/18/18 the facility hosted an Emergency Management Meeting fracilities throughout clay county. The meeting was conducted by the Clay county emergency manager (Bryan Green) and Assistant fire chief (Chastangland). 2. On 4/24/18 the ED and DOM hele staff meeting and trained/educated employees on the emergency preparedness binder. 3. Quizzes on emergency preparedred were handed out to staff and then patheir files upon completion. 4. Staff will be educated/trained on the emergency preparedness binder and and it will become part of our new employee orientation process. 5. The Director of Maintenance (DO Executive Director (ED) are responsion to the process of this POC.	the ssion or that of and or ee dad an all ness out in he inually M) and	
E 039	EP Testing Require	ments	E 03	39	5/21/18	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		04/	/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 CC X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 039 SS=C	CFR(s): 483.73(d)(2) (2) Testing. The [fact RNHCls and OPOstest the emergency [facility, except for Fall of the following: *[For LTC Facilities The LTC facility must the emergency plarunannounced staff procedures. The LT following:] (i) Participate in a factommunity-based of exercise is not acceptacility-based. If the actual natural or marequires activation of [facility] is exempt factommunity-based of full-scale exercise is the actual event. (ii) Conduct an additional exercise is not limicated, but is not limicated in limicated	cility, except for LTC facilities, or must conduct exercises to plan at least annually. The RNHCIs and OPOs] must do at §483.73(d):] (2) Testing. Set conduct exercises to test or at least annually, including drills using the emergency of facility must do all of the cull-scale exercise that is per when a community-based essible, an individual, or [facility] experiences an an-made emergency plan, the	EO	39		

NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.) STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 (X4) ID PROVIDER'S PLAN OF CORRECTION (X4) (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION (X3) G	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.) STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 (X4) ID PROVIDER'S PLAN OF CORRECTION (X4) (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)			245052	B. WING _		04/13/2018	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL					2810 SECOND AVENUE NORTH		
DEFICIENCY)		(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	(X5) COMPLETION DATE	
Continued From page 26 [facility's] emergency plan, as needed. '[For RNHCIs at \$403.748 and OPOs at \$486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency vents, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an emergency preparedness testing program in accordance with 42 CFR, Section 483.73(d)(2). This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: Record review of the binder titled "Emergency Preparedness" (no date) revealed that there was no emergency preparedness testing program in place. There was no documentation that the facility had participated in a community-based exercise. In an interview with the Administrator on 4/13/18 at 10:17am, he verified that there was no	E 039	*[For RNHCIs at § §486.360] (d)(2) The must conduct exertion of problem statem prepared question emergency plan. (ii) Conduct a papeleast annually. At discussion led by clinically relevant of problem statem prepared question emergency plan. (ii) Analyze the [Fito and maintain doexercises, and emergency plan. (iii) Analyze the [Fito and maintain doexercises, and emergency plan. This REQUIREMED by: Based on interview failed to develop at testing program in Section 483.73(d) affect all 53 reside facility at the time. Findings include: Record review of Preparedness" (non emergency preplace. There was facility had participexercise. In an interview with the second review of place. There was facility had participexercise.	and OPOs at lesting. The [RNHCI and OPO] recises to test the emergency and OPO] must do the er-based, tabletop exercise at abletop exercise is a group a facilitator, using a narrated, emergency scenario, and a set lents, directed messages, or is designed to challenge an entry exercise the ocumentation of all tabletop hergency events, and revise the O's] emergency plan, as entry entry exercise the ocumentation of all tabletop hergency events, and revise the O's] emergency plan, as entry entry exercise with 42 CFR, (2). This had the potential to ents currently resided in the of the survey.	E 03	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. On 4/18/18 the facility hosted an Emergency Management Meeting for facilities throughout clay county. The meeting was conducted by the Clay county emergency manager (Bryan Green) and Assistant fire chief (Chad Stangland). 2. On 4/24/18 the ED and DOM held ar	at	

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E 039	place.	edness testing program in	E 03	employees on the emergency preparedness binder. 3. Quizzes on emergency prepared were handed out to staff and then parties their files upon completion. 4. The ED has been in contact with Clay County Emergency Manager a working on getting a date establish perform a tabletop exercise with all 5. A community-based exercise will performed annually. 6. Staff will be educated/trained on emergency preparedness binder at and it will become part of our new employee orientation process. 7. The Director of Maintenance (DC Executive Director (ED) are responsored.	the and is ed to staff. be the nnually	
F 000	was conducted by the Medicaid Services of following a Minneson survey on March 13 Survey Dates: April Survey Census: 53 Medicare: 12 Medicaid: 34 Other: 7 Total: 53	ve Federal Monitoring Survey he Centers for Medicare & (CMS) on April 13, 2018 ota Department of Health 3, 2018.	F 00	0		
F 561 SS=D	Total Sample: 36 Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 56	1		5/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 561	promote and facilithrough support or not limited to the r (1) through (11) of §483.10(f)(1) The activities, scheduliwaking times), her care services consassessments, and applicable provision §483.10(f)(2) The choices about aspfacility that are sig §483.10(f)(3) The with members of the community activitification facility. §483.10(f)(8) The participate in othe religious, and community activitification facility. This REQUIREMED by: Based on interviet failed to promote a receiving showers resident (R39) of choices in the same Findings include:	termination. he right to and the facility must tate resident self-determination for resident choice, including but ights specified in paragraphs (f) this section. resident has a right to choose es (including sleeping and faith care and providers of health sistent with his or her interests, a plan of care and other for sof this part. resident has a right to make exects of his or her life in the nificant to the resident. resident has a right to interact the community and participate in the soft inside and outside the exects of the resident has a right to interact the community and participate in the soft inside and outside the executivities, including social, amunity activities that do not ights of other residents in the executive in the execution of the execu	F 561	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law.	r the dission or that of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 561	stage 5, depender low back pain, chrobstructive pulmo Record Review of Set (MDS) dated 3 C-cognitive Patter Interview for Mentindicated that R39 same MDS with the Functional Status, specified that R39 staff performance persons physical and During an interview stated, "I've receive When asked how "It makes me feel a bath once a week about his bathing preferred showers." During an interview the Unit Coordinate responsibilities incompated by the Unit Coordinate responsibilities incompated by the Unit Coordinate responsibilities incompated by the Unit Care (PCC) which system that health care. Record review of Preference & Other the nursing station	limited: chronic kidney disease, noe on renal dialysis, obesity, onic pulmonary edema, chronic nary disease and heart failure. R39's Quarterly Minimum Data 3/7/18 with the heading "Section n," R39 scored a 14 in a Brief al Status (BIMS) which was cognitively intact. In the ne heading "Section G" under "G0110 B. Transfer," was "Total dependence -Full all the time"with "Two+assist." w on 4/10/18 at 11:51am, R39 yed one shower in 3 months." did it make he feel, R39 replied, like a dogI would give my dog ek." When R39 was asked preference, R39 stated that he	F 5	1.It is the policy of the facility to pand facilitate self -determination resident's individual choices abo aspects of his or her life in the fare significant to the resident. Or many ways that this has been as for resident #39 is by reviewing reshower schedule with resident a determining when his showers waround his schedule as well as estaff on importance of following a care plans and providing all care directed by care sheets. R39 care and care plans updated and show sheets have been reviewed. 2. Because all residents count or activities of daily living all are positives of daily living all are positives are being audited and staffected by the cited deficiency, and their baths have been reviewed. Baths are being audited and staffected by the cited deficiency, and their baths have been reviewed. Baths are being audited and staffected by the cited deficiency, and their baths have been reviewed. The Polymore are sidents are monitored routing assure compliance. All residents been reviewed for bath choices. residents were affected. The Polymore and under the direction of nurses, on 5/9/2018 are receive in-service training regard and federal requirements for bath requirements, dignity, respect are resident cares. The training will the resident choice for planning cares, staff compliance, importate ensuring residents can be clean and skin intact. 4. Effective 4/28/2018, a quality-aprogram was implemented unde supervision of the director of nurse supervision.	of ut cility that he of the hieved esident hid ill be ducated esident as e sheets wer staff for entially esidents yed. If as well hely to have No other cy and wed. It on of the li staff will ing state hing docus on heir nee of and dry ssurance of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 578 SS=D	PCC, R39's deliver 2/2/18 to 4/10/18 rebed baths and only showers twice, one 3/16/18 in two mon During an interview Director of Nursing on how she ensure were complying wit showering. The DC to residents and loc documentation is many The DON was then Admission Preferer print out of showers 2/2/18 to 4/10/18. Adocuments, the DC requested showers baths. The DON alst time of 2/2/18 to 4/10/18 to	print out that was recorded in y of care regarding baths from evealed that R39 had received received his preferred on 3/2/18 and the other on ths. I on 4/11/18 at 1pm with the (DON), the DON was asked d that nursing assistants (NA) h resident's preference in N stated, "I look at charts, talk ok at the schedule. If hissing, I will talk to the NA." asked to review R39's "New nce & Other" sheet and R39's and bed baths given from after reviewing both N acknowledged that R39 had twice a week and not bed so confirmed that during the 10/18, R39 received his (3/2/18 and 3/16/18) only twice s. When asked about the the DON replied, scntnue Trmnt; FormIte Adv Dir 6)(8)(g)(12)(i)-(v)	F 56	monitor bathing schedules and state through. The director of nurses or designated quality-assurance representative will perform the follow systematic changes: audits of bath completion of baths/showers to do follows: 6 residents a week for 3 we then on 3 residents weekly for 2 me to ensure compliance. Any deficient will be corrected on the spot, and the findings of the quality-assurance chall be documented and submitted monthly quality-assurance committed meeting for further review or correct action. 5.DON will be responsible for this Formal states and states are the submitted for the submitted monthly quality-assurance committed mon	owing s and ne as eeks, onths ne ecks at the ee ctive	5/21/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	services deemed n inappropriate. §483.10(g)(12) The	dical treatment or medical nedically unnecessary or efacility must comply with the	F 578		
	requirements speci subpart I (Advance (i) These requirement inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable Stat (iii) Facilities are per entities to furnish the legally responsible requirements of this (iv) If an adult indivitime of admission a information or artice has executed an admay give advance individual's resident with State Law. (v) The facility is no provide this information.	fied in 42 CFR part 489, Directives). ents include provisions to written information to all adult ng the right to accept or refuse treatment and, at the formulate an advance directive. written description of the implement advance directives the law. ermitted to contract with other his information but are still for ensuring that the			
	the information to t appropriate time. This REQUIREMED by: Based on interview failed to ensure all	res must be in place to provide the individual directly at the NT is not met as evidenced and record review, the facility places where advance ed matched for one (R36) ple of 37.		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists of	the ssion

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F 578	"Uniform Code Leve Cardiopulmonary R physician on 12/27/R36 as a "Code Leve technology is used respiratory arrest." on 12/22/17. A review of R36's e under the "Census" Code" on the top of Information" section level 2: DNR" (do non 04/12/2018, this Record" [a cover shith that contains demopreferences, contain medical information document revealed Status: Code level 2 first page, and almopage "Advance Director or reviewing R36's chain audit of all the classical in the contains the contains the contains that contains demopreferences are contained by the contains the contai	ard chart document titled, el Directives for esuscitation" signed by the 2017 which was noted to have vel 1: All available reasonable in the event of cardiac or The form was signed by R36 lectronic health record (EHR) tab R36 was shown as "Full the page, but in the "Custom was "Code Status: Code ot resuscitate). When printed tab becomes the "Admission neet to a multipage document graphic information, and limited of the printed, "Other Information: Code 2-DNR" in the middle of the lost at the bottom of the second ective: Full Code." 14/12/2018 at 1pm, the folinical Services, after art, stated "We literally just did tharts for advance directives. th record and hard chart do	F 5	one was cited correctly. Correction is submitted to requirements established federal law. 1. It is the policy of the faresidents the right to form advance directives. One that this has been achieved reviewing the advance don't and ensuring with reside correct code status on fill for full code in chart and EMR however it was not mid-way through face shows the code has been clarified at EMAR. The current order code has been clarified at EMAR. The chart has been advance directives on fill reminded to notify SW if orders that are not clear resident and POA are accepted and POA are accepted and the code advance directives on the code and	cility to provenulate their of the many ved for R37 irective on fact and POA le. R37 had on face she ed in EMR to et it also so in place for and noted ir een correcte his case, after and ensure they find ar and ensure ctively involve. All hard chof 4/5/2018 are required on file all are cited deficed new POLS tiating a plarext quarter at up to date, eviewed and we residents insure curreridmitted with or accuracy.	nd vide own y ways is by iile order eet in that stated full ned and ter the was yed in narts and d to re ciency, ST n to as well in will be nt n All	
	on 04/12/2018, this Record" [a cover shith that contains demonstrated preferences, contain medical information document revealed Status: Code level 2 first page, and almonage "Advance Director of Regional Director of reviewing R36's chain audit of all the clother than the contains the second present the second preference of the second preferenc	tab becomes the "Admission neet to a multipage document graphic information, et information, and limited of information, and limited of the printed of the printed of the printed of the pest at the bottom of the second pective: Full Code." 14/12/2018 at 1pm, the of Clinical Services, after art, stated "We literally just did that for advance directives. The period of the period		EMAR. The chart has bee R37 profile updated. In the surveyor reported the control advance directives on filter reminded to notify SW if orders that are not clear resident and POA are accepted as a determining their wishes have been reviewed as a EMR reviewed by 4/20/2 2. Because all residents a have advance directives potentially affected by the 4/3/2018, the SW printed from MN.GOV and is initially review to update over near sensure all are current Orders will be signed, rechart. In addition, all new updated on policy and enadvance directives are a	een correcte his case, affortradictory e, the staff verthey find an and ensure ctively involve. All hard chor 4/5/2018 are required on file all are cited deficed new POLS tiating a plan ext quarter at up to date. Eviewed and we residents insure curreradmitted with or accuracy.	ed and ter the was my eved in narts and distorections, ST in to as well in will be int in All	

_	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 578	Continued From pa	age 33	F 5	discrepancies of which 4 compliant and updated im other residents were affect and Procedure for advance was also reviewed and up 3. To enhance currently comperations and under the director of nurses, on 4/4, training for admissions, so nursing was completed reand federal requirements directives and ensuring condocumentation in hard chard from physician and listed training emphasized the intensuring all residents condocumentation in hard chard from physician and listed training emphasized the intensuring all residents condocumentation in hard chard face sheet in EMR match wishes. Reviewed with standering on 5/9/2018 to reconsistency in orders. 4. Effective 4/28/2018, a comport of the SW to compliance of advance distribution of the SW to complete week x 4 weeks, then 1 a months Any deficiencies won the spot, and the findir quality-assurance checks documented and submitted and submitted the complete week x 4 weeks, then 1 a months Any deficiencies won the spot, and the findir quality-assurance checks documented and submitted the complete week x 4 weeks, then 1 a months Any deficiencies won the spot, and the findir of t	nmediately. No cted. The Policy ced directives odated. ompliant direction of the /2018 in-service ocial service and egarding state for advance onsistent nart with order on profile. The mportance of me in with proper ST on hand or iewed with are right status is chart and on residents aff at nursing einforce quality-assurance and under the ensure irectives. The reassurance on the following esident charts ced directives at Then the SW 2 audits per audit weekly x2 will be corrected ngs of the swill be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 578	Continued From pa	ge 34	F 578	quality-assurance committee mee 5.Admissions and SW will be resp for this POC.		
F 580 SS=D	Notify of Changes (CFR(s): 483.10(g)(Injury/Decline/Room, etc.) 14)(i)-(iv)(15)	F 580			5/21/18
	(i) A facility must im consult with the resconsistent with his representative(s) w (A) An accident inversults in injury and physician interventi (B) A significant characterioration in heastatus in either lifeclinical complication (C) A need to alter a need to discontinutreatment due to accommence a new f (D) A decision to traresident from the fastas.15(c)(1)(ii). (ii) When making notation (14)(i) of this sectionall pertinent informatical available and prophysician. (iii) The facility must resident and the result when there is-(A) A change in rootation as specified in §483. (B) A change in resident resident resident in §483.	olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or as); treatment significantly (that is, we an existing form of liverse consequences, or to orm of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) an, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the talso promptly notify the sident representative, if any,				

		S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH MOORHEAD, MN 56560	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION	
F 580	update the addres phone number of trepresentative(s). §483.10(g)(15) Admission to a corthat is a composite §483.5) must disclits physical configulocations that compart, and must speroom changes betunder §483.15(c)(9). This REQUIREME by: Based on observareview, the facility resident's attendin change in conditions sample of 37. Findings include: Review of R55's A was admitted to the diagnoses that increspiratory failure, chronic obstructive constipation and services of R55's need to the diagnoses of R55's need to the di	st record and periodically is (mailing and email) and the resident imposite distinct part. A facility edistinct part (as defined in ose in its admission agreement uration, including the various prise the composite distinct exify the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply its policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of the policies that apply to ween its different locations each of t	F 580	This Plan of Correction constitute written allegation of compliance fo deficiencies cited. However, subm of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. It is the policy of the facility to provider family. R55 was noted to have emfever and overall decline in health. Although some documentation wano temperature was taken, lung so not assessed, and no physician was contacted regarding the acute chat Over 2 days resident was sick and staff did receive chest x-ray it was immediately called to physician. Rhas since had resolution of aspirate pneumonia and staff educated on	r the ission or that of and ovide s and esis, ounds as nges. I when not esident ion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245052	B. WING		04/1	3/2018
	PROVIDER OR SUPPLIEF	ON & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 580	this shift. Resident emesis x 2. Emes and desert [sic]." 4/8/18 11:45am: " 4/8/18 11:25pm: "R [above] 100 so PF administered. Resident emesis x 2. Emes and desert [sic]." 4/8/18 11:25pm: "R [above] 100 so PF administered. Resident emesis x 2. Emesis e	was sitting up in bed for dinner trace and later experienced episodes of its contents consist of a meal. Temp 99.5" esident had elevated temp > RN [as needed] TYI [Tylenol] ident has a nasal congestion" W on 4/10/18 at 11:30am with 2), Z2 stated staff was not R55's condition. Z2 stated, "I te to take my dad's temperature sked, no one would ever have ever. He has a 100.5 5am, R55 was observed in and breathing through mouth. Sing her concerns regarding her and breathing through mouth. Sing her concerns regarding her at Tylenol prepared for him. Eare of his temperature." urse's notes dated 4/10/18 at "Resident is running a temp. 3 and lung sounds are m, "Resident is alert and today, wheezing in lungs." At [x-ray] received: Possible iration. Review of R55's chest	F 580	follow up on medical symptoms, immediately calling physician with on resident change and expecting than 8 hours to get response from call again. If still no response upda medical director. 2.Because all residents count on s timely and appropriate care all are potentially affected by the cited def monitoring for change in condition been reviewed and expectations or urgently address resident changes notifying MD immediately were discall residents have been reviewed to ensure no signs or symptoms of accissues have developed. Also, all resthat have any acute changes to the have been reviewed to ensure time notification completed and resident have been addressed No other reswere affected. The Policy and Procfor change of condition was also reand updated. 3.To enhance currently compliant operations and under the direction director of nurses, on 5/9/2018 all is staff received in-service training restate and federal requirements for monitoring for changes in condition updated on the findings of R37. The training emphasizes the importance taking all resident concerns serious monitoring symptoms and follow up following all interventions for effect maintenance and reporting of charpromptly to MD. 4. Effective 4/28/2018, a quality-ass program was implemented under the supervision of the director of nurses.	no less MD or te taff for ticiency, has f staff to by cussed. The cussed to by cussed to be sidents being care to be the custom of the custom	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	<u> </u>	
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F 580	available to the num 7:25pm that it was 17 hours later when had been notified on During an interview the Director of Nurse when asked about 1855 has episodes of "Find the cause, the the physician." The nurses' notes lacked physician had been elevated temperature. During an interview the Physician Assist that R55 had aspira R55's chest x-ray refindings upon his extended been notified of and elevated temperature two antibiotic medic stated that he experiment of the physician for soon as possible. The promptly informed of would have treated the reviewed on 4/2 Resident's Condition facility shall prompt	chest x-ray results became sing staff on 4/10/18 at not until 4/11/18 at 12:40pm, n R55's physician assistant f R55's x-ray results. on 4/12/18 at 11:40am with sing (DON), the DON stated, the nurse's interventions when of vomiting, the DON stated, e source of vomiting, contact DON confirmed that R55's d documentation that R55's notified of R55's emesis and re. on 4/11/18 at 11:30am with tant (PA), the PA confirmed ation pneumonia based on esults, symptoms and his kamination. When asked if he f R55's episodes of emesis erature, the PA stated, "No, I e aware of his emesis and re until 4/10/18. I just ordered eations for [R55]." The PA also cted the nurses to notify him any change in condition as the PA stated, "Had I been of his fever and vomiting, I	F 5	monitor residents for chang. The director of nurses or de quality-assurance represen perform the following systet the DON or designee will et done weekly to monitor chat condition and new orders for 1 week, then 6 residents weeks, then on 3 residents weeks. Any deficiencies will on the spot, and the finding quality-assurance checks we documented and submitted quality-assurance committed further review or corrective 5.DON will be responsible for the spot of t	esignated tative will matic changes: nsure audits ange of or all residents a week for 2 weekly for 4 I be corrected s of the vill be I at the monthly be meeting for action.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 580	condition and/or s Supervisor/Charg Attending Physicia there has been: resident's physica	page 38 sident's medical/mental statusThe Nurse e Nurse will notify the resident's an or On-Call Physician when A Significant change in the sl/emotional/mental condition; A resident's medical treatment	F 58			5/21/18	
SS=D	grievances to the that hears grievar reprisal and withor reprisal. Such grie respect to care ar furnished as well furnished, the behresidents, and oth facility stay.						
	facility must make resolve grievance accordance with t §483.10(j)(3) The on how to file a grievance to the resident. §483.10(j)(4) The grievance policy to fall grievances recontained in this p	e prompt efforts by the facility to s the resident may have, in					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 585	include: (i) Notifying reside postings in promif facility of the right (meaning spoken grievances anony of the grievance can be filed, that address (mailing number; a reason completing the re to obtain a writter grievance; and th independent entit be filed, that is, the Quality Improvem Agency and State program or protect (ii) Identifying a Gresponsible for overeeiving and tracconclusions; lead by the facility; mainformation associated by the facility; mainformation associated by the facility in the identifying and tracconclusions; lead by the facility; mainformation associated by the facility in the identifying and tracconclusions; lead by the facility; mainformation associated by the identifying and tracconclusions; lead by the facility; mainformation associated by the identification of the intervention of the in	ent individually or through nent locations throughout the to file grievances orally or in writing; the right to file mously; the contact information official with whom a grievance s, his or her name, business and email) and business phone able expected time frame for view of the grievance; the right decision regarding his or her econtact information of les with whom grievances may e pertinent State agency, ent Organization, State Survey Long-Term Care Ombudsman ction and advocacy system; rievance Official who is rerseeing the grievance process, sking grievances through to their ing any necessary investigations intaining the confidentiality of all stated with grievances, for titly of the resident for those tted anonymously, issuing decisions to the resident; and state and federal agencies as of specific allegations; taking immediate action to stential violations of any resident eged violation is being	F 58	35			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 585	as required by Stat (v) Ensuring that al include the date the summary statement the steps taken to is summary of the pe regarding the resid as to whether the g confirmed, any contaken by the facility and the date the wi (vi) Taking appropriaccordance with Store of the residents' rig or if an outside entithe State Survey A Organization, or loc confirms a violation rights within its are (vii) Maintaining ev result of all grievan 3 years from the ist decision. This REQUIREME by: Based interview at failed to ensure a r missing items was manner. This defic (R31) of one reside Findings Include: During an interview stated that R31 was sweatpants and pa pillow." Z4 indicate	ministrator of the provider; and	F 585	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists of one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility to allege residents the right to file a grievance they feel they are concerned with contents in the policy of this facility and it is the policy within the facility and it is the policy	the ssion or that of and ow se if are

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP COD		
MOORHI	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 585	this was reported items were not represponse from the requesting receipt stated that she was R31's missing iter. On 4/12/18 at 3:4' (SSW) confirmed grievance from R3 items. The SSW sfamily for prices of they were never p SSW confirmed they concerns be addressed to the possible The Prospecific details su as documented by grievance report, and the cause. 3.	to the facility. Z4 stated that the placed and that here was no e facility, except for the facility is for the missing items. Z4 is unable to locate receipts for ins. 7pm, the Social Service Worker that she had received a 31's family related to missing stated that she had asked the fighth the missing items however rovided by R31's family. The nat she had never followed-up	F 5	facility to respond to those grie R31 was noted to have missin and neck pillow and grievance official, it was noted to have be without follow up. The family we contacted for prices and family respond, unfortunately the issumption of followed up on again. In the after the surveyor reported the concern, the SW and ED discussed up with fair market value reimburse resident \$40 for iter 2. Because all residents that refacility calling it their home and have the right to express their all are potentially affected by the deficiency. On 4/13/2018, curr residents were audited to ensunderstand they can file a grie they have concerns, that the fafollow up timely, any outstanding rievances were resolved, and review added to morning stand other residents were affected. and Procedure for grievances reviewed. 3. To enhance currently complications and under the direct SW, on 5/9/2018 all staff and received handout with policy and grievance form. The hand out our policy and resident rights a appropriate time frame for follow also reminded resident to have with labeling items and ensuring that are expensive or sentimer be kept off site or in drawers to loss of property. 4. Effective 4/28/2018, a quality 4. Effective 4/28/2018, a quality 4. Effective 4/28/2018, a quality 4.	g clothing was not een reported as did not le was then s case, resident ussed and to ns. side in the therefor concerns, ne cited ent ure they vance if acility will ng grievance d up. No The Policy was ant tion of the esidents nd explained ow up. It es staff assist ng any items ntal should o prevent	

-	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 585	CFR(s): 483.12(b)(§483.12(b) The fac implement written p §483.12(b)(1) Proh neglect, and exploit misappropriation of §483.12(b)(2) Estal to investigate any s §483.12(b)(3) Incluparagraph §483.95 This REQUIREMENT by: Based on interview failed to develop ar included mistreatm of alleged violations taking, keeping and	Abuse/Neglect Policies 1)-(3) ility must develop and policies and procedures that: ibit and prevent abuse, pation of residents and resident property, polish policies and procedures uch allegations, and de training as required at	F 58	program was implemented under to supervision of the SW to monitor regrievances and resident inventorie ensure facility aware of resident ite. The SW or designee will complete audits per week x 4 weeks on resident in the 2 audits weekly for 4 weeks. A deficiencies will be corrected on the and the findings of the quality-assument the monthly quality-assument the monthly quality-assument committee meeting for further revision some supervision.	esident s to ems. 4 dents to net, Any e spot, urance bmitted ew or OC	5/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTIONS	ON		SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS	S, CITY, STATE, ZIP CODE	•	
MOORHI	EAD REHABILITATI	ON & HEALTHCARE CENTER		2810 SECOND A			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	involving abuse, indicated involving abuse, incomplete and misage are reported to the agency within the and (d) ensured the are reported to the designated representation of the agency within 5 with deficient practice residents residing. Findings include: Review of the fact "Vulnerable Adult During the shift the unexplained injuring the shift the unexplained injuring their Supervisor, safety. Following Supervisor will immost their Supervisor will immost prector of Nursing Supervisor will immost prector of Nursing Director of Nursing Director of Nursing determine if the incriteria for 'Reported alleg Director of Nursing determine if the incriteria for 'Reported are submitted to Heath] via the onthe 2 hour period Administrator det not meet the criteristate or federal grant of the state or federal grant and the supervisor with the criteristate or federal grant and the supervisor with the supervi	red that all alleged violations neglect, exploitation or luding injuries of unknown propriation of resident property e administrator and state required reporting timeframes; he results of all investigations e administrator or his or her sentative and to the state vorking days of the incident. This had the potential to affect all 53	F6	Correction requirement federal law. 1. It is the princidents are incident that deficiency of during states had been ustates all in be reported abuse or new will be reported abuse or new will be reported abuse or new will pictures or or humiliate additional in Nursing and importance adult cases facility compaction accidents afor any pote resident proput at nursi staff to ensuand neglect followed up 2. Because vulnerable at this citation abuse/neglect incidents are any resident reviewed and reviewed and reviewed and requirements.	is submitted to meet ats established by state at a colicy of this facility to repart and do timely follow up or at result in injury. The of this practice was note evisit and policy and proposed at a color and policy and proposed at a color and a color at a color and a c	d ocedure icy ble will tion of use, all will be nd no mean ted on policy. ed on ble health d diately A eated, ed to all abuse ediately ed by rector s to the all ed, and been within	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
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F 607	violations involving mistreatment, inclusions are reported immed hours after the alled that cause the alled in serious bodily in if the events that converted involve abuse and injury, to the admit other officials (inclusion Agency and adult law provides for justicities) in accordestablished procedinvestigation. The policy failed to exploitation as typicalled to include a from taking, keeping photographs and repolicy failed to investigations are administrator or his representative and with State law, included Agency, within 5 with Con 04/13/18 at 08 (ED) was made averlated to the missipolicy. The ED control in the control investigations are admits and the control investigations are admits and the control investigations.	port." poinclude that all alleged gabuse, neglect, exploitation or uding injuries of unknown propriation of resident property, ediately, but not later than 2 egation is made, if the events gation involve abuse or result jury, or not later than 24 hours ause the allegation do not do not result in serious bodily nistrator of the facility and to uding to the State Survey protective services where state risdiction in long-term care dance with state law through dures prior to the start of the conclude mistreatment and es of alleged violations and component that prohibits staffing and/or distributing recordings that demean or	F 60	state regulations. No other resi affected. The Policy and Proce abuse/neglect was reviewed ar 3.To enhance currently complic operations and under the direct director of nurses, on 5/9/2018 with assistance from SW receinservice training regarding the requirements. The training will abuse/neglect policy and safety and resident exploitation. Staff on following plan of care, approinterventions, timeliness of repohrc. No other residents were 4.Effective 4/28/2018, a quality program was implemented und supervision of the SW to any incidents/accidents to ensure policy followed. SW will audit a ensure understanding of policy incidents will be immediately reponsional further discussed darup, unless injury then reported with 2 hours, if allegations with file in 24 hours, and update to deficiencies will be corrected or and the findings of the quality-acchecks will be documented and at the monthly quality-assurance committee meeting for further accorrective action. 5.DON and SW will be responsible.	dure for ad updated. Int ion of the all staff red ion policy review of reporting to eaffected. Passurance er the rotocol and ill staff to All ported to by at stand to OHFC out abuse ED. Any in the spot, ssurance is submitted e eview or		

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F 607	Services (CMS) "S Memorandum 16-3 "Each resident has types of abuse, inc abuse includes, but facilitated or cause or using photograp manner that would resident(s)Each rand implement writ that prohibit all formabuse. Each nursir revise their written procedures to inclu home staff are prohphotographs or rec would demean or hwould include using cameras, smart photographs or second include using cameras, smart photographs or second recordings on Reporting of Allege CFR(s): 483.12(c) (Second Second Seco	ers for Medicare & Medicaid urvey and Certification 3-NH", dated 8/5/16, indicated the right to be free from all luding mental abuse. Mental is not limited to, abuse that is d by nursing home staff taking has or recordings in any demean or humiliate a nursing home must develop ten policies and procedures as of abuse, including mental ing home must review and/or abuse prevention policies and de and ensure that nursing ordings in any manner that it is any type of equipment (e.g., ones, and other electronic eep, or distribute photographs social media."	F 60			5/21/18

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F 609	serious bodily injuthe events that ca abuse and do not the administrator officials (including adult protective sefor jurisdiction in laccordance with Sprocedures. §483.12(c)(4) Reginvestigations to the designated represaccordance with Survey Agency, wincident, and if the appropriate correct This REQUIREMING. Based on intervier facility's staff failed possible abuse in and the facility fail the State within the one (R20) resident of resident-to-resident-to-residentistrator affer R258) of 17 resides ample of 37. Findings include: 1. Record Review included but were diagnoses: cerebro hemiplegia (paraly hemiparesis partial)	ry, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to of the facility and to other to the State Survey Agency and ervices where state law provides ong-term care facilities) in State law through established for the results of all the administrator or his or her sentative and to other officials in State law, including to the State ithin 5 working days of the eatleged violation is verified between alleged violation is verified between the administrator, and record review, the dotoreport an allegation of an allegation to the required time of two hours for the and failed to report allegations dent abuse immediately to the conting two residents (R22 and the entire the following that all paralysis) affecting right side, porosis (bone loss) and	F 6	This Plan of Correction consti written allegation of compliance deficiencies cited. However, so of this Plan of Correction is not admission that a deficiency extone was cited correctly. This If Correction is submitted to meet requirements established by stated and do timely follow incidents and do timely follow incident that results in injury. If R20 was noted to have voiced over not feeling safe due to state rough with her. It was brought resident council and not review morning meeting. When staff of with resident she didn't state safraid just didn't like the way the with her. No incident report was	e for the ubmission tan ists or that Plan of et tate and o report all up on any n this case a concern aff being up at ved until did speak he felt uat staff was	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		` '			(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	04/	13/2010	
		ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH APPROVIDENCY)	ULD BE	(X5) COMPLETION DATE	
F 609	System (MDS) da "Section C-cognitia a Brief Interview for indicated that R20 same MDS under Functional Status, extensive assistant dressing, toilet use Resident Council facility on 4/11/18 to address any cobeing present as put the start of meeting minutes were react the facility had address and concerns. While rean incident involvi "rough" and calling spoke up and ider resident. R20 was R20 stated that sh (SW) felt that it was feel safe all the tin Council Meeting, I willing to stay and privately. R20 agroup During an intervie asked to clarify the nursing assistant me that I'm mean added that NA4 sp asks, "What do yoway often. When I assigned to care for the same designed to care for the	R20's annual Minimum Data ted 3/9/18 under the heading ve Pattern," R20 scored a 14 in or Mental Status (BIMS) which was cognitively intact. In the the heading of "Section G" specified R20 "required nce" with bed mobility, transfer, e and personal hygiene. Meeting was conducted at the at 3pm with all residents invited ncerns without staff members part of the survey process. At 10g, the 3/29/18 resident council of to the residents to evaluate if dressed their expressed reading the minutes, there was 10g and 11g and 11g and 11g and 11g as he being that a saked if it had been resolved. The spoke to the social worker as addressed but she "doesn't ne." At the end of the Resident R20 was asked if she would be speak about the incident	F 60	OHFC completed, and commer taken seriously. R22 and R258 noted to have been involved in altercations upon review no not given to ED regarding event or Nursing and SW were also edulimportance of reporting all vulne adult cases to the OHFC (office facility complaints) and ensuring been notified of those events. 2.Because all residents are potentificated by the cited deficiency follow through, on 4/4/2018, the nursing reviewed with all staff the importance of reporting suspectiviolations. A new resident protein manual was created to educate components of the abuse program further educates staff or report and what to report to ensure this type of situation does not on the program also has an incident guide to assist staff to determin reportable and who to notify which discussed was the proper proceincident and accidents and the process to ensure DON and SV aware of any situation for imme follow up and the ED if any abust noted. Policy and procedure for events was reviewed. No other were affected. 3. To enhance currently compliate operations and under the direct director of nurses, on 4/4/2018 staff received in-service training requirements for reporting violation were also advised with every increardless of how small or if no	fication behavior. Cated on crable of health ED has entially and lack of director of e ed ction staff on am. The on when to cure that cour again. In report e what is en. Further dure for notification are diate se/neglect reportable residents on of the all nursing regarding ions. Staff sident		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		04/-	13/2018	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO		10/2010	
				2810 SECOND AVENUE NORTH			
MOORH	EAD REHABILITATION	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 609	R20 explained that so roughly that it runnecessary." R2 occurred. R20 state week ago. R20 water anyone, and R20 of Nursing (DON) DON's response, say much." When the name of the NR20 reported that Record review of as the heading wirevealed informative regarding the incidented as being rean occurrence date the same docume "Description of Concertified nursing a resident and [sic] of the document, Director and the Doth signatures. During an interview Activity Director (Awhat was discussive held on 4/10/18 wafter R20 reported nursing assistant, meeting. Nothing the incident involved AD stated, "Yes, sonursing assistant)	describe what rough meant. It "she [NA4] pulls my briefs off emoved my bandages. That's one was asked when this ted that this occurred about a sa asked if she reported this to replied that she told the Director. R20 was asked about the R20 stated, "(The DON) didn't R20 was asked if she identified A who was rough to the DON,	F 60	DON needs to be informed in as well as doctor, family/POA documented accordingly in pocare. Documentations must in up nurses notes, and approprinctification made to POA, ME and OHFC is necessary via E. This was reviewed again on 8 4.Effective 4/28/2018, a quali program was implemented up supervision of the SW to more incidents to ensure anyone we suspected abuse is reported to OHFC. All incidents, accidinjuries will be logged to ensure and investigation log. The SN designated quality-assurance representative will perform the systematic changes: the DO conjunction with SW will make immediately (within 2 hours) is abuse/neglect or injury was allegation with no injury up to The ED will be notified. All incidents/accidents or suspect abuse/neglect situations will be at stand up daily. The DON of will complete 6 audits per weathen 4 audits weekly x 2 week audits per month for 2 month compliance in this area. Any will be corrected on the spot, findings of the quality-assurance comeeting for further review or action.	and bint click include follow riate 0, DON, ED DON, ED DON or SW. 5/9/2018. Ity-assurance inder the into all ith injury or immediately ents and ire follow upction manual V or e following N in e report f any uspected – if 24 hours. Itted be reviewed in designee ex x 2 weeks as then 2 is to ensure deficiencies and the ince checks inted at the inmittee		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245052	B. WING _		04	/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	3/29/18, after the re R20 told him that N The AD then placed into the DON's box the name of the NA The AD stated that have included it in AD was asked if he immediately or soo nursing assistant w replied, "I didn't ser guess I was wrong. DON ever question incident or ask for t knew, who was des AD stated that the ID During an interview DON, the DON recinvolving R20. The the "Fix It Ticket" the could not recall the assistant) who was her statement by st R20 on 3/30/18, bu name" of the NA. During an interview Executive Director, Executive Director, Executive Director, Executive Director safe, and the inform 3/29/18 which incluwas rough with resinvas reviewed with stated that R20 new was not aware of a	recalled writing it up on esident council meeting when A4 was treating her roughly. It this document on 3/29/18. The AD was asked if he knew when he wrote the report up. he did, and that he should his "Fix It Ticket" report. The	F 60	this POC.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245052	B. WING		····	04/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		2810 S	T ADDRESS, CITY, STATE, ZIP CODE ECOND AVENUE NORTH RHEAD, MN 56560		
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F 609	3/29/18 "Fix It Tick with them had his standard with them had his standard with them had his standard was reported to stated," No." Review of the facilifor the "Vulnerable 12/23/17 revealed, Administrator shall incident/allegation "Reportable Incide reportable under Naubmitted to MDH Health) via the onthe 2 hour period." 2. Review of R17's 150 Physical", date "Pt [patient] was at nurse. Pt [R22's in talking to nurse an say anything to this yelled at him to get chest with the back initials] was remove was redirected. Pt to have sustained was very agitated a his action."	disciplinary action. However, the et" that had just been reviewed signature and was dated of on 4/13/18 at 8:19am with the and the Social Worker Executive Director was asked if hoccurred 14 days ago on 820 being treated roughly by a to the State. The ED dity's Policies and Procedures Adult" with a review date of "The Director of Nursing or determine if the meets the criteria for nt" All incidents deemed IN (Minnesota) statue are (Minnesota Department of line Reporting System within	F6	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER EAD REHABILITATIO	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 609	submitted on 1/13/1/13/18 at 11:30 am at nursing station to [R22's initials] appropriate nurse while sitti initials] did not say [R17's initials] saw him and then struct back of his closed of the result reported to the stat Incident Reporting-10156" submitted of "Investigation Suminitials] does not lik says that [R22's initialways making noise did not sustain any from the altercation. There was no evide immediately reported. During an interview Executive Director that the above incided was immediately resulted. Reporting-Investigation 1/11/1/10 no 1/11/18 at 12:00 resident [R258's initials].	tion Report Summary 309606" 18 at 1:25pm, indicated that on "Resident [R17's initials] was alking to the nurse resident oached and was also talking to ng on his walker. [R22's anything to [R17's initials]. [R22's initials] and yelled at a him in the chest with the fist." Its of the final investigation e agency titled "Nursing Home Investigation Report Summary on 1/17/18 at 6:42am, under mary" stated "Resident [R17's e resident [R22's initials]. He tials] is aggravating and is se, etc. Resident [R22's initials] bruising or apparent injuries are that this incident was sed to the administrator. If on 4/13/18 at 8:19am, the could not provide evidence that involving R17 and R22 eported to the administrator.	F 60	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610 SS=D	reported to the state Incident Reporting-10093" submitted on "Investigation Summinitials] has been explately. MD [physicia Amongst others have to resident's current staff and other resident's current staff and other resident's work] is working to place for [R3's initial. There was no evident immediately reported. During an interview Executive Director of that the above incident was immediately reported. The state of t	its of the final investigation agency titled "Nursing Home Investigation Report Summary in 1/15/18 at 2:22pm, under mary" stated "Resident [R3's stremely agitated and restless in], resident's guardian. We been contacted in regards to behavior and its effect on dents. Currently, SW [social have other interventions put in lis]." Ince that this incident was ed to the administrator. On 4/13/18 at 8:19am, the could not provide evidence ent involving R3 and R258 ported to the administrator. (Correct Alleged Violation 2)-(4) Inse to allegations of abuse, in, or mistreatment, the facility evidence that all alleged ughly investigated. Ent further potential abuse, in, or mistreatment while the rogress.	F 6			5/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION (X3) BUILDING	
		245052	B. WING		04/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 610	Continued From pa	age 53	F 610		
	incident, and if the appropriate corrections REQUIREME by:	thin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced w and record review the facility		This Plan of Correction constitutes	mv
	failed to thoroughly resident in an alleg (R20) resident and allegations of resid two residents (R22	r investigate and protect a lation of possible abuse for one failed to thoroughly investigate ent-to-resident abuse affecting and R258) of 17 residents in the sample of 37.		written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a	the ssion or that of
	Findings include:			federal law. 1.It is the policy of this facility to	
	included but were diagnoses: cerebra hemiplegia (paralyhemiparesis partia	of R20's Admission Record not limited to the following al infarction (stroke), sis on one side) and I paralysis) affecting right side, orosis (bone loss) and		investigate, prevent and correct alleviolations of residents. In this case case R20 stated she felt afraid and concerned about care with a staff member. No incident reporting don interventions taken or reported as required. R22 and R258 had alteres with physical behaviors, no incident	in this e, nor ations
	System (MDS) dat "Section C-cognitiva a Brief Interview for indicated that R20 same MDS under the Functional Status," extensive assistant dressing, toilet use Resident Council M	R20's annual Minimum Data ed 3/9/18 under the heading re Pattern," R20 scored a 14 in r Mental Status (BIMS) which was cognitively intact. In the the heading of "Section G specified R20 "required ce" with bed mobility, transfer, and personal hygiene. Meeting was conducted at the at 3pm with all residents invited		completed, no update given to ED. case, after the surveyor reported the system, the policy and procedure of abuse/neglect and reporting had be reviewed and updated. All staff were in-serviced, and information put at station in case staff need clarification while survey was still in process. Note ED and social services coordinator also educated on importance of investigating all incident and report vulnerable adult cases to the OHFO	In this le faulty n leen lee nursing on lursing, were
	to address any cor being present as p the start of meeting	icerns without staff members art of the survey process. At g, the 3/29/18 resident council to the residents to evaluate if		(office of health facility complaints). 2.Because all residents are potential affected by the cited deficiency and follow through, after the state surveing the stat	ally I lack of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED
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			2810 SECOND AVENUE NORTH		
MOORHEAD REHABILITATION	I & HEALTHCARE CENTER		MOORHEAD, MN 56560		
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concerns. While rea an incident involving "rough" and calling it spoke up and identitives an incident. R20 was a R20 stated that she (SW) and felt it was feel safe all the time Council Meeting, R2 willing to stay and sprivately. R20 agreed During an interview asked to clarify the inursing assistant (Nome that I'm mean an added that NA4 sponsasks "What do you noten. When R20 was assigned to care for continued to care for R20 was asked to de R20 explained that it so roughly that it rerunnecessary." R20 occurred. R20 state week ago. R20 was anyone, and R20 reof Nursing (DON). Poon's response, R20 say much." When R20 the name of NA who reported that she has Record review of a facility) as the headirevealed information	essed their expressed ading the minutes, there was a nursing assistant being the resident "mean." R20 fied herself as being that isked if it had been resolved. Spoke to the social worker addressed but she "doesn't e." At the end of the Resident 20 was asked if she would be peak about the incident ed. on 4/11/8 at 3:30pm, R20 was incident. R20 stated that IA)4 was "too rough. She told and then she ignores me." R20 iske harshly to her when she want?" and spoke this way as asked if NA4 was still ther, R20 replied that NA4 is her, R20 replied that NA4 is her as recent as last night. The isescribe what rough meant. The isescribe what rough meant. The isescribe what rough meant asked if she reported this to plied that she told the Director R20 was asked about the 20 stated, "(The DON) didn't is was rough to the DON, R20	F 6	and director of nursing review staff the importance of investi reporting suspected violations resident protection manual ware ducate staff on components program. The program further staff on what should be invest is abuse/neglect and determined cause of incident, when to reput to report to ensure that this type situation does not occur again program also has an incident to assist staff to determine who reportable and who to notify we discussed was the proper profincident and accidents and the process to ensure DON and Enaware of any situation for immedilow up. OHFC notified as repolicy and procedure for abuse was reviewed. No other resident affected. 3. To enhance currently complement operations and under the director of nurses, on 5/9/2012 receive a review in in-service regarding requirements for impreventing and correctly hand incidents and accidents. Staff advised with every incident rehow small or if no injury the Duse informed immediately as we doctor, family/POA and docum accordingly in point click care. Documentations must include nurse's notes, and appropriate made to POA, MD, DON, ED is necessary via DON or SW. 4. Effective 4/28/2018, a quality to the process and appropriate made to POA, MD, DON, ED is necessary via DON or SW. 4. Effective 4/28/2018, a quality to the process and appropriate made to POA, MD, DON, ED is necessary via DON or SW. 4. Effective 4/28/2018, a quality to the process and appropriate made to POA, MD, DON, ED is necessary via DON or SW. 4. Effective 4/28/2018, a quality to the process and appropriate made to POA, MD, DON, ED is necessary via DON or SW. 4. Effective 4/28/2018, a quality to the process and appropriate made to POA, MD, DON, ED is necessary via DON or SW. 4. Effective 4/28/2018, a quality to the process and appropriate made to POA, MD, DON, ED is necessary via DON or SW. 4. Effective 4/28/2018, a quality to the process and the process to the pro	gating and a. A new as created to of the abuse reducates igated, what hing root port and what pe of a. The report guide lat is when. Further cedure for a notification ED are nediate equired. See/neglect ents were liant ction of the 8 all staff will training westigating, ling all will also be gardless of ON needs to well as nented and OHFC follow up and OHFC	

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		245052	B. WING		04/	13/2018
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MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		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 CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 610	an occurrence dath the same docume "Description of Co (certified nursing a resident and [sic] sof the document, in Director and the Doth signatures. Or reviewed and these concerns such as and laundry items During an interview Activity Director (A what was discussed which was approximated being treat assistant. The AD meeting. Nothing an incident of rough stated, "Yes, she (nursing assistant) {that} she is mean the ED was asked processed. The AI Ticket" was procesup and placing it in The AD was asked when he wrote the he did, and that he "Fix It Ticket" repospoke to the DON reported that a nur 3/29/18. The AD reurgent, but I guess asked if the DON details of the incident of the same control of the cont	orted by R20 on 3/29/18 with e of 3/28/18 in the evening. In ht, below the caption, rection," it revealed, "CNA assistant) was rough with said 'you are mean!" At the end a was signed by the Executive ON with the date of 4/2/18 for ther Fix It Tickets were e same tickets addressed other hallways being too cluttered	F 6:	program was implemented un supervision of the DON and E all incidents to ensure anyone or suspected abuse is reporte immediately to OHFC. All inci accidents and injuries will be lensure follow up completed perotection manual and investignated qualit representative will perform the systematic changes: the DON conjunction with SW will make immediately if any abuse/neglewas suspected. All incidents/a suspected abuse/neglect situateviewed at stand up daily. The designee will complete 3 audit x 2 weeks then 1 audits weeks then 2 audits per month for 2 ensure compliance in this area deficiencies will be corrected and the findings of the quality-checks will be documented and the monthly quality-assurant committee meeting for further corrective action. 5.DON, ED and SW will be resthis POC.	D to monitor with injury d dents, ogged to er resident gation log. y-assurance following I in report ect or injury ocidents or itions will be e DON or s per week y x 2 weeks months to a. Any on the spot, assurance d submitted ce review or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			04/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		2810	EET ADDRESS, CITY, STATE, ZIP CODE O SECOND AVENUE NORTH ORHEAD, MN 56560		
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F 610	asked about it." During an interview DON, the DON recinvolving R20. The name of the NA (nough with R20, bustating that she did R20 would not "sar DON recalled R20 rough when chang asked if she had at this incident. The Edon't know where for questioned if she as DON replied that so not asked if she fenursing assistant where sary to proteimmediately initiate could not recall sporegarding the incided During an interview Social Worker (SW was a Care Conferconducted on 4/10 the SW and the Acpresent. The SW roursing assistant) "Don't recall what we discussion." During an interview Executive Director Executive Director safe, and the information of the same process.	ated that the DON "never of on 4/11/18 at 3:50pm with the called the 3/29/18 incident of DON could not recall the cursing assistant) who was not followed her statement by the speak to R20 on 3/30/18, but by the name" of the NA. The stelling her that the NA was ing clothes. The DON was then ny documentation regarding DON replied, "I wrote notes, but they are" The DON was asked R20 if she felt safe, the she hadn't. Because R20 was lt safe and the name of the was not obtained, the steps of R20 from NA4 were not each of the Activity Director	F 6	10			

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F 610	was reviewed with stated the R20 new was not aware of a Executive Director would have been did The "Fix It Ticket" vijust been discussed dated 3/29/18 by the During an interview 7pm which was 13 treated roughly by I stated that NA4, which was day, would be assigned wing from R20's roughly and NA4 would not The Executive Director were interviewed to nursing assistants after surveyor interviewer in the "Vulnerable 12/23/17 revealed, Supervisor of the sin question may be duties or suspende is for the protection Supervisor, Director will immediately insof the reported alleginvestigation may in b. Resident interviewed Environmental reviewed behavior review"	ident and said you are mean." them. The Executive Director er complained to him, and he buse or roughness. The added if he had known there isciplinary action. However, with R20's allegation that had d with him, was signed and e Executive Director. Ton 4/11/18 approximately at days after R20 reported being NA4, the Executive Director no was scheduled to work that gned to another wing (separate om) with nursing supervision, be assigned to care for R20. ctor added that other residents address the quality of care were providing. This occurred	F 6				

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	"Pt [patient] was at nurse. Pt [R22's init talking to nurse and say anything to this yelled at him to get chest with the back initials] was remove was redirected. Pt [to have sustained a was very agitated a his action." Review of the initial titled "Nursing Hom Reporting-Investiga submitted on 1/13/1/13/18 at 11:30 am at nursing station to [R22's initials] appr the nurse while sitti initials] did not say [R17's initials] saw him and then struck back of his closed for the resul reported to the stat Incident Reporting-10156" submitted or "Investigation Sumi initials] does not lik says that [R22's initials always making nois did not sustain any from the altercation evidence that a tho conducted.	nursing station talking to tials] approached and was also disitting in his walker. Did not pt. This pt saw [R22's initials], away and struck him in the of a closed fist. Pt [R22's ed from the area, and this pt [R22's initials] did not appear any injury at this time. This pt and made no excuse fro (sic) I report to the state agency le Incident ation Report Summary 309606" at 1:25pm, indicated that on "Resident [R17's initials] was alking to the nurse resident oached and was also talking to ng on his walker. [R22's anything to [R17's initials]. [R22's initials] and yelled at a him in the chest with the	F6	10		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		E SURVEY PLETED
		245052	B. WING		04/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	Executive Director of that the above incided was thoroughly investigated as the provided as thoroughly investigated on 1/11/10 on 1/11/18 at 12:00 resident [R258's initial thought that she was reported to the state Incident Reporting-10093" submitted on "Investigation Summinitials] has been explately. MD [physicial Amongst others have to resident's current staff and other resident's current staff a	could not provide evidence lent involving R17 and R22 estigation was conducted.	F 61			
F 623 SS=B	Executive Director of that the above incided was thoroughly inventorice Requirements	could not provide evidence lent involving R3 and R258 estigated. ts Before Transfer/Discharge	F 62	3		5/21/18
	resident, the facility	nsfers or discharges a				

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245052	B. WING		04/	13/2018
NAME OF PROVIDE		N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	·	
	ACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
representation representation representation representation facility representation representati	asons for the age and many must send a sentative of the Term Care Or ecord the reast arge in the residence with particle in the near the facility ent is transfer or de safety of in dangered undertion; he health of in dangered, un ection; he resident's ha more immediate the de by the resident has in 15(c)(5) Continuent in the continuent in the paragraph (continuent in the continuent in th	f the transfer or discharge and move in writing and in a ner they understand. The copy of the notice to a see Office of the State mbudsman. Sons for the transfer or sident's medical record in aragraph (c)(2) of this section;	F 6	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245052	B. WING		04/	/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	must include the fol (i) The reason for t (ii) The effective da (iii) The location to transferred or disch (iv) A statement of tincluding the name and telephone num receives such requite to obtain an appeal completing the form hearing request; (v) The name, addressed telephone number of the cong-Term Care Or (vi) For nursing fact and developmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the Developmental disabilities and Bill of Rights Accodified at 42 U.S.C (vii) For nursing fact disorder or related demail address and agency responsible advocacy of individuestablished under the for Mentally III Indivisional support of the transfer must update the received and the second of the transfer must update the second of the transfer must update the second of the transfer must update the se	lowing: ransfer or discharge; te of transfer or discharge; which the resident is arged; the resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State mbudsman; lity residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with bilities established under Part ental Disabilities Assistance et of 2000 (Pub. L. 106-402, c. 15001 et seq.); and ility residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder the Protection and Advocacy iduals Act. ages to the notice. the notice changes prior to er or discharge, the facility cipients of the notice as soon the updated information	F 6	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		245052	B. WING		04/13/201	18
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 1810 SECOND AVENUE NORTH MOORHEAD, MN 56560		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPL	(5) LETION ATE
F 623	In the case of facil the administrator of written notification to the State Survey State Long-Term of the facility, and the well as the plan for relocation of the red 483.70(I). This REQUIREME by: Based on intervier failed to ensure the for transfers were representatives, or and R55) of eight in hospitalization in the Findings include: 1.A. Review of R35 under "Nursing No called and spoke wr R35's sister], regathe hospital]" Review of R35's modocumentation that or that the Office of (LTC) Ombudsman transfer in writing. B. Review of R35's under "Nursing No reported [and] obs [gastric/jejunum] to the properties of the same properties of facility	ce in advance of facility closure ity closure, the individual who is of the facility must provide prior to the impending closure y Agency, the Office of the Care Ombudsman, residents of a resident representatives, as a the transfer and adequate esidents, as required at § ENT is not met as evidenced w and record review the facility at written notifications required given to the residents, resident the ombudsman for two (R35 residents reviewed for	F 623	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility report transfers and discharges to the ombudsmen. R35 and R55 were alto the hospital and notification was made regarding their transfer to the ombudsman office as stipulated show the presidents to have no docume supporting notification it was noted this practice had not yet been implemented within facility. Immed policy and procedure on transfers/discharges was updated, were educated, reminders sent to restations with policy and requirement 2. Because all residents that reside facility do either discharge or have to the contraction of the cont	the ssion r that of the same of the sent the se	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245052	B. WING		04/1	3/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0 1/1	0/2010
MOORH	EAD REHABILITATIO	N & HEALTHCARE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 623	Continued From pa	age 63	F 623			
	sent to the ER [em arrives [at 2:42pm] Further review of F	us. Order is given to have him ergency room]Ambulance and departs at [2:55pm]"		ER, all are potentially affected by the deficiency. Immediately all resident ransferred or discharged were revand update was noted to ombudsnown staff note any resident leaving	ts being iewed nan.	
	notice required for	documentation that a written transfer was provided to the ntative or the Office of the State		are aware of notification needed at turn make appropriate note in residents. Current residents were audit director of nursing to ensure all had appropriate notification in place. No	dent ted by d	
	under "SBAR [situal assessment, recondition" dated 3,	nmendation] - Change of /15/18, "Resident complains		residents were affected. The Policy Procedure for transfers/discharges revised on 3/29/2018; reviewed on 4/17/2018	was	
	and upper chest order is given to ha	in the general area of his throat On-call [provider] updated and ave resident taken to the ER for further evaluation"		3.To enhance currently compliant operations and under the direction director of nurses, on 5/9/2018 all staff will attend in-service training regarding this policy and the impor	nursing	
	documentation tha transfer was provide	edical record revealed no t a written notice before led to the resident's ne Office of the State LTC		of notifying ombudsman. The trair emphasize this is to be done as so possible for transfers and up to 30 prior for discharges and document notification is critical.	ning will on as days ation of	
	under "Nursing Noissues with g-tube is clogged. Unable several intervention [medical doctor] for the tube replaced. to have g tube repl [emergency depart replace gtube [sic] [nothing by mouth]	s progress notes revealed te" dated 3/21/18, "Staff having lumen is broken and leaks and to successfully unclog afternsContacted on call MD rorder to send to ER to have Order to send resident to ER aced per [name of doctor]ED ment] stated they will not tonight. Resident will be NPO until he is seen in the morning personnelSister was also		4.Effective 4/28/2018, a quality-ass program was implemented under the supervision of the SW in conjunction DON to monitor any transfers and discharges to ensure appropriate notification given. The SW or desimil complete 2 audits per week x 4 on residents that have transferred discharged, then 1 audit weekly for weeks ensure staff comply with curpolicy. Any deficiencies will be corron the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meet	gnee I weeks or 4 rrent rected	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 623	no documentation to representative nor in the representation in the	35's medical record revealed hat the resident's the Office of the State LTC notified of R35's transfer in the Social Worker (SW) on the SW stated, "I inform the ransfer] happens. I don't have 35's sister and the ving the notice." nurse's notes dated 4/9/2018 I, "Resident was sent to the ER due to his feeding tube being rent in to change resident dent feeding tube was pulled unsure to what happen. Signs] are WNLs [within normal physician] on call was reder from Dr.[name of resident to the ER. DON I] was notify [sic], resident d and informed family will be ent at the hospital." Redical record revealed no the Office of the State LTC notified of R55's transfer in the Office of the State LTC notified because R55 was hospital and returned to the 24 hours. The SW stated that ill be notified only if R55 was	F 623	further review or corrective action. 5.SW will be responsible for this F		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 625 SS=B	Emergency" policy 3/28/18 revealed, " to make an emerge hospital or other re implement the follothe representative memberAll notice need to be sent wrinotification to office Notice of Bed Hold CFR(s): 483.15(d) (Section 15 (d)) (Section 16 (d)) (Section 16 (d)) (Section 16 (d)) (Section 16 (d)) (Section 17 (d)) (Section 18 (ty's "Transfer or Discharge, with the last revision onShould it become necessary ency transfer or discharge to a lated institution, our facility will wing procedures:e. Notify (sponsor) or other family es of discharges and transfers tten transfer or discharge of ombudsmen." Policy Before/Upon Trnsfr 1)(2) of bed-hold policy and returnate before transfer. Before a sers a resident to a hospital or in therapeutic leave, the state bed-hold policy, if the resident is permitted to residence in the nursing dipayment policy in the state to of this chapter, if any; which must be consistent with this section, permitting a land of specified in paragraph (e)(1)	F 62			5/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245052	B. WING		04/13/2018
	PROVIDER OR SUPPLIEF	ON & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 SECOND AVENUE NORTH MOORHEAD, MN 56560	0 11 10 120 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 625	specifies the dural described in parage This REQUIREME by: Based on intervie failed to ensure the policy required for another facility we R44) of eight residence in the residence in the representation in the representative has been hold policy in the reported [and] obsequence [and] obsequence in the practitioner], [nam on his present starsent to the ER [em	ative written notice which ion of the bed-hold policy graph (d)(1) of this section. ENT is not met as evidenced w and record review the facility at notifications of bed hold residents that transfer to re provided for two (R35 and lents reviewed for the sample of 37. 5's progress notes revealed be deter dated 2/20/18, "This nurse with pt's [patient's] sister, [name rding getting sent to [name of the resident or resident's deen notified of the facility's	F 625	,	the ssion or that of and sure OA and ident R35 and no to en the tation this and acility. On bed cated, with in the es, all
	no documentation specified the facili- the resident to retu	R35's progress notes revealed that a written notice that ty's bed-hold policy permitting urn and resume residence in wided to the resident or to the		transferred or on leave were review updated bed hold policy given out. staff note any resident leaving they aware to get POA consent for bed send bed hold with resident to hosp	ved and When are nold,

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY MPLETED
		245052	B. WING _		04	13/2018
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COI		13/2010
MOORH	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 625	under "SBAR [situ assessment, reco Condition" dated 3 of pain/discomfort and upper chest order is given to h [emergency room] R35's medical rec documentation that policy was provided resident's represedemergency transfermation. Review of R35' under "Nursing Not having issues with leaks and is clogg unclog after sever call MD [medical of to have the tube reto ER to have gitu doctor]ED [emerwill not replace gitube NPO [nothing be notified." Further review of I no documentation representative was in writing. In an interview with 4/11/18 at 3:15pm	s progress notes revealed ation, background, mmendation] - Change of 8/15/18, "Resident complains in the general area of his throat On-call [provider] updated and ave resident taken to the ER for further evaluation"	F 62	with resident taking leave and POA with note in resident charesidents were audited by dire nursing to ensure all had appropriate notification in place. No other were affected. The Policy and for bed holds was reviewed on 3. To enhance currently compliant operations and under the director of nurses, on 5/9/201 attend in-service training regapolicy and the importance of the training will emphasize the done with all residents being a facility going out on leave or to hospital. 4. Effective 4/28/2018, a quality program was implemented unsupervision of the SW in conjum DON to monitor any transfers appropriate notification given. designee will complete 2 audix 4 weeks on residents that he transferred or left, then 1 audity weeks ensure staff comply policy. Any deficiencies will be on the spot, and the findings of quality-assurance checks will documented and submitted and quality-assurance committee further review or corrective acts. SW will be responsible for the spot in the sponsible for the	rt. Current ector of ropriate residents Procedure n 4/17/2018 iant ction of the 8 all staff will rding this ped holds. is must be sent out of ransferring cy-assurance ader the unction with to ensure The SW or ts per week ave it weekly for with current ecorrected of the be the monthly meeting for ction.	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		
		245052	B. WING			04/	13/2018
_	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		281	REET ADDRESS, CITY, STATE, ZIP CODE 10 SECOND AVENUE NORTH DORHEAD, MN 56560	ECTION (X5 HOULD BE COMPLE	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 625	notice. If the reside we don't issue the I further stated, "For the sister. It's eithe bed-hold from the rotice to the hospit for the resident to s "The nurses are su notice upon transfe do. I don't have a resister] receiving the In an interview with on 4/12/18 at 6:48 was] no documentathe nurses provided DON further stated to document if they sent it with or faxed	nt came back within 24 hours, bed-hold notice." The SW [R35], I would normally call r we get a verbal consent for responsible party or we fax the al [hospital discharge planner] sign." The SW also stated, pposed to give the bed-hold or but if they did not do it then I becord of them [R35 or R35's		225			
	7:29am revealed, " [shortness of breat [saturation] and wh [respiratory rate], fe low pitched, rattling (upper and lower) cough yesterday bu [temperature] WNL started: this mornin Background: Has h approximately 2 we Appearanceposs infection] with prese at 0800 [8am]. Rec	nurse's notes dated 4/7/18 at Situation: Resident has SOB h], lowO2 [oxygen] sats eezing, increased RR ebrile and rhonchi [continuous lung sounds] to bilateral lungs. Resident c/o [complained of] at O2 sats, RR and temp. [within normal limits] This ng at 0630 [6:30am] and a mild cough off and on for eks Assessment or ible URI [upper respiratory ence of temperature of 100.6 ommendations: Possible abx o send to ED [emergency					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		E SURVEY IPLETED
		245052	B. WING _	 	04/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE
F 625	1:43pm revealed, 'med/surg [medical with acute respirate and hypervolemia circulating blood in Review of R44 cline evidence that R44 had been notified i hold policy. During an interview SW, the SW stated bed hold notice for Review of the facili Emergency" policy 3/28/18 revealed, 'to make an emerghospital or other reimplement the follothe representative member; ask if the temporary transfer a progress note the Review of the facili of Bed-Hold Policy Bed-Hold Policy is resident/financially	aluation. Trace's notes dated 4/7/18 at 'Resident was admitted to 'surgical] status room #445, ory failure and fluid overload [a decreased volume of the body]." ical record revealed no or resident's representative in writing of the facility's bed of on 4/11/18 2:58pm with the did that she could not find the R44 in the medical record. Ity's "Transfer or Discharge, with the last revision on 'Should it become necessary ency transfer or discharge to a elated institution, our facility will owing procedures:e. Notify (sponsor) or other family y would like bed held for any s. This can be documented in at they would like bed held " Ity's undated "Minnesota Notice" revealed, "The notice of provided to the responsible party upon	F 62	25		
F 641 SS=D	admission and at t Accuracy of Asses CFR(s): 483.20(g) §483.20(g) Accura		F 64	.1		5/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245052	B. WING _		04/	13/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				2810 SECOND AVENUE NORTH		
MOORH	EAD REHABILITATIO	ON & HEALTHCARE CENTER		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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	Continued From p	age 70 nust accurately reflect the	F 64	41		
	resident's status.	:NT is not met as evidenced				
	Based on observative review, the facility Minimum Data Set	ation, interview and record failed to accurately code the t (MDS) related to dental status ent reviewed for dental in the		This Plan of Correction consists written allegation of compliant deficiencies cited. However, so of this Plan of Correction is not admission that a deficiency expone was cited correctly. This	ce for the submission of an xists or that	
	Findings include:			Correction is submitted to me requirements established by s	et	
		4/10/2018 at 10:54am nissing some teeth.		federal law. 1.It is the policy of this facility accurate assessments on all	to provide	
	revealed R9 had a with medical diagn	ated "Admission Record," in admission date of 4/08/2016 loses that included anemia, light loss, and nausea.		R9 MDS did not properly indic issues. In this case, after the indicated the incorrect information immediately the documentation reviewed on these residents.	cate dental survey ation on was	
	Social Services W does not coordinate	04/11/2018 at 10:08am, the orker (SSW) stated she did te dental and stated the Unit ed dental appointments.		noted to have poor oral hygies multiple broken teeth and care been updated. 2.Because all residents received of care based on their assess	ne and e plan has ve their level	
	Unit Coordinator s dental company as documentation. T Unit Coordinator c	he only documentation that the ould provide was dated ch indicated that R9 had dental		are potentially affected by the deficiency, on 4/18/2018, the reviewed how information is gimportance of doing hands or residents to ensure accurate In addition, nursing staff were on importance of documenting	cited MDS nurse gathered and review with information. educated g	
	"Significant Chang 3/01/2017, Section was checked for "o broken natural tee	OS assessments revealed a te in Status Assessment" dated in L "D. Oral / Dental Status" Obvious or likely cavity or th." Review of the Annual MDS 101/17/2018, indicated that		appropriately on residents and care sheets to ensure staff pr correct cares. All current residuere reviewed for accuracy a resubmitted when necessary determined to need significan Through this process 3 discre	oviding dent MDS's nd or if thange.	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(XS	3) DATE SURVEY COMPLETED
		245052	B. WING			04/13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, 3 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		TION SHOULD BE THE APPROPRIAT	
F 641	were present." In an interview on 0 reviewing the MDS the MDS Coordinat	ked for "Z. None of the above 14/12/18 at 2:40pm, after dated 1/17/2018 Section L's, or stated, "I coded the MDS in the has decay and broken	F 6	were noted and address ensure proper documer corrected. No other res affected. 3. To enhance currently operations and under the director of nurses, on 5/ staff were in-serviced transcreaments for assess MDS/care plans. MDS reducated on importance residents they assess a accuracy. All residents quarterly and annually, a interviews will be critical data. All triggers will be communicated to staff vand communication boo interventions in place. 4. Effective 4/28/2018, a program was implement supervision of the MDS monitor residents MDS accurate and correct. The designated quality-assure representative will perform systematic changes: after determined, audit of all accuracy will be compled audits per week x 4 which weekly x 2 months to error in this area. Any deficient corrected on the spot, at the quality-assurance communication of the spot, at the quality-assurance communication to error of the spot, and the quality-assurance communication to error of the spot, and the quality-assurance communication submit quality-assurance communication to error of the spot, and the quality-assurance communication to error of the spot, and the spot and submit quality-assurance communication to error of the spot and th	ntation; MDS sidents were compliant the direction of 1/9//2018 all nursions and nurse was the of seeing and ensure will be reviewed and staff and properties of the MDS nurse and properties will be and the findings the the modulities will be and the findings the the modulities action.	the rsing ed ering and s ance ata e or ng urse udit nce s of nthly for

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		245052	B. WING			04/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 655 SS=E	S483.21 Comprehe Planning \$483.21 (a) Baselin \$483.21 (a) The implement a baselithat includes the ineffective and persot that meet profession. (ii) Be developed wadmission. (iii) Include the mininecessary to proper including, but not lith (A) Initial goals base (B) Physician order (C) Dietary orders. (D) Therapy service (E) Social services (F) PASARR recons \$483.21 (a) (2) The comprehensive carcare plan if the corcii is developed with admission. (iii) Meets the required (b) of this section (b) of this section (c) this section (c) The initial goals (d) The initial go	ensive Person-Centered Care e Care Plans facility must develop and ne care plan for each resident structions needed to provide on-centered care of the resident onal standards of quality care. plan must- ithin 48 hours of a resident's imum healthcare information orly care for a resident mited to- sed on admission orders. The plan in place of the baseline inprehensive care plan- thin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the epresentative with a summary e plan that includes but is not of the resident. The resident and	F6	\$55		5/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		SURVEY PLETED
		245052	B. WING		04/1	3/2018
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 655	administered by the on behalf of the facility Any updated in of the comprehens. This REQUIREME by: Based on observative review, the facility plans within 48 host that included goals resident's current in resident/resident in of the baseline car R107, R35 and R5. Findings include: 1. Review of R31's (MDS) dated 2/9/1 to the facility on 2/2/18, revealed the interventions related problem areas for Review of R31's many care plan dated 2/2/18.	and treatments to be le facility and personnel acting cility. Information based on the details sive care plan, as necessary. ENT is not met as evidenced lation, interview and record failed to develop baseline care curs of a resident's admission and interventions that address needs and failed to provide the lepresentative with a summary re plan for four residents (R31, significant for four residents) in the sample of 37. Is admission Minimal Data Set latin lacked R31 was admitted latin lacked the necessary led to the listed goals and latin lacked record revealed a base latin latin lacked record revealed a base latin latin lacked record revealed a base latin latin lacked record revealed a base latin latin latin lacked record revealed a base latin	F 655		s my the ssion or that of and ovide and ne care an, 5 had amily ace for se line or ulate e care	
	During an interview Regional Director confirmed that R3 interventions and to documentation that	w on 4/11/18 at 12:06pm, the of Clinical Services (RDCS) 1's baseline care plan lacked		potentially affected by the cited def on 4/17/2018, the MDS nurse revie process of ensuring accurate MDS formulate baseline care plans. All or resident care plans have been revie and updated for accuracy, MDS nur been educated on necessity of implementing base line care plans	iciency, ewed 's to other ewed erse has	

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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 655	2. A review of the u cover sheet to a mu contains demograp contact information information] indicate the facility on 04/03 Observation of R10 revealed an above observation R107 or Practical Nurse (LP Review of R107's p document titled, "ho physical)," signed b 03/13/2018 with a ha "L (left) gluteal 5 or (decubitus - a press The typed portion of R107 had been hos 03/12/2018 with a confection) with MSS Staphylococcus aurobody's overwhelming response to infection damage, organ failed document titled, "di revealed R107 had (Percutaneous nep catheter (plastic tubyour skin into your lidrain urine from you outside your body.) Review of R107's p Plan" divider reveal an interview on 04/10 description of the content of the c	Indated "Admission Record" [a ultipage document that hic information, preferences, and limited medical ed that R107 was admitted to /2018. If on 04/09/2018 at 2:22pm knee amputation. During the complained of pain to Licensed (N)1. It aper chart revealed a popital H & P (history and y the hospital physician on landwritten note that R107 had (2.8 cm (centimeter) decub sure wound) unstageable." If the H & P indicated that spitalized from 02/11/2018 to complicated UTI (urinary tract A (methicillin-susceptible reus) with MSSA sepsis (the lang and life-threatening on that can lead to tissue sure, and death). Review of the scharge physician orders bilateral nephrostomy tubes hrostomy (PCN) tube is a language physician orders bilateral nephrostomy tubes hrostomy (PCN) tube is a language physician orders and language physician orders and language physician orders. In the language physician orders are planguaged to language physician orders and languaged to languaged the section was empty. In 10/2018 at 12:05pm, LPN1 a care plan, it would be in the	F	655	importance of discussing with reside POA. The policy on care plans has reviewed and updated. 3. To enhance currently compliant operations and under the direction director of nurses, on 5/9/2018 all restaff received in-service training regions base line care plans. The training emphasized the importance of mor ADL's, and treatment information of sheet follows the actual care perform MDS nurse to visualize residents a staff through interview to confirm dather through interview to confirm dather assessment of residing individual needs. 4. Effective 4/28/2018, a quality-assign program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure accurate and correct. The MDS nudesignated quality-assurance representative will perform the follow systematic audits of assessments formulating base line care plan base individual resident needs. They will completed by MDS nurse 2 audits week x 4 weeks then 1 audit weekled months to ensure compliance in the Any deficiencies will be corrected of spot, and the findings of the quality-assurance checks will be documented and submitted at the requality-assurance committee meeting further review or corrective action. 5.MDS nurse will be responsible for POC.	of the nursing garding nitoring n care med. nd ask ata. nt of lent urance ne o data urse or wing ed on be per y x 2 s area. n the monthly ng for	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	` '	E SURVEY MPLETED
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F 655	"Medication Admin resident was recei anticoagulant) 40n daily, insulin daily, intravenously ever 04/05/2018, oxyconeeded for pain, wand nephrostomy." Review of R107's R107 revealed two One had a focus of stay for strength a and can make his interested in group He also stays in classification of daily I deficit r/t (related to for the second foculisted: "I am assist x1 for [patient] to don proroom for stand-piv (wheelchair) level In an interview on MDS (Minimum Daprocess for baselin starts them, then to paperwork and Magives it to the sociation." Then, it writes it up for a sufficient of the second foculisted: "I am assist x1 for [patient] to don proroom for stand-piv (wheelchair) level."	EHR document titled, istration Record" indicated the ving enoxaparin (an ing (milligrams)/0.4ml (milliliters) nafcillin (an antibiotic) 2 grams y four hours through done 7.5mg every 4 hours as round care to a coccyx wound, tube care each shift. "Care Plan" tab in the EHR for pages initiated on 04/05/2018. In the resident is likely a short and antibiotics. He is alert x4 own choices. He is not too activities but enjoys visiting. The resident has an ADL iving) self-care performance by [blank]." No goal was listed us, and two interventions were dressing (encourage pt osthesis). I independent [sic] in ot transfers and toileting. W/c	F 655			
	there. The MDS C	oordinator looked thru three per from her file stacker and				

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F 655	stated "Oh, I don't been brought back that R107 was adra a baseline Care Pl stated, "no, it's not In an interview on Regional Director responded to a qu process for baselin stated, "Called ten just came up with the AANAC (Amer Assessment Coord process or policy f process changed a The RDCS stated nursing staff would plan and that the Afollow up to admist that there were no baseline care plan In an interview on MDS Coordinator holding up an AAN had R107's care p baseline care plan considered the base completed on 4/11 3. Review of R35's R35 was admitted In an interview on with R35 revealed person and place. communicated by	have it so it must not have a to me yet." When questioned nitted on April 3rd and if he had an, the MDS Coordinator back to me yet." 04/11/2018 at 12:04pm, the of Clinical Services (RDCS) estion regarding what was the ne care plans. The RDCS apporary care plan, we actually a form through a pathway on ican Association of Nurse dination) site. There is no or a baseline care plan. The around the first (of the month)." it was an expectation that a complete the baseline care ANAC form was more of a sion orders. The RDCS stated interventions to the AANAC form. 04/11/2018 at 2:30pm, the entered the conference room IAC form and stated that she lan. When asked if that was the seline care plan and it was	F 65	5		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	•		
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F 655	that goes through trachea, or windpi unable to talk). Review of R35's in care plan dated 2/baseline care plan and necessary infinest. Also, there we the baseline care given to the reside. During an interview Director of Nursing things that we need plan. It is missing DON was asked if that a copy or sum resident or responsee anything [documotes] within 48 hours, within 48 hours, resident or go over resident, provide a actually did this with 4. Review of R55's R55 was admitted diagnoses that increspiratory failure, chronic obstructive constipation and so Review of R55's be admission date of for his cognition, of dietary orders, dieservices, functions	the front of the neck into the pe which makes the person nedical record revealed a base 15/18. Review of R35's add not include instructions ormation to properly care for was no evidence that a copy of plan itself or the summary was ent or resident representative. W on 4/12/18 at 6:35pm, the g (DON) stated, "There are a lot of information." When the a there was any documentation mary was provided to the insible party, she stated, "I didn't umentation in the progress ours." The DON further stated, of supposed to talk to the recopy and document that she	F 6	55			

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F 656 SS=D	care plan revealed and interventions to During an interview Regional Director or read R55's baseling current baseline care built up with the assadmission follow up RDCS stated, "I excare plans have wrinterventions. Whe interventions to me stated there was not Develop/Implement CFR(s): 483.21(b)(1) The implement a comport care plan for each resident rights set if §483.10(c)(3), that objectives and time medical, nursing, an eeds that are ider assessment. The odescribe the follow (i) The services that or maintain the resphysical, mental, as required under §483.24, §48 provided due to the	ther review of R55's baseline no interim goals approaches of address R55's needs. You 4/11/18 at 12:08pm, the of Clinical Services (RDCS), effect care plan and stated, "The are plan that they are using is sessment. This is more of to to admission orders." The pect to see in the baseline itten approaches and in asked if R55's care plan had set R55's needs, the RDCS one. It Comprehensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable efframes to meet a resident's ind mental and psychosocial attified in the comprehensive comprehensive care plan must ing - attare to be furnished to attain ident's highest practicable and psychosocial well-being as 13.24, §483.25 or §483.40; and att would otherwise be required 13.25 or §483.40 but are not to resident's exercise of rights luding the right to refuse	F 6			5/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 656	(iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resi (iv) In consultation versident's represen (A) The resident's gesired outcomes. (B) The resident's getsired outcomes. (B) The resident's getsired outcomes. (B) The resident's getsired outcomes. (C) Discharge. For this pur (C) Discharge plans plans, as appropriate requirements set for section. This REQUIREMENT by: Based on interview failed to develop a related to risk for as resident reviewed fraddress care problem (a surgically created windpipe (trachea) airway for breathing resident reviewed from the sample of 37. Findings include: 1. Review of R55's R55 was admitted to diagnoses that included to the sample of 37.	services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)- goals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to ies and/or other appropriate	F 656	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility to proconsistent quality care to ensure rehave comprehensive care plans. Fat risk for aspiration and needs to be assessed for potential signs and symptoms of aspiration. Care plan address any risks or how to monito aspiration in tube feeding patient w	the ssion or that of and ovide sidents 355 is be did not r for	

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F 656	Continued From p chronic obstructive constipation and s Review of R55's A Minimum Data Ser R55's Brief Intervies score was five that cognitive impairmerevealed R55 requirements of Review of R55's Confor Feeding Tube of "Describe impact or resident and your decision." The ansimal malnutrition, dehydronic revealed diagnosis swallowing). Review of R55's Sevaluation plan and revealed diagnosis swallowing). Review of R55's prevealed, "Rist for aspiration with Review of R55's prevealed an order formula) 1.2 liters	age 80 e pulmonary disease, ubdural hemorrhage. dmission Assessment t (MDS) dated 3/20/18 revealed ew for Mental Status (BIMS) t indicated R55 had severe ents. Review of the same MDS uired extensive assistance with	F 6	556		s ot of trach after I care in was cted by cted by the suring rewed is with en RAI outside	
	procedure in which placed through the stomach. PEG allo medications to be	n a flexible feeding tube is a abdominal wall and into the bws nutrition, fluids and/or put directly into the stomach, uth and esophagus) tube.			staff received in-service training reg monitoring for patients with trach's tube feedings. The training emphas the importance of monitoring care p and ensuring staff know when a spe diagnosis is presented, certain care	garding and sized blans ecific	
	"Dependent on tub beverage intake d	are plan dated 4/2/18 indicated, be feeding/inadequate food and ue to: acute respiratory failure." bal revealed, "Maintain			standard for maintaining optimum le health based on nursing education as monitoring trach care including be limited to; monitoring trach sites for	evel of such out not	

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NAME OF	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP	•		
MOORH	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 656	plan interventions feedings as order monitor lab data a nothing by mouth; service as needed. During an intervie Speech Therapist who had a swallow tube puts him at ristated that the sta supervision when interventions shound the state of t	and body weight." R55's care included: Enteral formula and ed; monitor intake and output; is available; monthly weights; screen/evaluation by rehab d and water flushes as ordered. W on 4/12/18 at 2:09pm with the (ST), the ST stated that R55 wing disorder and a feeding sk for aspiration. The ST further ff should provide direct feeding R55. When asked what all be put in place to monitor ration, the ST stated, "Listen to dis every shift or at least daily to ing signs of pneumonia; check more often." When asked if a had been developed after the R55 for care and treatment, the n't had a care plan made for w on 4/12/18 at 10:02am, the reviewed R55's CAA on a stated that the Interdisciplinary levelop a care plan for R55 at risk for aspiration, malnutrition. When asked if a plan dated 4/2/18 was ddressed R55's risk for interventions were in place to opirations, the MDS Coordinator nothing in the care plan. I don't	F 6	infection, changing trach ti trach if disposable or inner nurse to review care plans addressing triggers to ens needs outside triggers and included in care plan. 4. Effective 4/28/2018, a querogram was implemented supervision of the MDS and monitor residents MDS and accurate and correct. The designated quality-assurar representative will perform systematic audits of assess formulating care plan base resident needs. They will be MDS nurse 2 audits per withen 1 audit weekly x 2 monomore compliance in this area. And will be corrected on the specific findings of the quality-assumill be documented and sumonthly quality-assurance meeting for further review action. 5.MDS nurse will be resported.	r cannula. MDS after ure aspects of d RAI are uality-assurance d under the d DON to d ensure data MDS nurse or nce the following sments ed on individual pe completed by eek x 4 weeks onths to ensure ny deficiencies ot, and the urance checks ubmitted at the committee or corrective		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 656	Continued From pa	_	F 656				
	unspecified site if li	ory of malignant neoplasm of p, oral cavity, and pharynx; attention to tracheostomy.					
	there was no care part tracheostomy. Revelons revealed that	orrent care plans revealed that plan related to R35's iew of R35's resolved care there was a care plan related omy upon admission but was n 4/3/18.					
	the month of April 2	s Order Summary Report for 2018 revealed the following cheostomy] cares BID [twice lay Trach size 6"					
	summary report revorders related to the and how often the itracheostomy tube cannula (outer tube open) which has a coughed out and is be replaced nor was	errent care plans and order vealed no interventions or e care of R35's tracheostomy inner cannula (part of the that fits inside the outer e that holds the tracheostomy lock to keep it from being removed for cleaning) should as there any instruction to and symptoms of infection or					
	system used by nu communicate impo patients) for R35's	lex (a medical information rsing staff as a way to ortant information on their hallway revealed under "Care d a trach but there was no to its care.					
	on 4/12/18 at approabout the care plan	the Director of Nursing (DON) eximately 6:35pm, when asked for R35's tracheostomy care, did not see any care plan					

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, Z 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ZIP CODE		
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F 656	addressing the trace if R35 needed a catracheostomy, she Review of the facilit Comprehensive" pot 12/23/17, indicated care plan is based that includes, but is Each resident's condesigned to: a. Incorporation areas; b. Incorporation identified problems services that are recarei. Reflect curpractice for problem Areas of concern the resident assessment tools (Assessments) before the care plan; 5. Catesigned after care relationship between and their causes6 and their causes6 and their causes, at that are targeted are interdisciplinary data gathering, procomplex clinical de According to Long Assessment Instrumpublished on Octob "When Is the RAI N"facilities are respissues that are rele regardless of wheth the RAI (42 CFR 48).	ch." When the DON was asked re plan related to the stated, "Yes Ma'am." ty's "Care Plans - Dicy with the review date of plan at the comprehensive on a thorough assessment of a not limited to, the MDS; 3. In the properties of the risk factors associated with properties for each element of rently recognized standards of the areas and conditions4. The triggered during the properties are triggered during the properties of the resident of the resident's problem areas and conditions4. The triggered during the properties of the resident's problem areas and developing interventions and meaningful to the resident of processes that require careful per sequencing of events and	F 6	56			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		04/	13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 657 SS=D	stated under "Limita instrumentsThe F assessment includic completing the MDS Triggers] are trigger CAA [Care Area Ast the process of comportions of the RAI assessment that makes and manager residents. Neither the RAI includes all analyses, or concluproblem solving and of nursing home residents. The Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the Care Plan Timing at CFR(s): 483.21(b)(2) A combetion of the CFR(s):	ntions." The Manual also ations of the RAI-related AI provides tools related to a substantial detail for S, how CATs [Care Area red, and a framework for the sessment] process. However, pleting the MDS and related does not constitute the entire ay be needed to address at the care of individual the MDS nor the remainder of of the steps, relevant factors, sions needed for clinical didecision making for the care sidents" Ind Revision (2)(i)-(iii) Thensive Care Plans in the care plan must in 7 days after completion of assessment. Interdisciplinary team, that imited to	F 65			5/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 657	disciplines as dete or as requested by (iii)Reviewed and ream after each as comprehensive an assessments. This REQUIREME by: Based on observative review, the facility were updated for the residents reviewed 37. Findings include: 1. Review of R9's (a cover sheet to a contains demograph contact information information information information information information, abnow the were not lmitted disturbance, chronomolecular hallucinations, abnow disorder and receive 2/28/2017. Review of R9's car "Patient is on Hospof life care r/t (relative Dementia secondary dysphagia Date Initiated: 04/1 will be comfortable Date Initiated: 04/1 will base of the secondary of the comfortable date Initiated: 04/1 will be comfortable date Initiated: 04/1 will base of the secondary	n. ate staff or professionals in rmined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the	F 657	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists of one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility to proconsistent quality care to ensure resultance and it was determined that is no care plan coordination with hoservices and staff are not clear on whospice does or when they do it thus providing continuity in care. R36 is a dialysis and in reviewing care plan addialysis policy and protocol care did match. R40 had multiple intervention place due to suicidal ideation noted admission. The resident is not suicidant the care plan had not been upout this case, after the survey determined that is not suicidant the care plan had not been upout this case, after the survey determined that is not suicidant the care plan related to dialysis create communication protocol and update care plan related to dialysis patients. Hospice also met with facility updated care plan and set days and	the ssion or that of and vide sidents 9 is on there spice what is not on with not ons in upon dal, dated. nined to lity and	

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F 657	"Allow patient to verabout dying proces. Coordinate Care Finitiated: 04/14/20 Evaluate effectives medications/interverbate Initiated: 04/20 informed of chang 04/14/2017 Revision on: 11/24 any change in compate Initiated: 04/2017 In an interview on a patient care plar the care, the Direct "We have a care plar the care, the Direct "We have a care plar the care, the Direct "We have a care plar the care, the Direct "We have a care plar the care, the Direct "We have a care plar the care, the Direct "We have a care plar the care, the Direct "We have a care plar the care, the Direct "We have a care plar the care, the Direct "We have a care plar the care of the Lister Conference revealed a care	ach the goal included: erbalize fears and concerns es, Date Initiated: 04/14/2017; Plan with my Hospice, Date 17, Revision on: 11/24/2017; ness of rentions to address comfort, 14/2017; Keep my family e in condition, Date Initiated: 4/2017; and Notify hospice of dition or medication changes 14/2017." 04/12/18 at 11:47am regarding for hospice that coordinates ctor of Nursing (DON) stated, plan in the system that includes responded, "Hospice an that tells us what they will responded they have monthly pice. 15pm the Unit Coordinator (UC) wing information regarding the which revealed: Summary" dated 02/13/18 reference for R9 that included a censed Social Worker (LSW)	F 657	for cares, group sheets updated so are aware of hospice cares. R40 caplan updated based on assessment resident is no longer at risk for self-2. Because all residents care is direct the care plan, all are potentially affe by the cited deficiency, on 4/17/201 MDS nurse reviewed process of enaccurate MDS's to formulate comprehensive care plans. All other resident care plans have been reviewed and updated for accuracy, MDS nurse and dialysis and discussed need to join services for comprehe care plan. Care plans and care she reflect necessary changes. The poprocedure for hospice services, dia and care planning have been reviewed updated. 3. To enhance currently compliant operations and under the direction director of nurses, on 5/9/2018 all restaff received in-service training regularly in care and building comprehensive care planed building care planed building care planed based on indesignated quality-assurance representative will perform the following care planed based on indesignated planed	are t t charm. cted by ected 8, the suring r ewed rse ds with the nsive ets will icy and lysis wed of the nursing garding ervices, plan lans. urance ne o data urse or wing evidual eted by veeks	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 657	UC, also at the nurtime per week." LP do depends on what they might do morn they might try to ba (activities of daily littoileting). If (they ar provide socialization They have a form they did. The hospi weeks. She may at check with nursing (Activities of Daily I movement." In an interview on Cregarding what care Nurse Aide (NA) 4 hall often, but typical Hospice will get him bath day or a partial (NA4) knew what coprovides cares, NA pocket, turned to R says he's on hospic often they come; the front I could go When asked what the front I could go When asked what the front I could go When asked what the front I could go A review of the "Dainformation reveale Alert/Pleasantly Cobite, take a drink; to	a week;" at which time the se's station, stated, "only 1 N3 stated, "typically, what they at time they come. If early, ing cares. If it is his bath day, the him and help with ADLs ving, e.g. shaving, dressing, re) here at breakfast, they will n and encourage him to eat. hey fill out to let us know what ce nurse comes every 1 - 2 tempt to do vital signs. She'll regarding weight, ADL living) changes and last bowel 04/13/2018 at 8:30am re hospice provides for R9, stated, "Well, I don't work this ally, if it's a morning visit, an up, give him a bath if it's his all bath." When asked how she are and how often hospice 4 pulled a care sheet from her 9's information and stated, "it ce, but it doesn't mention how ere is a hospice schedule at check."	F6	compliar will be co findings will be do monthly meeting action.	nce in this area. Any deforrected on the spot, an of the quality-assurance coumented and submitt quality-assurance comfor further review or consurse will be responsible	nd the e checks red at the mittee rrective		

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F 657	In an interview on C Regional Director of stated the facility diffor hospice service: R9's care plan show between the facility RDCS stated, "No, on." 2. Review of R36's revealed an original of 06/05/2017 and a 12/05/2017, with m renal disease (ESF Review of R36's ca "The resident need failure/ESRD. Fistu extremity). Receive Wednesday, Friday Initiated: 06/06/201 resident will have n complications from date. Date Initiated 01/08/2018 Target Interventions to ach Lidocaine-Prilocain 30-60 minutes prior Date Initiated: 12/0' take B/P [blood pre- Initiated: 06/06/201] bleeding occurs, ap for 10-15 minutes. 911. Notify physicial elevated blood pre-	marines. Report refusals of 24/13/18 at 10:40am, the f Clinical Services (RDCS) d not have a care plan policy s. In response to the query if wed a coordination of cares and the hospice services, the it's something I will be working undated "Admission Record," I admission date to the facility a readmission date of edical diagnosis of end stage (D). re plan, revealed a focus of: s dialysis r/t renal la to LUE (left upper s dialysis M/W/F [Monday, of at [facility name]. Date 7." The care plan's goal, "The o s/sx (signs/symptoms) of dialysis through the review to 6/06/2017 Revision on:	F 6	657		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 657	receive dialysis on and Wednesday at Initiated: 06/06/201 Monitor for dry skin Date Initiated: 06/06 output. Date Initiated and report to doctor 06/06/2017; Monitor update Dr. [name] a 08/23/2017." A review of the facil "Hemodialysis Policia reviewed 04/03/201"D. Comprehens must develop a complan for each reside objectives and time resident's medical, needs. 1. The care plan sheldentify potential risidialysis (CHF, pulme electrolyte imbalance -Measurable goal for complications. -Monitor for complications, chest pain distress, chest pain	Alled dialysis appointments. I Monday and Friday at 1:30PM 1200 at [facility name]. Date 7 Revision on: 12/07/2017; and apply lotion as needed. 6/2017; Monitor intake and ed: 06/06/2017; Monitor labs of as needed. Date Initiated: r thrill/bruit q (every) shift and as needed. Date Initiated: r thrill/bruit q (every) shift and as needed. Date Initiated: lity's policy titled, ey" created 12/27/2017 and 8, revealed: live Care Plan The facility inprehensive care ent that includes measurable etables to meet a nursing and psychosocial ould address the following: literature sks and complications of lonary edema, drug toxicity, ee) or potential risks and cations. Into a cations of lonary edema, etc. It or access site for signs of lolume. In g. is site. In on. In on.	F 6	57			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 657	related to dialysisCompatible goals a SNF (skilled nursing provider." In an interview on 0 regarding R36's car "The care plan does of the policy." 3. On 4/09/18, a clir R40 was admitted to diagnoses that inclue Parkinson's disease bodies, and major of Review of R40's car revealed R40's beh ideation had the foll included: placing hi prevent injuries; low floor on either side; and, place padding bed. Observations on 4/4 4/12/18 at 09:00am headboard and the behind his head wa was not in the close the floor. On 4/11/18 at 10:14 the Minimum Data is was unsure if the re-	ge 90 ppropriate scheduling as they and interventions between the gracility) and dialysis 4/13/18 at 10:40 AM, re plan, the RDCS confirmed, so not match the requirements nical record review revealed to the facility on 11/07/17 with uded but no limited to equal to a compare the plan dated 11/09/17 avior related to suicidal lowing interventions that so dresser in the closet to whole with mats placed on the remove head and foot board; on the wall at the head of the control of the co	F 6	57			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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F 658 SS=D	(Registered Nurse) longer suicidal and revised. RN1 also s fall hazard for him a On 4/11/18 12:00 p Director of Nursing that R40 was no lor "[R40's] care plan r Services Provided CFR(s): 483.21(b)(\$483.21(b)(3) Com The services provide as outlined by the comust- (i) Meet professional This REQUIREMED by: Based on observative review, the facility of practice related to a borrowing of medic physician's orders of R55); and, checking placements for two	am, during an interview with RN1 stated that R40 was no R40's care plan needed to be stated that the mats created a and were discontinued. m, during an interview with the (DON), the DON confirmed needed to be revised." Meet Professional Standards	F 65	This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, submof this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1.It is the policy of this facility to propose the policy of the	or the nission or that n of and	
	the following: a. 4/9/18 - Guailfen 10 milliliters (ml) ev cough.	physician's orders revealed esin (cough medication) syrup ery four hours as needed for e (laxative) solution give 30 ml		medications as directed by physic medication directions. Multiple me errors occurred. R55 has g-tube a medications were mixed together, placement was not checked, med pushed all are not standards of medication administration. R35	edication and g-tube	

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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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F 658	Continued From p	age 92	F 658			
	by mouth two time c. 4/9/18 - Miralax by mouth every 24 constipation. Mix in juice, soda, coffee On 4/10/18 at 9:19 (LPN)1 was obsermedications. LPN into a calibrated medications. LPN1 v. confirmed that she LPN1 stated, "Year During the same cobserved pouring calibrated medicationstead of 30 ml. TLPN1 borrowed R: R44's use. LPN1 complete the	s a day for constipation. (laxative) give 17 grams (gm) hours as needed for n eight ounces (oz) of water, or tea prior to administration. Oam, Licensed Practical Nurse ved preparing R44's oral I poured the cough medication edication cup and poured more verified the amount and prepared more than 10ml. h it's a little over 10." Observation, LPN1 was the lactulose solution into a ion cup and poured 20 ml The surveyor also observed 207's lactulose medication for confirmed that she had only give to R44. ed preparing R44's Miralax poured the Miralax powder into	F 656	medications were also mixed and placement was not checked prior to administering medications. In this after the survey determined there is significant errors, medication revies showed meds not available for reseand pharmacy advised to send immediately. Staff were instructed reach out to DON if they are not remedication refills timely and education of the resident medications is allowed. Also reviewed with nurses proper way to administer g-tube medications, g-tube placement, net reatments, and dosing medication Medication errors were documented education completed. 2. Because all residents have the requality care and receive medication the facility all are potentially affected the cited deficiency, on 4/12/2018 DON and RDCS reviewed with state proper medication administration, and using residents own medication borrowing. All medications have be reviewed to ensure supply is available.	o case, were w idents to eceiving sted that is not is the ebulizer is. ed, and ight to ins from ed by the ff g-tubes ons not een	
	Guailfenesin more Lactulose less tha Miralax mixed with	Dam, LPN1 administered R44's that the ordered dose; n what was ordered and the water that was less than the ong with all R44's other		MAR reflects g-tube placement an ordered for proper dosing. Medica administration policy reviewed. No residents were affected. 3.To enhance currently compliant operations and under the direction director of nurses, on 5/9/2018 all	d cups ation other	
	a. 3/23/18 - Diclofe gel 1% apply trans pain. b. 3/14/18 - Aspirir	s physician's orders revealed: enac Sodium (pain medication) dermally two times a day for n EC (enteric-coated) low ayed Release give 81 milligram		staff will receive in-service training medication administration, doing 3 checks, medication refills, borrowing meds, and g-tube medication train 4. Effective 4/28/2018, a quality-assign program was implemented under the	on ng ing. surance	

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F 658	(PEG - a procedure tube is placed throu into the stomach. P and/or medications stomach, bypassing one time a day. c. 3/20/18 - Fluticas (used to treat nasa congestion, sneezii in both nostrils one d. 3/19/18 - Ipratrop albuterol sulfate (brour times a day. e.3/13/18 Bumetan tube once daily. f. 3/13/18 Carvedild 3.125mg via PEG tube once h. 3/14/18 Escitalop via PEG tube once h. 3/14/18 Lisinopr 10mg via PEG tube j. 4/8/18 Acetamino mouth every four herever. k. 3/19/18 Ferrous 1tsp 5ml via PEG tube 50mg/5ml give 10mday. On 4/9/18 at 9:45ar Diclofenac Sodium indicated, "Use the	ous Endoscopic Gastrostomy in which a flexible feeding uph the abdominal wall and PEG allows nutrition, fluids to be put directly into the gethe mouth and esophagus) sone Propionate Suspension I symptoms such as any and runny nose) two sprays time a day. Solum bromide 0.5mg and ronchodilator) 3ml inhale orally ide (diuretic) 1mg via PEG of (for high blood pressure) two twice daily. The propional symptoms are perfectly in the propional symptoms of the propional symptoms and in the propional symptoms and in the surveyor noted that gel had a label instruction that dosing card attached inside	F 6	558	supervision of the DON to monitor medication administration policy an procedures. The DON or designate quality-assurance representative wiperform competencies on all staff administering medications and use g-tubes. DON will then audit med put audits per week x 4 weeks then 2 weekly x 2 months to ensure compliant this area. Any deficiencies will be corrected on the spot, and the finding the quality-assurance checks will be documented and submitted at the number of the process of the	of asses audit liance ngs of e nonthly	
	this carton box labe apply 4 gm to affec	el." The label also indicated to ted areas. Observation did not use the dosing card.					

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F 658	LPN1 put a small a finger and applied On 4/10/18 at 9:50 preparing R55's m following tablets in time and poured ir Bumetanide, Carv Finasteride, Lisino LPN1 entered R55 medications with v gastrostomy tube to the GT port ther water. Observation revea placement of the GT hen LPN1 remove the syringe (without port, poured R55's barrel of the syring syringe to push the tube. Further observation the GT with 50 ml syringe to aspirate the medication cup aspirated the docuother medication in one to the GT port and liquid medications On 4/9/18 at 10 am administering nasa	amount of the gel onto her the gel onto R55's shoulders. Dam, LPN1 was observed ledications. LPN1 put the one pouch, crushed at one one cup: Aspirin EC, edilol, Escitalopram, pril and Acetaminophen. Dis room, mixed the crushed warm water. LPN1 opened the (GT) port, attached the syringe of flushed the GT with 50 ml of the led that LPN1 did not check the GT before flushing the water. The led the syringe and reattached at the plunger) back to the GT is diluted medications into the ge and used the plunger of the diluted medications down to the same of water then used the same of the Ferrous Sulfate elixir from the sup. LPN1 mixed the two liquid the syringe, attached the syringe and the plunger to push the	F6	558			

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		245052	B. WING		04/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE 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)	LD BE	(X5) COMPLETION DATE
F 658	R55's face mask for drug delivery device medication in the for lungs). LPN1 then administer R55's more opened his mouth, piece into R55s' more nebulizer machine. LPN1 did not providing an out during the during the administ treatment and was the mist of the medication and interview stated that she did give R44. LPN1 als LPN1 further stated Miralax, LPN1 stated borrowing R207's (medication, LPN1 smedication, LPN1 smedication. When borrow other reside "No. We don't want medications, so we supplies." LPN1 was amount of water mowder. LPN1 stated up to five oz. I shou cups, 4 oz per cup During an interview LPN1, LPN1 stated dosing card of the LPN1 further stated	am, LPN1 was unable to find or his nebulizer treatment (a e used to administer orm of a mist inhaled into the use a mouth piece to ebulizer treatment. R55's then LPN1 put the mouth outh and turned on the Observation revealed that de R55 instructions to breathe e procedure. R55 fell asleep ration of the nebulizer not able to adequately inhale	F 65	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 658	all. When asked if R55's enteric coat defeats the purposasked about the nadministered to R for each nostril. It for each nostril. It for each nostril." Vadministration for didn't have a face mouth piece. When to breath in and on When asked if R5 administered appropriate to carry out of R44's guailfene R55's aspirin EC, medications. LPN1 also failed to by combining, crust medication all at other combining crust medication all at other combining to the property before medication. LPN1 failed to ensinhaling the mist of nebulizer treatments. Review of the faci "Administering Me Tube" indicated, "together prior to a server server to a s	it was appropriate to crush ed aspirin, LPN1 stated, "No, it se of delayed release." When umber of nasal spray she 55, LPN1 stated, "I sprayed one hought the order was one spray When asked about the nebulizer R55, LPN1 stated, "I know I mask to use but I used a en asked if she instructed R55 at, LPN1 stated, "No, not really." 5 nebulizer treatment was opriately, LPN1 stated, "I guess ow standards of practice by the correct physician's orders sin, lactulose and Miralax and nasal spray and diflonac gel to follow standards of practice shing and administering R55's nce via his GT. To follow standards of practice I medication from another failed to check GT placement administration for R55.	F 65	8			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEI	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 658	not crush or split through an entera the pharmacy or f Medication List' prior to administrate require a specific not crush enteric volume [GRV] to feedingWhen consider the deceptable GRV is medication by gramedication into the holding the tubing insertionIf administertionIf administertionIf administered in administere	medications for administration all tube unless first checking with acility approved 'Do Not Crush Tablets that must be crushed ation through an enteral tube order related to crushingDo coatedCheck gastric residual assess for tolerance of enteral prect tube placement and nave been verifiedAdminister wity flow. Pour diluted e barrel of the syringe while a slightly above the level of nistering more than one with 15 mL (or prescribed erile or purified water between dility's policy created on viewed on 4/3/2018, Medication dicated, "Medications must be eccordance with the orders, wired time frame The attering the medication must HREE (3) times to verify the not medication, right dosage, right thod (route) of administration medication."	F6	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		04/13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 SECOND AVENUE NORTH MOORHEAD, 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 APPROPF DEFICIENCY)	BE COMPLÉTION	
F 658	of the route ordered	age 98 the order and appropriateness d. Confirm that the patient can medication by the ordered	F 658			
	cation-Guidelines.p Registered Nurses' medications (using supply for another) medication errors. and address the re- borrowed medication	ebsite, -content/uploads/2015/05/Medi odf, "Medication Guidelines for " indicated, "Borrowing medication from one client's increases the risk of Organizations should identify asons why RNs administer ons (Grissinger, 2013). As acy policy regarding this				
F 684 SS=D	Council Acts (Board standardsprovision	ebsite, www.ncsbn [National d of Nursing].org, "Further on of care as ordered or orized health care providers"	F 684		5/21/18	
	applies to all treatment facility residents. Be assessment of a restrict that residents received accordance with proportion of the comportance of	fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis	the	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIEF	₹		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				2810	SECOND AVENUE NORTH		
MOORH	EAD REHABILITATIO	ON & HEALTHCARE CENTER		MOC	DRHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Continued From ppneumonia for one reviewed for tube changes for one (I reviewed for skin of the skin o	e (R55) of one resident feeding; and, document skin R39) of three residents condition in the sample of 37. S Admission Record revealed to the facility on 3/13/18 with cluded but not limited to: acute type 2 diabetes mellitus, e pulmonary disease, subdural hemorrhage. Admission Assessment to (MDS) dated 3/20/18 revealed ew for Mental Status (BIMS) at indicated R55 had severe ents. Review of the same MDS aired extensive assistance with illity and toilet use. Care Area Assessment (CAA) dated 3/26/18 revealed, of this problem/need on the rationale for care plan swer was "At risk for dration and aspiration." Speech Therapist's (ST) and treatment dated 3/19/18 sof dysphagia (difficulty in ew of the same ST notes for	F 6	o a o C refer for feet 1 q g a p h refer to c R c a h u th W irr g 2 for d refer c c	f this Plan of Correction is not an dmission that a deficiency exists ne was cited correctly. This Plan Correction is submitted to meet equirements established by state ederal law. It is the policy of this facility to pruality care. R55 was noted to hatube and during medication dministration, tube was not check as puree diet but not determined esident can tolerate on top of feed lan and progress note updated. Exident can tolerate on top of feed lan and progress note updated. Exident can tolerate on top of feed lan and progress note updated. Exident from constipation ould have led to distention and enday had an abscess which was ontinuously war, red and not beind ddressed. Resident finally sent in ad to have it drained. Staff did not pdate MD timely nor follow up on the continued to worsen during stomediately BM protocols were restube protocols, and skin monitor. Because all residents depend or care all are affected by the cite eficiency, on 4/17/2018, the DONe eviewed all residents with g-tubes onstipation as noted in dashboard.	or that of and ovide ve sed for ed, and that ds. Care bietician o failed which nesis. g and t area ay. are viewed, ing. o staff d	
	for aspiration with Review of R55's p revealed an Osmo liters (L) at 80 mill Percutaneous End	sk Factors: Pt [patient] at risk documented dysphagia." shysician's order dated 3/20/18 blite (tube feeding formula) 1.2 iliter (ml)/hour continuous via doscopic Gastrostomy (PEG - a h a flexible feeding tube is		p w N 3 o d	MR, skin changes and wounds. olicy on quality care was reviewe as tube feedings and skin monito to other residents were affected. To enhance currently compliant perations and under the direction irector of nurses, on 5/9/2018 all taff will receive in-service training	d as pring. of the nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			04/	13/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	ODE .		
MOORHI	EAD REHABILITATIO	N & HEALTHCARE 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 PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 684	stomach. PEG allo medications to be plypassing the mound of the provided and a state of the puree [items] and 2 described an order of puree [items] and 2 described an interview R55's son, Z1 state of the puree purposes of the purposes of	abdominal wall and into the ws nutrition, fluids and/or put directly into the stomach, with and esophagus) tube. Inysician order dated 4/5/2018 for, "Oral intake at meals. Two 2 honey thick liquids/meal." If you 4/9/18 at 2:10pm with ed that there had been ns where R55 had been dr. "I wish they would turn off his a couple of hours so he has an eems that he is receiving this ems that he is receiving this at PT [Physical Therapy]/OT rapy]." Intel "Resident had emesis x was sitting up in bed for dinner later experienced episodes of s contents consist of a meal	F6	regarding normal monitori data to physicians and foll changes in resident status BM in 3 days follow protor manage and administer to meds and assess for aspident 4.Effective 4/28/2018, a quality-assurance represest perform the following systia audits done weekly on overare for those with g-tube movements, skin and wou and MD follow up; 5 residente on 2 residents weekly to ensure compliance. An will be corrected on the spindings of the quality-assimil be documented and significant monitoring for further review action. 5.DON will be responsible to the spinding of the spinding for further review action.	low up with standard up with standard under the committed are committed	th ed if no or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		245052	B. WING			04/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE 2810 SECOND AVENUE NOR' MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD BE O THE APPROPRIAT	
F 684	100.5 temperature. On 4/10/18 at 11:15 bed, flushed face a While Z2 was voicin dad's temperature, look good today, he Practical Nurse (LP stated, "Oh! I have That should take cathis time, LPN1 was R55's crushed med gastrostomy tube (0 that R55's head of 30-degree angle. Wof the GT, the surve administered R55's gastrostomy tube (0 On 4/10/18 at 11:20 observed LPN1 administer medicatinhaled into the lung R55's lung sounds administer medicatinhaled into the lung R55's lung sounds administration of R56's nung sounds administration of R56's nung sounds administration of R56's nung sounds administration of R55's nung sounds administration	Sam, R55 was observed in and breathing through mouth. In the concerns regarding her Z2 also stated, "He doesn't be feels so warm." Licensed (N)1 responded to Z2 and a Tylenol prepared for him. The are of his temperature." During sobserved administering lications through R55's GT). The surveyor observed bed was elevated less than Vithout checking the placement eyor observed LPN1 crushed medications via	F 6	684		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(SURVEY PLETED
		245052	B. WING			04/1	3/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 684	revealed, "Cardiom consolidation could aspiration." Based on R55's recresults were available 4/10/18 at 7:25pm. Review of R55's nutle 12:40pm revealed Fibeen notified of R55 almost 17 hours aft R55's chest x-ray. Review of R55's nutle 15:23pm through 4/1 further assessment R55's vital signs, to to monitor signs and his overall condition. During an interview Z2, Z2 stated R55 field 4/2/18 and was give stated that on 4/9/1 staff that R55 needs constipation. During an interview R55's daughter (Z3)	est x-ray result dated 4/10/18 egaly with retrocardiac represent pneumonia or cord review, R55's chest x-ray ble to the nursing staff on rse's notes dated 4/11/18 at R55's physician assistant had 5's x-ray results. This was er the facility had the results of rse's notes from 4/10/18 at 1/18 12:40pm indicated no s had been done to check evaluate R55's lungs sounds, d symptoms of aspiration and	F 6	,			
	no one seem to kno Z3 stated, "When y so many days, and	ow why he had been vomiting." ou haven't had your bowels in your stomach is full and ou think that would cause you					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZI 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	.	
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F 684	Review of R55's borevealed R55 had a after R55 had received Review of R55's bounded After R55 had received Review of R55's bounded R55's bounded R55's bounded R55's bounded R55's bounded R55's bounded R55's tended	ge 103 wel movement record a bowel movement on 4/3/18 ved a suppository on 4/2/18. wel movement records dated 18, 4/7/18, 4/8/18 and 4/9/18, evealed R55 had not had a on 4/12/18 at 11:40am with sing (DON), when asked about R55 who had a tube feeding ed, "Keep the head of bed rees while the TF is on, hold if okay with the physician and a asked about her expectation interventions are in place to eveloping aspiration by stated, "Check for residual lacement before the start of on administration, to position the head of bed." When g interventions when R55 had g, the DON stated, "Find the of vomiting, contact the R55's lung sounds, see if a lung sounds for aspiration or the may administer R55's ave a standing order for ever. The nurse should be apperature at least half an hour of was given." The DON also es' notes and confirmed that tacked indication of ongoing nonitoring for signs and ation. The DON also confirmed the revealed no documentation and had been notified of R55's		584		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
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F 684	his constipation time. During an interview. Speech Therapist (had been working weeks. The ST state swallowing disorder at risk for aspiration direct supervision wasked what interver monitor R55's risk. "Listen to [R55's] luleast daily to check pneumonia; check When asked if a care developed after the care and treatment a care plan made for Review of R55's over failed to address present aspiration and failed prevent aspiration in feeding tube and succoordinator when in 10:02am confirmed addressing R55's respectively.	at the nurses failed to address rely. on 4/12/18 at 2:09pm with the (ST), the ST stated she only with R55 less than three ted that R55 who had a r and a feeding tube puts him n. The staff should provide when feeding R55. When ntions should take place to for aspiration, the ST stated, and sounds every shift or at for developing signs of [R55's] vital signs more often. The ST stated, are plan for R55 had been as ST had evaluated R55 for the ST stated, "I haven't had for him." I werall care plan dated 4/2/18 roblem for R55's risk for d to address interventions to pneumonia related to R55's wallowing difficulty. The MDS at R55 did not have a care plan isk for aspiration.	F 684			
	the Physician Assis R55 had aspiration chest x-ray results, upon his examinati been notified of R5 elevated temperaturot been made awatemperature until 4	on 4/11/18 at 11:30am with stant (PA), the PA confirmed pneumonia based on R55's symptoms and his findings on. When asked if he had 5's episodes of emesis and ure, the PA stated, "No, I have are of his emesis and elevated /10/18. I just ordered two ons for [R55]." The PA also				

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_	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY 2810 SECOND AVENU MOORHEAD, MN 5	JE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	stated that he experor the physician for soon as possible. It promptly informed would have treated causes of aspiratio "Aspirating from yo An elevated temper R55 was slowly dead to the surveyor had not read to the surveyor had not read to the work of the wor	ceted the nurses to notify him any change in condition as The PA stated, "Had I been of his fever and vomiting, I him sooner." When asked for a pneumonia, the PA stated, ur vomitus or the tube feeding. The rature can be an indication that reloping a pneumonia." The equested the facility's policy on the end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received the requested policy. The end of the survey, the received policy. The end of the stated, under the end of the end of the survey, the received policy. The end of t	F 6	84			

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F 684	for aspiration. If fewrong site (such a stomach of a patie feedings), the risk Assess for Gastro Feedings Guidelin Society of Critical American Society Nutrition recomme for tolerance to enabdominal distentipain, observing fo and monitoring gas Because gastric diregurgitation, it is residual volumes hours in critically it to communicate, a abdominal discompresent, feedings physician notified. single abnormal fiindicators of GI interesting to the stomach of the stomac	dedings are administered at the less the esophagus, or even the lent who requires small-bowel for aspiration is increased. Intestinal Intolerance to Tube less developed jointly by the Care Medicine and the for Parenteral and Enteral lend that patients be monitored leteral feedings by noting ion, complaints of abdominal repassage of flatus and stool, stric residual volumes. Istention predisposes to recommended that gastric (GRVs) be measured every 4 ll patientsIf patients are able lask if they are experiencing lifort or nausea. If vomiting is should be stopped, and the leterance to tube feedings, such leterance to tube feedings, such leterance in the stopped, and the leterance to tube feedings, such leterance in the stopped in the leterance to tube feedings, such leterance in the stopped in the leterance in the feedings, such leterance in the stopped in the stop	F6	84		
	t/issue-20, a clinic Institute for Geriat Aspirations in Old- indicated, "Best P Prevention Assess Aspiration: Sudde symptoms (such a cyanosis) associa regurgitation of ga (such as hoarsene	corg/try-this/general-assessmen al website of the Hartford ric Nursing under Preventing er Adults with Dysphagia ractices: Assessment and smentClinical symptoms of n appearance of respiratory as severe coughing and ted with eating, drinking, or estric contents. A voice change				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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) COMPLETION DATE
F 684	DURING TUBE FE feedings, the follow importantKeep th least 30° during cortube-fed person is a any of the following intolerance are presfullness, abdominal signs are indicative that may, in turn, in regurgitation and as contentsMeasure every 4 to 6 hours of and immediately be This assessment is tube-fed person is to of gastrointestinal in 2. Record Review of included but were indiagnoses: chronic dependence on rempain, chronic pulmon obstructive pulmon diabetes. Record Review of Fet (MDS) dated 3/C-cognitive Pattern Interview for Mental indicated that R39 is same MDS with the Functional Status," dependence-Full st with "Two+person(sunder "Section M-Section M-Sec	in high-risk TION OF ASPIRATION EDINGFor patients with tube ing considerations are e bed's backrest elevated to at ntinuous feedingsWhen the able to communicate, ask if signs of gastrointestinal sent: nausea, feeling of pain or cramping. These of slowed gastric emptying crease the probability for spiration of gastric gastric residual volumes during continuous feedings efore each intermittent feeding. especially important when the unable to communicate signs	F 6	84		

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_	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	, CODE	<u> </u>	. 6, 20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD E HE APPROPRI		(X5) COMPLETION DATE
F 684	heading "Nursing under "CHIEF CO present illness]" reresident has an arthe skin] and indurthe abdomen, rightouch. Negative for of "ASSESSMENT infection of the abdarea. Will treat wit infection) 150 [mg x [times] 7 days ware a day for 30 minut dressing." Record review of the there were no doc assessment of the redness, swelling, to incorporate protomoist packs twice interventions to action interventions to action interventions to action intervention of the process of	an assistant notes with the Home Note" dated 11/8/17 MPLAINT/HPI [history of evealed, "Staff report that ea of erythema [reddening of ration [becoming hardened] to to lower quadrant. Tender to revers" Under the heading AND PLAN: 1. Soft tissue domen, right lower quadrant in doxycycline (antibiotic to fight emilligrams] by mouth every day arm moist packs applied twice es x 7 days, with a protective right lower quadrant for pain, drainage and/or the order ective dressings with warm a day for seven days as dress the soft tissue infection hysician assistant on 11/11/17 in R39's "Weekly Skin review-V3" 10:17pm revealed, ess to groin and [collection of pus that has built enthal that includes symptoms of mth and swelling] to right lower was the first nursing at indicated R39 had any	F6	84			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245052	B. WING		04	/13/2018	
	PROVIDER OR SUPPLIER EAD REHABILITATIO	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	dated 10/30/17, 10, no documentation of developing abscess of redness, pain, where the second review of R 9/6/17 to 11/13/18 indicated that R38 redness, pain, warr lower quadrant. Record review of R 11/14/17 at 9:17 am documentation by a "Resident has Larg [right] lower abdom [centimeter] W [wide core circumference warm and tender to white/yellow dry flat Purulent [containing drainage obtained at Record review of R 11/14/18 at 9:49 am abscess to abdome despite [of] oral ant pain at the sitePe assistant] send pt the evaluated. Review of the Eme (name of the hospit "ASSESSMENT/PL" 1. Necrotic carbundead tissue]: Surge shad done a bedsigner of the surgest that the site is	2/23/17 and 10/16/17 indicated of any assessment of a sthat would include symptoms armth, drainage and swelling. 39's progress notes from revealed no assessments that was starting to experience on the and/or swelling to the right. 39's progress notes dated which was the second a nursing staff which indicated, e {sic} abscess area to Rt en measures 18cm of 4 cm. Area is red, firm, or touch. Center of area with a syskin. Noted small amount of g pus] drainage, culture of and Physician updated." 39's progress notes dated indicated, "Pt [patient] has en that continues to worsen ibiotic usePt is experiencing or [name of the physician of ER [emergency room] to be orgency Room (ER) notes titled	F6	884			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245052	B. WING		04/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	(DON) on 4/12/18 a review the progress September to Nove in her computer. The could identify any not that R39 was starting abscess. The DON DON was then asked review-V3" dated 10/16/17. The DON documentation of a would include redner The DON replied, " During an interview approximately 12:3 could recall the incit R39 stated that he insect bite, but he whe could show whe located, R39 pulled lower quadrant was During a phone into 11:50am, the Medic what were her experegarding skin chart that she expected, and the staff" regar	Il be continued" with the Director of Nursing at 4pm, the DON was asked to a notes for R39 from ember of 2017, before 11/14/17 he DON was asked if she ursing notes that indicated ng to develop any signs of an replied, "I didn't see it." The ed to review the "Weekly Skin 0/30/17, 10/23/17 and I was asked if there was any developing abscess which ess, swelling, drainage or pain. No" with R39 on 4/12/18 0pm, R39 was asked if he dent regarding his abscess. thought it started with an was not sure. When asked if re the abscess was previously his shirt up and on his right a pink, healed area. erview with on 4/13/18 at cal Doctor (MD1) was asked ectations of the nursing staffinges to residents. MD1 stated "complete clarity between me ding skin changes.	F 684			E/01/10
F 686 SS=D	CFR(s): 483.25(b)(§483.25(b) Skin Int §483.25(b)(1) Pres	egrity	F 686			5/21/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP		
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL 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 686	(i) A resident recei professional stand pressure ulcers and ulcers unless the idemonstrates that (ii) A resident with necessary treatment with professional spromote healing, promote healing, pr	y must ensure that- ves care, consistent with ards of practice, to prevent id does not develop pressure individual's clinical condition they were unavoidable; and pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent eveloping. ENT is not met as evidenced ation, interview and record failed to ensure preventative place to prevent the essure ulcer injury for one it to assess, document, and a pressure injury for one ive residents reviewed for	F 686	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of the facility to protreatment and services to prevent pressure ulcers. R55 was noted to been lying on back for a very long to the nurse went to do dressing charand did not wash area that was red and noted it didn't have dressing which went to put new one on. Documentation was inconsistent, a resident was not offloaded as nece R39 was noted to have reddened at that was covered with cream and dressing, but documentation showed sign of a skin issue. On both reside wound care and documentation did address resident's risk for skin breat and need for interventions. Care sli	the ssion or that of and vide have ime. nge dened hen onts and sadown		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE 310 SECOND AVENUE NORTH IOORHEAD, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	R55 was at risk of R55 did not have a admission. Reviewed of R55's the following: 3/21/18 - redness to toes. 3/28/18 - redness to 4/4/18 - redness to 4/4/18 - redness to Review of R55's phrevealed Mepilex (for daily. The order did the area before approximate to skin integrity of the care plan goal reversity of the resident every 2 hours of the care plan intervention of the care plan interven	developing pressure ulcers. Iny pressure ulcers on Weekly Skin Review revealed In sacrum and to bilateral great In sacrum and toes It so sacrum and to bilateral great It so sacrum and toes It so sacrum and toes It so sacrum and to bilateral great It so sacrum and toes It so sacrum and to bilateral great It so sacrum and toes It so sacrum and to bilateral great It so sacrum and toes It s	F 6	86	and care plans updated, assessment completed, and wound documentatimplemented. 2. Because all residents have diagonal which could lead to alteration in skintegrity or due to illness have potentially aby the cited deficiency, wound documentation has been reviewed, interventions for prevention are in pand documented clearly on care should be with a work of the work	oses n ntial for ffected blace leets. and s noted any n or essure ensive ose other of the staff litoring staff litately, ent always and all d and,	
	positioned on his back his right side and leading on his sacral a	ack with a pillow underneath gs. R55 was observed directly			further alterations in skin integrity, a applying dressings to clean areas a	always and all d and, s the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	,	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE,	ZIP CODE	
MOORH	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 686	On 04/10/18 8:51 his back, head of buttocks/sacral was surface of the ma 04/10/18 10:33 am wound care on Reentered R55's rook change, the survey had no dressing. buttocks were reducentimeters (cm) noted a small ope When asked to dehis sacral area, LI surveyor observed and applied it to Fobserved LPN1 dibefore LPN1 applasked if LPN1 had applying the wour Review of "Prever Ulcers: Quick Ref Pressure Ulcer Ac Pressure Ulcer A	am R55 was observed in bed on bed (HOB) elevated. R55 as directly in contact with the	F 6	reporting of changes in Education done on impromprehensive assessing pressure ulcers and impappropriate intervention 4. Effective 4/28/2018, a program was implement supervision of the direct monitor residents with integrity and updating Market plans with any changes appropriate follow throut of nurses or designated representative will perform systematic changes: the will ensure audit all residence and the findings of the content weeks to ensure compliate the monthly quality-accommittee meeting for a corrective action. 5.DON will be responsible.	ortance of ment of skin, olementation of s quality-assurance ted under the tor of nurses to mpaired skin ID, family and care to ensure gh. The director quality-assurance orm the following e DON or designee dents with e at risk weekly x 4 ance than 2 onths. Any ected on the spot, quality-assurance ited and submitted ssurance further review or	

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	PROVIDER OR SUPPLIEF	ON & HEALTHCARE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 686	4/10 18 1:30pm, F back, HOB elevate 4/10/18 3:45pm, F back, HOB elevate 4/11/18 8:20am, F back, HOB elevate 4/11/18 9:30am, F back, HOB elevate 4/11/18 2:00pm, F back, HOB elevate 4/11/18 4:30pm, F back, HOB elevate 4/11/18 4:30pm, F back, HOB elevated 4/12/18: 9am, Res HOB elevated, but During an interview stated she had proon 4/10/18 at 7:40 a pillow on his side placed underneath relieved the pressistated no. NA1 stathat area, the sore want that to happe During an interview NA2, NA2 stated, am not able to turn When asked, if pur relieved pressure no. During an interview the Director of Nut that she had asses 4/11/18 but had no assessments note	Resident in bed lying on his ed, buttocks not offloaded. Resident in bed lying on his ed, buttocks not offloaded. Resident in bed lying on his ed, buttocks not offloaded. Resident in bed lying on his ed, buttocks not offloaded. Resident in bed laying on his ed, buttocks not offloaded. Resident in bed laying on his ed, buttocks not offloaded. Resident in bed laying on his ed, buttocks not offloaded. Resident in bed laying on his ed, buttocks not offloaded. Resident in bed laying on his back, stocks not offloaded. We on 4/11/18 at 2pm, NA1 by orded incontinence care to R55 am and repositioned R55 with ea. When asked if the pillow in R55's right side helped are on R55's buttocks. NA1 atted, "If he continues to stay on e will get worse and we don't	F 686			

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		245052	B. WING		04	/13/2018	
	PROVIDER OR SUPPLIEF	ON & HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 686	but blanchable and When asked to de DON stated, R55 width open area, Series dermis presenting pressure ulcer. Whareas on his sacrato the facility, the I When asked about prevent R55 from injury, the DON state hours, offload the for any changes, as Review of the facil "Wound Care" with there were no previncorporated into in 2. Record Review included but were diagnoses: chronic dependence on repain, chronic pulmobstructive pulmodiabetes. Record Review of Set (MDS) dated 30 C-cognitive Patter Interview for Mentindicated that R39 same MDS with the Functional Status, dependence-Fulls with "Two+person under "Section Midentified as being dermission of the same with the sa	age 115 d with some excoriations seen." escribe R55's sacral area, the had 0.4cm length and 0.4cm Stage 2 (partial thickness loss of as a shallow open ulcer) hen asked if R55 had open al area when R55 was admitted DON stated, R55 had redness. It possible interventions to developing a pressure ulcer ated, "Turn him every two area, monitor sites and report and notify the physician." Ity's policy with the heading of n a revised date of 12/23/17, ventative measures ts policy for pressure injuries. of R39's Admission Record not limited to the following c kidney disease, stage 5, nal dialysis, obesity, low back ionary edema, chronic hary disease heart failure and R39's Quarterly Minimum Data B/7/18 with the heading "Section n," R39 scored a 14 in a Brief al Status (BIMS) which was cognitively intact. In the ne heading "Section G " specified that R39 was "Total staff performance all the time" (s) physical assist." In addition, Skin Conditions," R39 was at risk for developing pressure t have any pressure ulcers on	F 686				

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F 686	Continued From p admission.	age 116	F 6	86			
	dressing change to completed by Lice was observed that with one small (less breakdown. The L (antifungal cream and itchiness) to the applied a mepilex one open skin are as to how the skin that it was "getting asked, if R39 had the LPN2 stated the observed before the Record review of I dated 4/9/18, 3/26 revealed that there open skin to R39's which contradicted open skin breakdom ewly identified on Review of R39's c "Pressure ulcer ac documentation that breakdown was id and/or any interve healing. Review of R39's p 2/2/18 to 4/10/18 r	are plan under the heading of ctual or at risk" there was no at indicated that a skin entified by the nursing staff ntions were in place to promote rogress notes dated from revealed that there were no identified any skin breakdown					

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_	PROVIDER OR SUPPLIEF	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	-	
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F 686	During an interview DON, the DON was expectations were has redness or sk replied, "I would excall the physician. protocol is not won My role (DON services) is to look at look at all redden. The DON was ask open skin area to replied that she dishe tracked reside the DON replied the DON was asked to the DON, without her nursing assists R39's skin was "neadded "when you When the book was already been writte was then asked if when the nursing skin changes, the asked if there were interaction between the DON replied," if she asked the neskin breakdown, so During a phone in 11:50am, the Med what were her expregarding skin changes with the staff" regards asked if she had be asked if s	age 117 w on 4/12/18 at 4pm with the as asked as what the of her nurses when a resident in breakdown. The DON expect them to notify me, and I would look if the current rking, and look for a new order. Wes as the facility's wound care to residents' skin. I don't officially areas. I focus on open areas." I de dif she knew that R39 had an the gluteal area, the DON donot. The DON was asked how ents with wound care concerns, that she had a book. When the collocate this book for review, being asked, stated that one of ants had informed her that to the aling as it should" and have minute, take a look at it." as reviewed, R39's name had en in by the DON. The DON she could recall the name and assistant notified her of R39's DON could not. The DON was any documentation of this en her and the nursing assistant, No." The DON was questioned, ursing assistant if R39 had a he could not recall if she had. I terview with on 4/13/18 at ical Doctor (MD1) was asked bectations of the nursing staff anges to residents. MD1 stated area, mD1 stated area, mD1 stated area, mD1 replied area, mD1 replied	F 6	86		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZII 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	P CODE		
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F 686	"There should be not under Policy with the with the name of the with a revised date purpose of this proof for the care of wour Review the resident special needs of the heading of "Docum following information resident's medical register (i.e., wound bed conditioned when inspecial needs of the heading of "Prevent Ulcers: Quick Refer Pressure Ulcer Adv Pressure Ulcer Adv Pressure Ulcer Adv Pressure Injury Allia published 2014 und All Individuals," individuals at risk of ulcers, unless controlition of the individuals at risk of ulcers, unless controlition of the individual stribution support of the individual condition, of the individual condition, of the individual condition, of the individual condition and get the frequency and respositioning regiments."	en notified. MD1 added, otification. Not acceptable." The heading of "Wound Care" of facility's organization name of 12/23/17 it indicated, "The bedure is to provide guidelines ands to promote healing 2. It's care plan to assess for any of resident"Under the entation" it indicated, "The nishould be recorded in the record 6. All assessment data lor, size, drainage, etc.) of the indicated by National isory Panel, European isory Panel and Pan Pacific ance, Second edition of the "General Repositioning for cated, "1. Reposition all of the indicated 2. Consider the realindicated 2. Consider the result of the individual's: tissue of the individual's.	F 6	86			

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F 686	early signs of press her/his tolerance of schedule. If change occur, the reposition re-evaluatedReposition the individual of pressure is relieved choosing a particular is important to assess actually relieved or positioning the individual relieved or positioning the individual can the individual can to medical condition at that increase press positionLimit head individual on bed remedical condition of considerationsIncoming shear force necessary, avoid he slouched position the sacrum and Respiratory/Trache CFR(s): 483.25(i) § 483.25(i) Respiratory care and tracheals care, consistent wit practice, the compressions	ure damage and, as such, the planned repositioning is in skin condition should ning care plan needs to be ositioning Techniques 1. Tidual in such a way that I or redistributed. When ar position for the individual, it is swhether the pressure is redistributed. 2. Avoid vidual on bony prominences anchable oning Individuals in Bed 1. de-lying position (alternately, is side) or the prone position if olerate this and her/his Illows2. Avoid lying postures ure, such as the 90° side-lying d-of-bed elevation to 30° for an ist unless contraindicated by refeding and digestive lividuals should be positioned revent sliding down in bed and esIf sitting in bed is ead-of-bed elevation or a nat places pressure and shear coccyx."	F 68			5/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
	OLIMANA DV. OT	ATEMENT OF DEFICIENCIES			RECTION	
(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) COMPLETION DATE
F 695	Continued From pa	age 120	F 69	95		
		subpart. NT is not met as evidenced				
	review, the facility of a surgically created (trachea) that provide breathing) care as protect against informicroorganisms); a monitor when the inchanged for one (For respiratory care Findings include: R35 was admitted diagnoses which in squamous cell care neck; personal hist unspecified site if it and, encounter for Observation of LPI providing tracheosis 9:50am revealed the of saline and two personation and pure standard tracheostomy care which had visible y secretions inside the cleaning solution, it applicator to clean	tion, interview and record failed to: perform tracheostomy d hole (stoma) in the windpipe ides an alternative airway for eptically (using methods to ection by pathogenic and, put a process in place to mer cannula was due to be 1335) of one resident reviewed in the sample of 37. To the facility on 2/15/18 with included the following: cinoma of skin of scalp and ory of malignant neoplasm of ip, oral cavity, and pharynx; attention to tracheostomy. N3 (Licensed Practical Nurse) tomy care to R35 on 4/11/18 at mat the LPN3 prepared one part arts of hydrogen peroxide potic) to make the cleaning staline for rinsing. LPN3 soaked cannula in the cleaning the brush from the kit to clean the inner cannula ellow colored phlegm and the tubing. Using the same LPN3 used a cotton tipped the outer cannula. LPN3 used ed applicator to clean the		This Plan of Correction conswritten allegation of compliar deficiencies cited. However, of this Plan of Correction is nadmission that a deficiency eone was cited correctly. This Correction is submitted to me requirements established by federal law. 1. It is the policy of the facility tracheostomy care to all resion appropriate diagnosis and assessment. One of the manthis has been achieved for R determining when inner cannothat the MAR did not note whis should be changed. Also not cleaning was not effective for disinfection. MD and MAR ar Care sheets and care plans to 2. Because all residents are rhave proper access and assi respiratory/trach equipment apotentially affected by the cite DON reviewed trach care and change orders to ensure staff when to change out, monitor equipment. All current reside for trach changes and added other residents were affected on trach care has been revieupdated. 3. To enhance currently comp	ice for the submission of an exists or that a Plan of eet state and to provide dents based by ways that 35 is inula should be it was noted in trach ed policy on a proper e updated. Equired to stance with all are ed deficiency. It is deficiently trach fupdated on and clean ints assessed to MAR. No it. The policy wed and	
	stoma but used the visible yellow color	e same cleaning solution with ed phlegm.		operations and under the director of nurses, on 5/9/20		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING _	·····	04/	13/2018	
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP C			
MOORH	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	According to the venture of the facing policy dated 12/27 Guidelines," "1. As a. During cleaning tracheostomy tube changes, eith Further review of and Stoma Care," peroxide-soaked with saline-soaked with saline-soaked wipe with clean, delectronic treatmer revealed that there monitor when R35 changed. In an interview with 4/12/18 at 3:17pm how the nurses kind due to be changed order to change the reviewed the eMA there was nothing	vebsite, ndclinic.org/health/treatments/1 ny-care, "Hold the inner pasin and pour the hydrogen into it. Use as much hydrogen eed to clean the inner cannula lity's "Tracheostomy Care" //17 revealed under "General septic technique must be used: and sterilization of reusable es;c. During tracheostomy her reusable or disposable" the policy revealed under "Site "2. Clean the stoma with two gauze pads3. Rinse the stoma d gauze pads4. Wipe with dry of the stoma with the gauze padsAllow to air dry or	F 6	receive in-service training for trach cares and trach change do not see such orders in please the conversation with the Mithese orders. Residents with been reviewed to ensure contraining emphasizes the impropriate of the diagnosis, and appropriate of the director of the director of monitor residents with a track director of nurses or designed quality-assurance represent perform the following system the DON or designed will all the following system the properties of the performance of the quality-assurance change of the quality-assurance committed quality-assurance committed further review or corrective and the properties of the performance of the performance of the quality-assurance committed further review or corrective and the performance of the performance of the quality-assurance committed further review or corrective and the performance of the perform	ges and if they ace to initiate D to update of trach's have in the footname of the interest to ch. The sated in the findings in the findings ecks will be at the monthly e meeting for action.		

NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER CALL DEPLIEVE SUMMARY STATEMENT OF DEFICIENCIES SPECEND AYENUE NORTH MOORHEAD, MN 56560 DRIVEN SECOND AYENUE NORTH MOORHEAD, MN 56560 DRIVEN DRIVEN SECOND AYENUE NORTH MOORHEAD, MN 56560 DRIVEN DRIVEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
MOORHEAD REHABILITATION & HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 695 Continued From page 122 (truther stated, "There should be a physician order in the electronic health record when it should be changed." During interview on 4/12/18 at 6:35pm with the Director of Nursing (DON), the surveyor relayed the observation of LPN3 providing tracheostomy care and asked the DON of her expectations when the nurses were providing tracheostomy care. The DON stated, "It [tracheostomy care] should be according to the policy," When asked about the facility's process to monitor when R35's inner cannula was due to be changed, the DON stated, "It [tracheostomy tated 12/27/17 indicated under "General Guidelines," "4. Tracheotomy Uses should be changed as ordered and as needed (at least monthly)" F 698 Dialysis CFR(s): 483.25(l) S483.25(l) Dialysis The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility falled to adhere to fluid restrictions for one resident (R38) of three			245052	B. WING	·····	04/13/2	018
FREEDY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 695 Continued From page 122 further stated, "There should be a physician order in the electronic health record when it should be changed." During interview on 4/12/18 at 6:35pm with the Director of Nursing (DON), the surveyor relayed the observation of LPN3 providing tracheostomy care and asked the DON of her expectations when the nurses were providing tracheostomy care. The DON stated, "It (fracheostomy care is should be achanged, the DON stated," It (fracheostomy care) should be according to the policy." When asked about the facility's process to monitor when R35's inner cannula was due to be changed, the DON stated, "We need to start putting that to trigger the nurses to see that it is due to be changed." A facility "Tracheotomy Care" policy dated 12/27/17 indicated under "General Guidelines," "4. Tracheostomy tubes should be changed as ordered and as needed (at least monthly)" F 698 SS=D CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to adhere to fluid restrictions for one resident (R38) of three			N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH		
further stated, "There should be a physician order in the electronic health record when it should be changed." During interview on 4/12/18 at 6:35pm with the Director of Nursing (DON), the surveyor relayed the observation of LPN3 providing tracheostomy care and asked the DON of her expectations when the nurses were providing tracheostomy care. The DON stated, "It [tracheostomy care] should be according to the policy." When asked about the facility's process to monitor when R35's inner cannula was due to be changed, the DON stated, "We need to start putting that to trigger the nurses to see that it is due to be changed." A facility "Tracheotomy Care" policy dated 12/27/17 indicated under "General Guidelines," "4. Tracheostomy tubes should be changed as ordered and as needed (at least monthly)" F 698 SS=D CFR(s): 483.25(l) \$483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REOUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to adhere to fluid restrictions for one resident (R38) of three	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COM	PLÉTION
37. String Findings include: Of this Flat of Correction is not all admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	F 698	further stated, "The in the electronic head changed." During interview on Director of Nursing the observation of Lare and asked the when the nurses we care. The DON statishould be according about the facility's prinner cannula was of stated, "We need to the nurses to see the Afacility "Tracheoto 12/27/17 indicated "4. Tracheostomy ordered and as need Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must en require dialysis recewith professional stromprehensive per the residents' goals This REQUIREMEN by: Based on observator review, the facility for restrictions for one residents reviewed 37.	A/12/18 at 6:35pm with the (DON), the surveyor relayed PN3 providing tracheostomy DON of her expectations are providing tracheostomy ed, "It [tracheostomy care] to the policy." When asked process to monitor when R35's due to be changed, the DON of start putting that to trigger that it is due to be changed." Tomy Care" policy dated under "General Guidelines," tubes should be changed as a ded (at least monthly)" Sure that residents who elive such services, consistent andards of practice, the son-centered care plan, and and preferences. No interviews and record alled to adhere to fluid resident (R38) of three		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists o one was cited correctly. This Plan of	my the esion r that	1/18

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		0.	4/13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, Z 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ZIP CODE		
(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 DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 698	10/6/17 indicated, "centimeters]/day FI provides 720cc, rer nursing/pleasure. Fand document noneducation/reminder after noon]. Every substitution During an interview R38 while he was in what amount of fluirestriction diet. R38 bedside table there with an attached structure of water. Record review of R heading of "Alteration in eling fluids" was listed as interventions contrated that restricted R38's day. During an interview Nursing Assistant, of R38, NA6 was a restriction was compresented her care of two pages which and information recopreferences, skin day the care plan for aid	38's physician order dated of 1000cc [cubic uid Restriction. Dietary maining 280cc for Record intakes q [every] shift compliance, rs given pm [post meridiem,	F 69	requirements establishe federal law. 1.It is the policy of the fadialysis care to all reside appropriate diagnosis ar One of the many ways the achieved for R38 is deteorder for fluid intake to be After survey noted that fon resident fluid restriction immediately addressed sheets, care plan and disupdated. Resident will newater to his room. 2.Because many resider restrictions related to cadiagnosis, many are pote by the cited deficiency. If with MD the order, clarificand instructed staff to for and entered in communicurrent residents on residialysis were reviewed a information matched and aware. No other resident The policy on hemodialy reviewed. 3.To enhance currently coperations and under the director of nurses, on 5/9 receive in-service training intakes and ensuring staresident more than they training emphasizes the following a plan of care, diagnosis, and appropriated. Effective 4/28/2018, a program was implement supervision of the directors.	acility to provide ents based on a dassessment. hat this has been ermining actual of 1000cc per date aulty information on it was and the care etary were of get pitchers of the are on the area on the entially affected DON reviewed ied the 1000cc ollow care sheets ication book. All trictions due to and ensured designed the affected. The area of the edirection of the 1000cc ollow care sheets ication book. All trictions due to and ensured designed to the 1000cc of	y.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	·		
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F 698	"Dialysis Diet, 150 confirmed that thi and indicated that on the sheet which was allowed. During an intervie NA7, NA7 was as residents. NA7 was residents' fluid res NA7 presented ar Restrictions" print instruction sheet, 1000cc. NA7 was these instructions NA7 replied, "I pur mostly ice. I fill it to During an observa R38's room, there blue lines across the amount of flui of water measure was 500cc. During an observa R38's room, the samount of flui of water measure was 500cc. During an intervie LPN2, LPN2 was fluids that was in replied, "600cc." many cc's was R3 LPN2 answered, problem." LPN2 was plan, and confirm	DOML restriction" NA6 s care plan was the most recent t R38 was restricted to 1500cc h was 500cc more than R38 w on 4/12/18 at 1:35pm with signed to pass water to as asked how she adhered to strictions when passing water. In instruction sheet with "Fluid red on the top. Review of this listed R38's fluid restriction as then asked how she followed when passing water to R38. t more ice than water, make it	F6	monitor residents on dialys intake. The director of nur designated quality-assurar representative will perform systematic changes: audit 3 weeks than 1 resident for ensure no pitchers left in resident not consuming my doctors order. Any deficier corrected on the spot, and the quality-assurance check documented and submitte quality-assurance committ further review or corrective 5.DON will be responsible	rses or nce the following 2 residents for or 5 weeks to oom and ore than the ncies will be the findings of cks will be d at the monthly ee meeting for e action.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		,	04/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (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 CC ((EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 698	intervention for R38 physician's orders. During an interview DON, the DON was for aides. The DON that was given to thi instead of the 1000 prescribed amount physician. The DON The DON was asked which included 150 amount in R38's flureviewing the care getting over what h DON was informed 500cc of water in h water pitcher) durin stated, "Not the stamaintain. Not at all. pitcher." Under the Policy with Plans-Comprehens facility's organization 12/23/17 it indicated plan is based on a lidentifying problem developing interver meaningful to the reprocesses that requiproper sequencing decision making. Not manage the task in physician (primary to this process."	a which is contrary to on 4/12/18 at 4:30pm with the saked to review the care plan I confirmed that the care plan I confirmed that the care plan I can firmed that the care plan I can firmed that the care plan I can fill the care of I confirmed that the care plan I confirmed that the care plan I confirmed that was not the of fluids ordered by the I stated, "This is incorrect." and to review R38's care plan I confirmed the DON stated, "He is that R38 was served over its drinking cup (referred as I confirmed that R38 was served over its drinking cup (referred as I confirmed the should not get the water I confirmed the should not get the water I confirmed the same with a revised date of I comprehensive care thorough assessment The comprehensive care thorough assessment The comprehensive care thorough assessment The careful data gathering, of events and complex clinical o single discipline can isolation. The resident's healthcare provider) is integral	F6	98		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 698 F 755 SS=E	4/3/18 it indicated un Communication and care center dietary consultant RD [reginacting with other into visit and observed intake and preferer in: Planning food and restricted diet."	on name with a revised date of under "General do Coordination of Care: The staff, the dietary director and stered dietitian] participate in terdisciplinary team members a resident's food and fluid inces. This information is useful and fluid choice into the	F 6			5/21/18	
SS=E	§483.45 Pharmacy The facility must pr drugs and biologica them under an agre §483.70(g). The fa personnel to admin permits, but only ur a licensed nurse. §483.45(a) Proceda pharmaceutical ser that assure the acc dispensing, and ad						
	§483.45(b) Service must employ or obt pharmacist who- §483.45(b)(1) Prov aspects of the prov the facility.	Consultation. The facility rain the services of a licensed ides consultation on all ision of pharmacy services in oblishes a system of records of tion of all controlled drugs in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		04/1	3/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	, 0 10.2010	
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F 755	order and that an a is maintained and This REQUIREME by: Based on observareview, the facility administration on matched the physic (R55); and failed to disposed properly (R207) of three res Medication Pass. Findings include: 1. Review of R55's 3/13/18 revealed: Emilligram (mg) via Gastrostomy (PEG flexible feeding tubabdominal wall and nutrition, fluids and directly into the sto and esophagus) tu (for high blood prestwice daily; Escitale via PEG tube one time PEG-tube one time PEG-tube one time	emable an accurate emable are in emable an accurate emable are in emable an accurate emable are in emable are ended emable an accurate emable are in emable are ended emable an accurate emable are in emable are ended emable an accurate emable are in emable an accurate emable are in emable are ended emable an accurate emable are in emable and record emable an accurate emable and record emable and record	F 755	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists o one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of the facility to follor drug administration policies and appropriately discard medications of discharged residents. R55 had an offor meds to be given via g-tube medications stated given by mouth, discrepancy was not noted by the madministering nor the pharmacy who dispensed. The order was clarified, pharmacy instructed to follow doctor orders. R44 received medication for who had been discharged it was stated facility used other meds to save monomorphic than the same appropriately discharged medication is not allowed. The order was clarified, pharmacy instructed to follow doctor orders. R44 received medication for who had been discharged it was stated in the same appropriately discharged medication is not allowed. The order was reviewed with staff and medications must belong to the resistant medications is not allowed. The order was reviewed medication is be removed and either sent with resistant with resistant medications.	the ssion r that of and ow forder The urses en and r R207 ated ney. Ident If a hould sident,	
	preparing R55's m	am, LPN1 was observed edications. LPN took R55's he medication cart.		returned to pharmacy, or discarded. 2.Because all resident rely on facility ensure proper medication administry and right to their own medications the	y to ation	

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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
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F 755	Review of the medimedications for R5 one tab by mouth to 3.125mg one tab by Escitalopram 10mg daily; Finasteride 5 daily and Lisinopril once daily." The routes on R55'that R55's medications PEG tube. During an interview asked for the medic pharmacy that did right physician's order, Lithe routes on the minth physician's order, Lithe	cation labels for the following 5 revealed, "Bumetanide 1mg wo times a daily; Carvedilol y mouth twice daily; one tablet by mouth once ing one tablet by mouth once 10mg one tablet by mouth once 10mg one tablet by mouth series or series or a distribution of the cation labels indicated that were to be administered R55's on 4/11/18 at11am, when cation labels provided by the not match with R55's in PN1 stated she didn't notice redication labels did not match	F 7	755	citation has the potential to affect a residents. Resident medications weremoved from med cart for dischar residents, any meds missing were ordered, and orders for those receimeds via other means (not po) wer reviewed. The policy on discharged residents was reviewed and update other residents were affected. 3. To enhance currently compliant operations and under the direction director of nurses, on 5/9/2018 all ristaff will be in-serviced on using remedications, not substituting, remoineds from cart not in use and moninght route when reviewing the 5R's medication administration. 4. Effective 4/28/2018, a quality-assiprogram was implemented under the supervision of the director of nurse check all med carts and orders for residents with g-tubes. The DON of designee will complete 2 med cart per week x 4 weeks, then 1 audit with x2 months to ensure compliance. A deficiencies will be corrected on the and the findings of the quality-assuphecks will be documented and substitute meeting for further review corrective action. 5. Pharmacy and DON will be respondent this POC.	ere ged ving e I ed. No of the nursing sidents ving itoring itoring s to urance ne s to r audits reekly any e spot, rance omitted ew or	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 755 F 759 SS=D	dispensing box to p discharge residents pick them up." Review of R207's mas discharged from the survey of the end of the survey had not received the free of Medication CFR(s): 483.45(f) (1) §483.45(f) Medication the facility must end facility f	LPN1 stated, "But we have a put in left over medications for and the pharmacy will come medical record indicated R207 m the facility on 3/23/18. Veyor requested for the pisposals of Medications. At ey on 4/13/18, the surveyor e requested information. Error Rts 5 Prcnt or More) on Errors.	F 7		r the	5/21/18
	greater. The facility 36.59 percent with opportunities for en (R35, R44, and R55 the medication pass). Findings include: 1. Review of R35's the following: a. 4/1/18 - Zinc Sulf (milligrams) via PEG	had a medication error rate of 15 errors out of 41 for involving three residents b) who were observed during		of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. It is the policy of the facility to sa administer medications to the residence that the policy of the facility to sa administer medications to the residence that the policy of the facility to sa administer medications administration audit in which 3 resections (R35, R44, and R55) received wround meds, wrong doses, wrong route, assessed properly for medication	or that of and fely dents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			04/1	13/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOODU	AD DELLABILITATIO	NA UEALTHOADE OFNITED	2810 SECOND AVENUE NORTH		810 SECOND AVENUE NORTH		
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		N	MOORHEAD, MN 56560		
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F 759	Continued From pa	age 130	F 7	59			
	dietary supplement	•			administration such as neb treatme	ents	
	aiotai y cappionioni				and checking placement of g-tube.		
	On 4/10/18 at 9:41a	am, LPN2 was observed			the surveyor notified nurse leaders		
	preparing R35's PEG-tube medications. LPN2				regarding errors and magnitude of		
		of stock supply of Zinc Sulfate			immediately staff were addressed,		
		e medication, placed it in a			educated and counseled on poor p	ractice.	
		d mixed it with approximately			Every effort was made immediately		
		ater, and then administered it to			ensure same mistakes would not h	appen	
		separately with the remainder			again.		
		orning medications. LPN2			2.Because all residents rely on staf		
	verified that Zinc Sulfate 220mg was				safe care all are potentially affected cited deficiency, staff were reminded		
	administered to R3	5.			ensure all residents have their own		
	On 04/13/18 at 10:	18am, the Director of Nursing			medications, follow proper indication		
		ed regarding the surveyor's			administration and always use the		
		PN2 during the medication			when giving medications. All reside		
		information was provided.			medications and orders reviewed.		
	•	'			other residents were affected. The	policy	
	2. Review of R44's	physician's orders revealed			on medication administration has b		
	the following:				updated.		
		esin (cough medication) syrup			3.To enhance currently compliant		
	` ,	ery four hours as needed for			operations and under the direction		
	cough.				director of nurses, on 5/9/2018 all r		
		e (laxative) solution give 30 ml			staff will be in-serviced on safe me		
		s a day for constipation.			administration, medication errors, r	eview	
		(laxative) give 17 grams (gm)			survey findings, g-tube use for	nto	
		hours as needed for eight ounces (oz) of water,			medications and proper assessment 4. Effective 4/28/2018, a quality-ass		
		or tea prior to administration.			program was implemented under the		
	juice, soua, conce	or tea prior to administration.			supervision of the director of nurse		
	On 4/10/18 at 9:19a	am, Licensed Practical Nurse			monitor medication administration.		
		red preparing R44's oral			director of nurses or designated	-	
		poured the cough medication			quality-assurance representative w	ill	
		edication cup and poured more			perform the following systematic at		
		erified the amount and			medication competency on all staff		
		prepared more than 10ml.			med pass audits 3 staff per week x		
	LPN1 stated, "Year	n it's a little over 10."			weeks, then 1 staff weekly x2 mont		
					ensure compliance in this area. An		
	During the same of	oservation, LPN1 was			deficiencies will be corrected on the	e spot,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		04/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 759	calibrated medicati instead of 30 ml. Til LPN1 borrowed R2 R44's use. LPN1 or 20ml available to g LPN1 was observe medication. LPN1 pa cup and mixed it On 4/10/18 at 9:300 Guailfenesin more Lactulose less than Miralax mixed with ordered amount alomedications. 3. Review of R55's a. 3/23/18 - Diclofe gel 1% apply transopain. b. 3/14/18 - Aspirin strength tablet dela (mg) via Percutane (PEG - a procedure tube is placed throu into the stomach. Fand/or medications stomach, bypassing one time a day. c. 3/20/18 - Fluticas (used to treat nasa congestion, sneezii in both nostrils one	the lactulose solution into a concup and poured 20 ml ine surveyor also observed 107's lactulose medication for confirmed that she had only live to R44. It dispersions that she had only live to R44. It dispersions that she had only live to R44. It dispersions that she had only live to R44. It dispersions that she had only live to R44. It dispersions that she had only live to R44's that the ordered dose; a what was ordered and the water that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44's other It dispersions that was less than the long with all R44'	F 759	and the findings of the quality-ass checks will be documented and stat the monthly quality-assurance committee meeting for further rev corrective action. 5. The Pharmacy and DON will be responsible for this POC.	ubmitted iew or	
	albuterol sulfate (bi	ronchodilator) 3ml inhale orally ide (diuretic) 1mg via PEG				

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F 759	tube once daily. f. 3/13/18 Carvedild 3.125mg via PEG tg. 3/14/18 Escitalor via PEG tube once h. 3/14/18 Finaster prostate) 5mg via Fi 3/14/18 Lisinopr 10mg via PEG tube j. 4/8/18 Acetaming mouth every four h fever. k. 3/19/18 Ferrous 1tsp 5ml via PEG t l. 3/13/19 Docusate 50mg/5ml give 10m day. On 4/10/18 at 9:45 Diclofenac Sodium indicated, "Use the this carton box labe apply 4 gm to affect revealed that LPN1 LPN1 put a small a finger and applied of On 4/10/18 at 9:50 preparing R55's me following tablets in time and poured in Bumetanide, Carve Finasteride, Lisinop LPN1 entered R55 medications with w gastrostomy tube (ol (for high blood pressure) ube twice daily. pram (antidepressant) 10mg daily. ide (to reduce enlarged PEG tube once daily. iil (for high blood pressure)	F7	759			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, Z 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	IP CODE		
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F 759	placement of the Ginthen LPN1 removes the syringe (without port, poured R55's barrel of the syringe syringe to push the the tube. Further observation the GT with 50 ml of syringe to aspirate the medication cup aspirated the docus other medications in one to the GT port and liquid medications of the GT port and liquid medication in the following the delivery device medication in the following. LPN1 then the during the administration of the G55s' more pened his mouth, piece into R55s' more pened his mouth, piece pened his mo	ed that LPN1 did not check the T before flushing the water. ed the syringe and reattached the plunger) back to the GT diluted medications into the e and used the plunger of the diluted medications down to a revealed that LPN1 flushed of water then used the same the Ferrous Sulfate elixir from the use sodium liquid from the up. LPN1 mixed the two liquid syringe, attached the syringe used the plunger to push the down the tube. In, LPN1 was observed a spray to R55. LPN1 sprayed of two sprays in each nostril. Dam, LPN1 was unable to find or his nebulizer treatment (a second to administer the used to administer of a mist inhaled into the use a mouth piece to ebulizer treatment. R55's then LPN1 put the mouth both and turned on the Observation revealed that the R55 instructions to breathe procedure. R55 fell asleep ration of the nebulizer not able to adequately inhale	F 7	59			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 759	Regional Director Director of Nursing observation with L pass. The RDCs sissues and concer During an interview stated that she did give R44. LPN1 al LPN1 further state Miralax to supplen lactulose. When a Miralax, LPN1 state borrowing R207's medication, LPN1 medication. When borrow other resid "No. We don't war medications, so w supplies." LPN1 war amount of water in powder. LPN1 state up to five oz. I sho cups, 4 oz per cup During an interview LPN1, LPN1 state dosing card of the LPN1 further states	opm, the surveyor informed the of Nursing (RDCS) and the gregarding the surveyor's PN1 during the medication stated there had performance	F 75	,			
	all. When asked if R55's enteric coat defeats the purpos asked about the n administered to R5 for each nostril, I t for each nostril." V	it was appropriate to crush ed aspirin, LPN1 stated, "No, it se of delayed release." When umber of nasal spray she 55, LPN1 stated, "I sprayed one hought the order was one spray when asked about the nebulizer R55, LPN1 stated, "I know I					

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F 759	Continued From padidn't have a face in mouth piece. When to breath in and out When asked if R55 administered appronot." On 4/11/18 at 11:10 giving medications check the placeme checked R55's GT the water, LPN1 as and stated, "I wasn crushing meds all a medications all at ousing the plunger or R55's medications practices, LPN1 refurther comments. Review of R55's phwritten orders to crufurther review of R no information regard combining and givin once via his GT.	nask to use but I used a nasked if she instructed R55 t, LPN1 stated, "No, not really." nebulizer treatment was priately, LPN1 stated, "I guess Dam LPN1 when asked about via GT tube, LPN1 stated to nt first. When asked if she placement before she flushed ked herself if she did or not 't sure." When asked if at the same time, giving all the one time via R55's tube and if the syringe to administer were appropriate nursing mained silent and made no appropriate nursing mained silent and made no appropriate nursing mained silent and benefits of the R55's medical record indicated arding the risk and benefits of the R55's medications all at	F 7				
	Tube" indicated, " I together prior to ad tube. Administer ea not crush or split m through an enteral the pharmacy or far Medication List' T prior to administrati require a specific o	ty's undated policy, lication through an Enteral Do not mix medications ministering through an enteral ach medication separatelyDo edications for administration tube unless first checking with cility approved 'Do Not Crush ablets that must be crushed on through an enteral tube rder related to crushingDo patedCheck gastric residual					

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F 761 SS=E	feedingWhen cor acceptable GRV ha medication by gravi medication into the holding the tubing sinsertionIf adminismedication, flush wamount) warm steri medications." Review of the facilit 12/27/2017 and revi Administration indicadministered in accincluding any requir administering the mlabel THREE (3) tin right medication, rigmethod (route) of a medication." Label/Store Drugs a CFR(s): 483.45(g) Labeling Drugs and biological labeled in accordant professional princip appropriate access instructions, and the applicable. §483.45(h) Storage	sess for tolerance of enteral rect tube placement and twe been verifiedAdminister ty flow. Pour diluted barrel of the syringe while slightly above the level of stering more than one ith 15 mL (or prescribed alle or purified water between seved on 4/3/2018, Medication ented, "Medications must be cordance with the orders, red time framThe individual nedication must check the nes to verify the right resident, and tologicals the and Biologicals (a) of Drugs and Biologicals als used in the facility must be need to the corder of the property of the same place of the property of the same place of the place of	F 76			5/21/18

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F 761	§483.45(h)(2) The locked, permanen storage of controll the Comprehensiv Control Act of 197 abuse, except who package drug dist quantity stored is to be readily detected. This REQUIREME by: Based on observative review, the facility medication storage R19, R16, R40, Rative observed medication storage room. 1. On 4/10/18 at 9 preparing R44's macatulose (laxative cart that belonged During a medication at 9:50am, LPN1 paspirin EC (enterior Propionate Suspesuch as congestion Bumetanide (diure pressure); Finasted prostate); Escitalo Lisinopril (for high Acetaminophen (a elixir; and, Docusa LPN1 was unable	access to the keys. I facility must provide separately the affixed compartments for ed drugs listed in Schedule II of the Drug Abuse Prevention and and other drugs subject to the facility uses single unit the ribution systems in which the minimal and a missing dose cand distribution systems in which the minimal and a missing dose cand distribution systems in which the minimal and a missing dose cand distribution systems in which the minimal and a missing dose cand distribution. ENT is not met as evidenced ation, interview and record failed to ensure proper the for eight residents (R35, R10, 44, R55 and R207) and one of distribution carts, from a total of cation carts and one medication carts and one medication to R207 for R44's use. In pass observation on 4/10/18 or pass observation or 4/10/1	F 761	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of the facility to foll safely store and appropriately discarded; medications of discharged resident Multiple residents were noted to ha medication errors. Medications stormed carts and storage room were labeled correctly, discarded, medications were left on cart and medications were left on cart and medications left in cart dispensed by unlabeled. This was reviewed with immediately; medications must bely the resident sharing medications is allowed, med carts never to be left unlocked and unattended, medications is allowed, medication in secured cart processing the secured	the ssion or that of and ow ard ss. ve red in not arts d, out staff ong to not ions must

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 761	During an interview stated R207 had be lactulose should not other resident's us procedures on how residents are disch stated, "We don't we medications, so we supplies." When a medications were "Always lock the material LPN1 left the cart said, no. 2. On 4/13/18 at 10 an unlocked medication and Miralax medication and Miralax medication cart the At 10:20am, LPN2 room. During an interview LPN2, when asked medication cart and of the medication cart and of the medications were lock the cart and in top of the medication. On 4/12/18 and 4/12/18	locked and left all R55's of the med cart unsupervised. If on 4/11/19 at 10:45am, LPN1 een discharged and R207's of the in the medication cart for e. When asked about the vito dispose medications when harged from the facility, LPN1 want to toss out discharged except hem as our back up sked how to ensure residents safely secured, LPN1 stated, redication cart." When asked if locked shook her head and cocked shook of Lactulose ations. On top of the ere were also several lancets. It came out from a resident's come out from a resident's come out from a resident's safely secured, LPN2 stated to ot to leave any medications on on cart unless attended.	F 761	giving. 2.Because all resident rely on facili ensure proper medication administ and right to their own medications to citation has the potential to affect a residents. Resident medications we removed from med cart for dischar residents, any meds missing were ordered, and med carts monitored being locked. The policy on medicatorage was reviewed and updated other residents were affected. 3. To enhance currently compliant operations and under the direction director of nurses, on 5/9/2018 all r staff will be in-serviced on using remedications, not substituting, lockin cart, labeling meds, removing med cart not in use and monitoring right when reviewing the 5R's to medicatom administration. 4. Effective 4/28/2018, a quality-ass program was implemented under the supervision of the director of nurse check all med carts and medication passes. The DON or designee will complete 2 med cart audits per we weeks, then 1 audit weekly x2 monensure compliance. All staff will do medication administration compete and then have med pass audits completed 3 staff per week x 4 weethen 1 staff weekly x2 months to er compliance in this area. Any deficie will be corrected on the spot, and the findings of the quality-assurance child will be documented and submitted monthly quality-assurance committed monthly quality-assurance co	ration this III ere ged for ation I. No of the nursing sidents and med is from route tion surance he is to in ek x 4 this to ency eks, insure encies he necks at the ee	

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F 761	Dispositions of Medat the end of the surreceived the requestable. 3. On 4/9/18 at 3:30 filled with approximan unsecured open time of the observation of the pills were his moderation aide) 1 revealed there were filled with loose pills the medication aide) 1 revealed there were filled with loose pills the medications belong stated that both resemedications at the pass and that she was a further observation revealed a total of for second drawer of the On 4/13/18 at 10:18 (DON) was informed findings. The DON	's policies and procedures on dications. On 4/13/18 at 1pm, rvey, the surveyor had not sted information. Opm a clear medication cup ately five pills was observed in drawer in R16's room. At the tion, R16 had confirmed that orning medications. "Group 2" medication cart on om with TMA (trained and the MDS Coordinator etwo clear medication cups is located in the top drawer of two clear medication cups is located in the top drawer of the top drawer of the top drawer of the ed to R40 and R44. TMA1 idents had refused their time of the evening medication was "saving those for later." In of the "Group 2" cart ive loose pills located in the ne medication cart. Bam the Director of Nursing d regarding the above stated the expectation was to	F 76	action. 5.Pharmacy and DON will be refor this POC.	esponsible	
	and if resident refus should be disposed A medication storage the facility, however survey exit.	ge policy was requested from rone was not provided upon Store/Prepare/Serve-Sanitary	F 81	2		5/21/18

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F 812	approved or considerate or local author (i) This may include from local produce and local laws or received in This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for \$483.60(i)(2) - Store serve food in accordance from consuming for Serve food in accordance from the facility of the Serve food in accordance for food this REQUIREME by: Based on observation of the facility of the 53 residents kitchen. Findings Include: During the initial to observation of the 53 residents kitchen. Findings Include: A review of the "driver of the serve of the day of the	fety requirements. Cure food from sources dered satisfactory by federal, writies. If food items obtained directly res, subject to applicable State egulations. If oes not prohibit or prevent group produce grown in facility of compliance with applicable produced produce residents odes not preclude residents odes not preclude residents odes not procured by the facility. The prepare, distribute and redance with professional service safety. If is not met as evidenced to a resident had the potential to affect 51 that received food from the facility of the kitchen, an walk-in refrigerator on pm, revealed a clear plastic gg salad dated 04/02/2018, has bread with a label of "prep	F 812	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists o one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law. 1.It is the policy of this facility to enshealthy and safe meal service. Sor the many ways that this has been densuring clean environment and sa preparing and serving food and beverages to residents. After the sureported finding expired dates or unitems in kitchen it was determined and properly managing expired food	the ssion or that of and sure me of lone is fely urveyor ndated staff

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F 812	O4/09/2018, reveault of the end o	aled a gallon pitcher labeled as '04/03/18." Jued, at the dish washing room, agg salad container and loaf pan on a cart with other dirty dish on a cart with other distribution of a cart with othe	F8	Immediately the dietary may out items and updated standates. 2.Because all residents remeals here in facility all an affected by the cited deficid 4/17/2018, the dietary mare clean of the fridge to remoitems. Cleaning out fridge expired is now done daily cleaning schedule. 3.To enhance currently concept operations and under the director of dietary, on 5/7/2 staff reviewed proper storations with dietary manager to enter are safe to serve. 4.Effective 4/28/2018, a querogram was implemented supervision of the director monitor fridge for expired director of dietary or desig quality-assurance represe perform audits of fridge to week for 4 weeks then 1x months to ensure compliad manager or designee. Any will be corrected on the specific findings of the quality-assurance representations of the quality-assurance will be documented and sumonthly QAPI meeting for or corrective action. 5.Dietary manager and may be responsible for this PO	ff to monitor ceive their e potentially ency, nager did deep ve all outdated items that are with kitchen mpliant direction of the 2018 dietary age and dates issure all items uality-assurance d under the of dietary to tems. The nated intative will be done 2x per per week for 2 ince via dietary is deficiencies ot, and the urance checks ubmitted at the further review aintenance will		

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 812	within 3 to 4 days. Namount of a hot egainto several shallow quickly." In a telephone inter	r cooked egg dishes and use When refrigerating a large g-containing leftover, divide it containers so it will cool	F 812		
F 865 SS=E	stated that 51 of the from the kitchen. QAPI Prgm/Plan, D CFR(s): 483.75(a)(assurance and performance	F 865		5/21/18
	Survey Agency no I promulgation of this \$483.75(h) Disclose A State or the Secretisclosure of the reexcept in so far as	ure of information. etary may not require cords of such committee such disclosure is related to such committee with the			
	and correct quality a basis for sanction This REQUIREMED by: Based on interview failed to maintain a assurance (QAA) c identifying and resp	s by the committee to identify deficiencies will not be used as		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists of	the ssion

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		245052	B. WING		04/13/20	018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	(X5) PLETION DATE
F 865	all 53 residents in Findings include: During an interview Executive Director specific problem a identified or perfor that had been mad following: reduce t successfully disches short stay resident number short stay increase the numb pneumococcal vad short stay resident the number of resi residents. The facility's QAPI potential quality is following: 1. The facility failed that: a) included m types of alleged violations i exploitation or mis unknown source a property are report State Survey Agen timeframes; and) r investigations to th designated repres Survey Agency wit incident.	the facility. In on 4/13/18 at 8:30am, the provided information on reas that had been recently mance improvement changes de which only included the he number of short stays arged to community, reduce a pain levels, increase the resident influenza vaccines, her of short stay resident coines, decrease the number of antipsychotics, and decrease dents with pain in long stay committee failed to identify sues as evidenced by the d to develop an abuse policy instreatment and exploitation as colations; b) ensured that all involving abuse, neglect, treatment, including injuries of and misappropriation of resident the to the administrator and acy within the required reporting report the results of all the administrator or his or her centative and to the State thin 5 working days of the of failed to report an allegation	F 865	one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1.It is the policy of the facility to entat the Quality Assurance Perform Improvement committee identifies develops appropriate action plans to system failures. The facility fails have appropriate action plans relat system failures including abuse proinvestigations and reporting. Pressulcers, medication issues (errors, storage), and tracheostomy care. met on 4/30/18 where it was identifuncted and implementing PIPs. In discussion with Medical Director and QAPI members, it was determined reviewed that QAPI had previously ineffective. Administrator educated everyone on the QAPI program, the guidelines, processes and how to a data, etc. to begin to effectively adsystemic failures to improve quality facility. 2. Lack of appropriate action plans system failures can affect all reside the facility. After identifying system failures from survey, ad hocs were identified and implemented, and brown to QAPI on 4/30/2018. At this mee opportunities for improvement were identified, prioritized, root cause was determined, and performance improvement plans were initiated, reviewed and continue to be monit	and sure lance lance and related led to led to led to led by liled	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245052	B. WING		04/13/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		٦
MOORH	EAD REHABILITATIO	N & HEALTHCARE 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 CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE COMPLÉTION	
F 865		age 144 the facility failed to report this	F 865	3.To enhance currently compliant		
	allegation to the St two hours for one (report allegations of immediately to the	ate within the required time of (R20) resident and failed to of resident-to-resident abuse administrator affecting two d R258) reviewed for abuse.		operations and under the direction Administrator, education reviewed elements and goals of the QAPI pr assistance and tools for accurate of review, and proper identification of cause while assuring goals are SM	the ogram, lata root	
	protect a resident i abuse for one (R20 thoroughly investig	t abuse affecting two residents		(specific, measurable, attainable, reand time oriented). All staff will recin-service training regarding QAPI program, who is on the committee their roles, what is discussed, frequof meetings, who to report suggest bring to QAPI, where monthly posti	ealistic eeive and uency ions to	
	provide timely interpreumonia for one tube feeding.	d to assess, monitor and rventions to prevent aspiration (R55) resident reviewed for		review of prior months QAPI are, e 4.The QA committee will meet mor discuss action plans related to deficiencies noted during survey, re and analyze audits and determine	eview	
	measures were in development of pro (R55) resident and appropriately treat	d to ensure preventative place to prevent the essure ulcer injury for one to assess, document, and a pressure injury for one ewed for pressure injuries.		appropriate continued monitoring of system changes in addition to other already identified on the QAPI plant agenda. The medical director will be present monthly and pharmacy continued will be present at a minimum quart not present minutes will have submitted.	r items pe nsultant erly; if	
	medication error ra affected three resid	d to ensure it was free of a stee greater than 5% that dents (R35, R44, and R55.)		them prior to meeting to allow for in during meeting, then will be review signed monthly. Audits are in place reviewed monthly to assure that all	nput ed and e and	
	aseptically and put when the inner car	d to perform tracheostomy care a process in place to monitor anula was due to be changed he resident reviewed for		supporting documentation from each department head is submitted to the Administrator the Monday prior to refor adequate time to review. After the minutes and supporting documentation will then be sent to	e meeting QAPI	
	storage for eight re	d to ensure proper medication esidents (R35, R10, R19, R16, d R207) and one of two		and COO for review. This plan of correction will be monitored at the QAPI meeting and audits to continu	monthly	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245052	B. WING _		04/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLÉTION
F 865	observed medication facility medication storage room. Review of the facility Performance Improved indicated "II. Progrand Monitoring this monitor data based goal of reducing are resulting in overall increasing star ration resident satisfaction discussed quarterly Infection Prevention CFR(s): 483.80(a) (1) §483.80 Infection Control provides comfortable environdesigned to provide comfortable environdevelopment and tradiseases and infection program. The facility must esand control program. The facility must esand control program a minimum, the following services and communicable staff, volunteers, visproviding services a arrangement based.	y's "Quality Assurance and vement plan," undated, gram Feedback, Data Systems is an ongoing process to on assessment with having a east hat are flagging and emprovement of performance, and grand resulting in higher and resulting in higher and the with the QA committee" a & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: Stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals	F 88	such a time that shows consi substantial compliance with the regulations and the facilities has been met, as determined representative of the regional team. 5.The Administrator or design responsible for this POC.	he QAPI plan I by a I executive

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		STRUCTION		E SURVEY PLETED
		245052	B. WING			04/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		2810 SE	ADDRESS, CITY, STATE, ZIP CODE COND AVENUE NORTH HEAD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	procedures for the but are not limited to (i) A system of surve possible communication infections before the persons in the facilia (ii) When and to whose communicable disereported; (iii) Standard and the tobe followed to proceed (iv) When and how it resident; including the followed involved, and (B) A requirement to least restrictive postic cumstances. (v) The circumstances. (v) The circumstances (v) The circumstances (vi) The circumstance (vi) The hand hygier by staff involved in the system of the corrective actions to \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must half possible for the system of the survey of the system of the survey of the system of the	en standards, policies, and program, which must include, oceillance designed to identify able diseases or ey can spread to other ty; nom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a put not limited to: aration of the isolation, exinfectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct that or their food, if direct the disease; and the procedures to be followed direct resident contact.	F8	80			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245052	B. WING		04/13/2018
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	1 0 17 107 2010
MOORHE	EAD REHABILITATIO	N & HEALTHCARE CENTER		810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 880	Continued From pa	age 147	F 880		
	IPCP and update the This REQUIREMED by: Based on observative review, the facility control practices reconstructions.	nduct an annual review of its heir program, as necessary. ENT is not met as evidenced ation, interview and record failed to follow proper infection elated to the storage of		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submi	the
	resident in the san Findings include: R18 was admitted	on 12/23/16 with a diagnoses		of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law.	of and
	anxiety and pain. Review of R18's M Record (MAR) dat revealed an order Solution 052.5 (3	ledication Administration ed 4/01/18 through 4/030/18 for "DuoNebs (Dual Nebulizer)) MG [milligrams].ML[milliliters] rol 1 dose inhale orally four		1lt is the policy of the facility to provinfection prevention practices. Upo survey it was noted resident R18 hamask at bedside which was not cle and undated. Policy of dating and cleaning was not being followed. Immediately facemask changed ou dated. 2Because many resident's use facemasks, many are potentially affected.	n ad neb aned it and
	had a nebulizer ma laying uncovered on on the nebulizer w An observation on nebulizer mask lay	4/09/18 at 2pm revealed R18 ask attached to his nebulizer, on his bedside table. The tubing as undated. 4/10/18 at10am revealed the ring uncovered on the bedside on the nebulizer was undated.		the cited deficiency. All residents of use oxygen or nebulizers were reviand supplies switched out and laber The policy on nebulizers has been reviewed. 3To enhance currently compliant operations and under the direction director of nurses, on 5/9/2018 all restaff will be in-serviced on nebulize	on who ewed eled. of the nursing
	nebulizer mask lay table. The tubing of	4/11/2018 at1pm revealed the ring uncovered on the bedside on the nebulizer was undated. 4/12/2018 at10am revealed		masks, cleaning and allowing air didating all types of masks and tubing basic infection prevention policy. 4Effective 4/28/2018, a quality-assi program was implemented under the	ry, g, and urance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 880		laying uncovered on the	F 8	supervision of the DON to m		
F 947 SS=D	undated. On 04/12/2018, at with the Director of the facility's Infectio expected all staff to control policies inclustorage of R18's new An undated policy, Medication through Nebulizer" under the Procedure: Step 29 (facemask) is compag with the resider Step 30. Change edseven days or acconsequired In-Service CFR(s): 483.95(g) (Secontinuing Competed be no less than 12 (Secontinuing Competed be no less than 12 (Secontinuing Competed Secontinuing Competed Seco	a Small Volume (Handheld) e section "Steps in the . When equipment bletely dry, store in a plastic nt's name and the date on it. quipment and tubing every rding to company policy." e Training for Nurse Aides 1)-(4) d in-service training for nurse nust- ufficient to ensure the ence of nurse aides, but must hours per year. de dementia management at abuse prevention training. ess areas of weakness as e aides' performance reviews nent at § 483.70(e) and may needs of residents as	F 94	nebulizer supplies. The DO designated quality-assurance representative will perform the systematic audits on resident nebulizers; 3 residents per with weeks, then 1 resident weeks to ensure compliance in this dating, cleaning and changing Any deficiencies will be correspot, and the findings of the quality-assurance checks with documented and submitted quality-assurance committee further review or corrective at 5The DON will be responsible POC.	the following onts with week x 4 kly x2 months area — ng weekly. ected on the at the monthle meeting for action.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	E SURVEY IPLETED
		245052	B. WING _		04/	13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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)	JLD BE	(X5) COMPLETION DATE
F 947	to individuals with of address the care of This REQUIREMENT by: Based on interview failed to provide restraining for one nurpersonnel record with practice had the point the facility. Findings include: During an interview stated that nursing roughShe told meignores me." R20 at the her when NA4 as and that she speak. On 4/12/18, at 7:45 facility's Relias (we reviewed. The transprevention training NA4 in 2017 or 201. On 4/12/18, at 9am transcript in the fact training system. E1 NA4 had not compliprevention training that E4's last training December 2016.	nurse aides providing services cognitive impairments, also if the cognitively impaired. NT is not met as evidenced and record review, the facility sident abuse prevention sing assistant whose as reviewed. This deficient tential to affect all 53 residents tential to affect all 53 residents as is and then she ded that NA4 speaks harshly sks R20 "What do you want?" is this way to R20 often.	F 94	This Plan of Correction constitution written allegation of compliance deficiencies cited. However, subsorted this Plan of Correction is not admission that a deficiency exist one was cited correctly. This Plan Correction is submitted to meet requirements established by stated federal law. 1. It is the policy of the facility to trainings for nursing aides is contained and the resident abuse training to one Norequired by the regulation. 2. The facility has determined the residents have the potential to be by this deficient practice if staffing adequately trained on abuse, not exploitation upon hire and annual Nursing aids out of compliance complete training requirements Relias of 12-hoour training by 53. Beginning 4/28/2018 staffing to provided Relias training module staff to complete abuse, neglect exploitation requirements by Ma 2018. On 5/9/18 the DON (or dwill provide all staff with the resistaffing to set up all staff with negative staffing to set up all staff with the resistaffing to set up all staff with the staff with negative staff with the s	for the omission an its or that an of ite and ensure inpleted ovide AR as at all e affected are not glect and ally. It is and y 20th, esignee) dent in ation. A ed for	
	asked about the ap	parent lack of mandatory ng for NA4. No additional		and annually to assure enrollme	nt,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		04/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 947	"Vulnerable Adult," "Training," stated "A to attend training th meetings on issues prevention/interven Appropriate interver and/or catastrophic residents/patients. A knowledge of allega to recognize signs of stress which may le	ry's abuse policy titled revised 12/23/17, under All employees will be required rough orientation and annual related to abuse tion. This includes: 1. Intions to deal with aggressive reactions of 2. How staff should report their ations without reprisal. 3. How of burnout, frustration and the ead to abuse. 4. What the neglect and misappropriation	F 94	reviewed. 4. Audits will be completed weel staff to assure compliance, and employees during that time frar assure compliance and any definited will be corrected on the seducational status of employee added to review indefinitely and at every QAPI to assure month staffing coordinator or Designer monitoring all staff nursing aide complete annual 12-hour training 5. The staffing coordinator (or dwill be responsible for the POC	I with new me to ficiencies pot. The s has been dongoing by the e is to es to esignee)	

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY		ID: VNGR Facility ID: 0	0038
MEDICARE/MEDICAID PROVIDER (L1) 245052 2.STATE VENDOR OR MEDICAID NO. (L2) 154578700		3. NAME AND ADDRESS OF FACILITY (L3) MOORHEAD REHABILITATION & F (L4) 2810 SECOND AVENUE NORTH (L5) MOORHEAD, MN			4. TYPE OF 1. Initial 3. Termina 5. Validation	2. Receration 4. CHO) tification W	
5. EFFECTIVE DATE CHANGE OF OW (L9) 02/01/2017 6. DATE OF SURVEY 03/13/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TIC 2 AOA 3 Other		7. PROVIDER/SUI 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE		vey After Complaint	(L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	78 (L18) 78 (L17)	Compliand1.	nce With dequirements are Based On:	gram	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNR 5. Life Safety Code * Code: B *	_ 6. Sco _ 7. Mo	ope of Services Limit edical Director tient Room Size	
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 78 (L37) (L38)	N 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(Ll	15)	
16. STATE SURVEY AGENCY REMAR IJ was cited at F 689 IJ removed IJ of K cited at F812 - IJ removed 3 G's cited at F 676, F 686 and F 69	March 13, 2018 bu March 9, 2018 b	t remained at the lov	ver s/s of G	Ξ):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Jonathan Anderson, HF	E NE-II	(04/30/2018	(L19)	Douglas S. Larson, Enf	orcement Sp	ecialist 05/	02/2018 _(L2)
PA	ART II - TO BE	COMPLETED	BY HCFA R	EGIONAI	L OFFICE OR SINGLE ST	ATE AGENC	Y	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Pa 2. Facility is not Eligible			IPLIANCE WITH GHTS ACT:	CIVIL	21. 1. Statement of Final2. Ownership/Control3. Both of the Above	ol Interest Disclosur		
22. ORIGINAL DATE OF PARTICIPATION 03/01/1979	23. LTC AGREEM BEGINNING		4. LTC AGREEN		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure	05	(L30) NVOLUNTARY 5-Fail to Meet Health/S	•
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATI A. Suspension B. Rescind Sus	n of Admissions:	(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	0 0	6-Fail to Meet Agreeme <u>VTHER</u> 7-Provider Status Chan _t 0-Active	

(L45)

30. REMARKS

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

01111

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted March 30, 2018

Mr. Jesse Doschadis, Administrator Moorhead Rehabilitation & Healthcare Center 2810 Second Avenue North Moorhead, MN 56560

RE: Project Number S5052027

Dear Mr. Doschadis:

On March 13, 2018, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on March 9, 2018, that the conditions, cited at F812, resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

We also verified, on March 13, 2018, that the conditions, cited at F689, resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective April 4, 2018. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiencies cited at F689, F812, F676, F686, F697. (42 CFR 488.430 through 488.444)

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 § 488.41(a), effective June 1, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 1, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 1, 2018.

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.

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Moorhead Rehabilitation & Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 13, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Per day civil money penalty for the deficiencies cited at F689, F812, F676, F686, F697. (42 CFR 488.430 through 488.444)

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 PoC must meet the

criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 1, 2018, the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 September 13, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

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

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

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

PRINTED: 04/30/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE 2810 SECOND AVENUE NOR MOORHEAD, MN 56560			10.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD FO THE APPROPE	BE	(X5) COMPLETION DATE
E 001 SS=F	Initial Comments A survey for complemergency Prepare conducted March 6 March 9th, March 6 during a recertificar Participation 483.7 Emergency Program The facility's plan of as your allegation of Department's acceptation of the first plan in the substantial confus been attained a verification. Establishment of the CFR(s): 483.73 The [facility, exceptomply with all appeare gency prepare [facility] must establish must esta	liance with CMS Appendix Z redness Requirements, was 6th, March 7th, March 8th, 12th and March 13th, 2018, 15tion survey. The Condition of 3: Establishment of the m was found not met. of correction (POC) will serve of compliance upon the ptance. Your signature at the bage of the CMS-2567 form will tion of compliance. acceptable POC an on-site ty will be conducted to validate mpliance with the regulations in accordance with your the Emergency Program (EP) the for Transplant Center] must licable Federal, State and local edness requirements. The olish and maintain a mergency preparedness the requirements of this regency preparedness program to the limited to, the following 482.15:] The hospital must licable Federal, State, and reparedness requirements. The	EC	DEFICIE		KIATE	4/24/18
LABORATORY	•	iop and maintain a nergency preparedness DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE			(X6) DATE

Electronically Signed 04/09/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
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E 001	*[For CAHs at §4 with all applicable emergency prepa CAH must develor comprehensive eprogram, utilizing This REQUIREM by: Based on intervirual facility failed to estable which meets the emergency prepa and procedures, based emergency patient population disaster. This defit to affect all 59 reservirual facility failed to estable for the health, safety patient population disaster. This defit of the facility failed to affect all 59 reservirual facility failed to affect all 59 reservirual facility failed to affect all 59 reservirual facility failed facilit	ets the requirements of this an all-hazards approach. 85.625:] The CAH must comply be Federal, State, and local aredness requirements. The op and maintain a emergency preparedness an all-hazards approach. ENT is not met as evidenced ew and document review the stablish an emergency plan conditions of participation for aredness which included policies communication, community y drills, and staff training to meet and security needs staff and anduring an emergency or ficient practice had the potential sidents residing in the facility.	EO	The preparation of the follocorrection for this deficience constitute and should not be as an admission nor an agrifacility of the truth of the factonclusions set forth in the deficiencies. The plan of comprepared for this deficiency solely because the provision federal law require it. With foregoing statement, the factoric with respect to:	ry does not the interpreted reement by the cts alleged or statement of prrection was executed ons of state and but waiving the cility states	
	the facility was cop.m., with the Dippersent. The DOI appendix Z, was requirements and emergency plan for provided various -A document title and Vulnerability Occurring Events events such as a	mergency preparedness plan for onducted on 3/9/18 at 12:15 rector of Maintenance (DOM) M indicated he had heard of not aware of all the d was unsure the status of the for the facility. The DOM documents for review: de Kaiser Permanente, Hazard Assessment Tool, Naturally a undated, which listed various ctive shooter, bomb threat, mass suspicious odor, transportation		 1.All Golden Living stuff was from binder, and information to reflect current facility nare policies. 2.An Emergency Plan will be by ED and DOM to address facility will coordinate with the healthcare facilities and the a whole during an emerger disaster. 3.ED set up meeting with Common Emergency Manager Bryarmeeting will take place at Note that the place that the pl	on was updated me and one developed is how the other e community as ancy or a Clay County in Green. The Moorhead	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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E 001	However, the assess assessment of the special needs of the facility, and a list emergency services engineer, police deservices and repair telephone list. In adpolicy titled Golden Emergency Manage which addressed arror fire, armed robb facility. - Emergency manners for such emergency manners for such emergency the building, Snow Safety, Hurricane, Electron of the building, Snow Safety, Hurricane, Electron of the special shooter. All the portion of the special shooter of the special should be special shooter. The facility's various the facility's various the facility's and the confidence of the special shooter.	at of risk for each category. It is sement did not include an resident population and at population. Evacuation Plan, revised ned an organizational chart for it of telephone numbers for is such as ambulance, city partment, transportation services and an employee dition, the manual contained a living Center Moorhead, ement, updated 10/11/16, in emergency response such ery, suspicious mail within the ual which contained policies of response as how to evacuate Emergency/Blizzard, Tornado Elopement, nuclear attack, ins, Fire Alarm System al Evacuation, and Active licies in the manual were titled er and had last been	EC	001	from FM Ambulance Services will be attendance to go over emergency preparedness information. 4.ED will set up a full-scale evacual drill with the help of community resusch as the Fire Department and Ambulance Services. 5.Full scale evacuation and table to exercise will be done annually with participation of staff. 6.Transfer agreements have been by ED and sent to Essentia Health Sanford Health on 4-3-18. They indicate the they would sign but needed to send legal team first. 7.A memo will be placed on the communication book notifying staff the Emergency Preparedness Bind been updated and they should fam themselves with it. 8.An all staff meeting will be conducted and train staff of emergency preparedness information. The Emergency Preparedness Bind be revised and updated annualled. The ED and DOM are responsible this POC.	tion ources op the signed and licated if to that er has illiarize cted on the on. inder ly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 001	of a plan on comithe community, a how the facility or facility, across he state and local putter and local putter tornado warning. However, the recany further training facility which included had been develop approach assess. Full Scale Exercise review of document Watch and Simul conducted on 6/1 held a tornado was the facility and hallways of the facility and hallways of the facility and of documentation laparticipated in a context agencies participated in the prior and was not emergency plan was not emergency plan was not sure was not sure were in place at participate and place at participate and was not sure were in place at participate and place and place at participate and place at participate and place and pla	the facility lacked documentation municating within the facility, with and other agencies, to identify pordinates patient care within the salthcare providers, and with ablic health. of the training records provided ealed staff had been trained on a response within the facilty. ords lacked documentation of ag on a emergency plan for the added policies and procedures peed from an all hazards	EC	001			

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E 001	He indicated he way vulnerability assess completed, and state unsure if any analysteen done The DO records, and state further training recotraining since he state in the state of training since he state of the	s unsure when the sment tool had been ted "maybe last July" and was sis of the assessment had M confirmed the training d he was unaware of any ords nor had he conducted any arted in the facility. Is lucted by the Minnesota lth on March 6, 7, 8, 9, 12, and ey resulted in an Immediate 89 when R1 had not been assessed for falls to determine ons to prevent injury. Further, oriately implemented the use of for R1, which increased R1's ury. R1 continued to self in falls, which resulted in a risk originary or death due to his J began on 11/23/17, and was 13, 2018 at 2:00 p.m. I began on a routine basis; and hal residents R22, R7, R26, 9, R45, R5, R44, R28, R42, 56, R10, R29, R4, R208, R14, 25, R52, and R30 identified by me the unpasteurized, fried or and who were at increased a potentially life-threatening in as a result. The IJ began on	F 00			
	removed on March In addition, the survive when R25 and R35 unpasteurized, fried for 27 of 27 addition R108, R38, R37, R R27, R55, R114, R R209, R12, R20, R the facility to consuundercooked eggs risk of contracting a Salmonella infection	13, 2018 at 2:00 p.m. yey resulted in an IJ at F812 identified to consume deggs on a routine basis; and hal residents R22, R7, R26, 9, R45, R5, R44, R28, R42, 56, R10, R29, R4, R208, R14, 25, R52, and R30 identified by me the unpasteurized, fried or and who were at increased a potentially life-threatening				

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F 554	care, an extended so March 9, 2018. The facility's plan of as your allegation of Department's accepance enrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. Resident Self-Admit CFR(s): 483.10(c)(f) §483.10(c)(f) The indefined by §483.21 this practice is clinical than the practice is clinically than the practice is clinicall	fying substandard quality of survey was conducted on f correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required a first page of the CMS-2567 and its submission of the POC will cion of compliance. acceptable electronic POC, and ar facility may be conducted to notial compliance with the en attained in accordance wit	F 000		
	stored medication i administering the m Findings include: R31's 30-day Minim 1/25/18, identified F	2 residents (R31, R107) who in their room and were nedication. num Data Set (MDS) dated R31 had intact cognition. On R31 was seated in a		of this Plan of Correction is not an admission that a deficiency exists or the one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide adequate supervision and assistance amedication administration. One of the	9

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
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F 554	wheelchair in his ro had a bedside table his left side which he medication bottles was self administer room. R31 then motwo single pills place to these as his "which blue" pills, and hand for review. The first orange collabel affixed to the with acetaminopher 11/29/17, with direct every four hours as was approximately and R31 stated he. The second orange pharmacy label affice cephalexin (an antiwas covering the rewould not allow the stated this was his had and the pills we when questioned conday, R31 responde. R31's Order Summidentified an order of hydrocodone-aceta (milligrams) 1 table however lacked any cephalexin to be acophysician orders lacked any cephalexin orders lacked any cephalexin to be acophysician orders lacked any cephalexin orders lacked any	om watching television. He immediately next to him on ad two orange colored sitting on top. R 31 stated he ing the medications in his wed a napkin which exposed ed on the table. R31 referred te pill" and his "blue and dark ded one bottle to the surveyor dored bottle had a pharmacy side, which listed hydrocodone in (a narcotic) and filled on tions to administer one tablet in needed for pain. The bottle 1/2 full with oblong, white pills took these pills "twice a day." It colored bottle had a exed to the side, which listed biotic), however, R31's hand emainder of the label and he surveyor to review. R31 antibiotic for a foot infection he ere "hard to take" sometimes. In how many he was taking a d, "[I] think its six tablets."	F 5	many ways that this has been a for resident #31 is by reviewing medication policy and self-adm policy with resident and asking would like to have option of kee at bedside which was determinitroglycerin and tums. R31 was for knowledge of medications, so dosages and administration. On place and care plan updated. R noted to have orajel at bedside reviewed medication use, safet ability to use correctly. R107 can at bedside, order in place and cupdated. In this case, after the reported the medications found bedside, the staff was reminded immediately to nursing to ensure self-administration assessment completed, an order obtained, a plan updated. The policy to be next resident council meeting an new admits ensuring understant facility policy. 2. Because all residents receiving medications are potentially affected deficiency, 4/4/2018, the conursing along with ED in-service to ensure understanding of reported to ensure t	nistration f R31 ping meds d to be reviewed afe use, der in 107 was and have gel are plan surveyor at to report e is nd care eviewed at nd with all ding of g cted by the irector of ed all staff orting any OTC policy of d, and the ssed so ance of ion of taff to do. n will be nd the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ^T A. BUILDI	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER EAD REHABILITATIO	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	·	
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F 554	R31's care plan dar cellulitis (infection of chronic pain and di medications associantibiotic(s) and hy lacked any dictation R31 self administer R31's progress not had complaints of cas saying, "I take T for that purpose." On 3/7/18, at 9:58 a his room in his wheor medications visil stated he put them them to the surveyor mid sentence which before he awoke sa R31 did not elabora infection and the ashe took his "pain pin never totally relieve medication bottles using them" and insreport them to staff On 3/7/18, at 10:17 (LPN)-C and traine were notified of R3 Neither were aware medications, howeremoved medication occasions, mostly reprior. TMA-A explainurses and it was "	ted 1/19/18, identified R31 had of soft tissue) is his foot and rected staff to administer lated with these including his drocodone. The care plan in or interventions pertaining to ring his own medications. The dated 2/26/18, identified R31 chest pain and recorded R31 rums for it, I got it in my room a.m., R31 was again seated in the lectric that is dresser and showed or. R31 then closed his eyes in lasted for several seconds anying "[I] think I'm going to die." atte further. R31 stated his foot responded he "shouldn't be structed the surveyor to not	F 5	All residents will be interviewed they have meds in room and addetermine if they can be assess that they understand policy. Nu and housekeeping will update I immediately if after interviews versidents completed and individual discussion any medications inco OTC's are found in room. In addicting upon admission and rand audits will be completed on all rensure no medications are four not administered by the facility self-administered by the facility self-administer will store their main top drawer of nightstand and private key for that drawer for self-administered medications softher residents were affected. 3. To enhance currently compliad operations and under the direct director of nurses, on 4/4/2018 received in-service training registate and federal requirements self-administration of medication updated on the 2 residents, R3 R107, to ensure staff aware of at bedside. The training emphasimportance of safe medications any other medications found in the right residents have to self-The staff reviewed the competer assessment residents need to demonstrate safe and accurate and dispensing of medications. remind resident to report to nursemind resident residents residents report to nursemind resident to report to nursemind resident residents report residents res	cordingly sed and raing staff pON rith all ual uding dition, all n policy of dom room esidents to d that are without and order. edications have a afe rafely. No nt ion of the all staff arding for ns and l and heir meds sizes the reporting room and administer. ncy use, dose Also, to	

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NAME OF	PROVIDER OR SUPPLIEF	?	<u> </u>	STREET ADDRESS, CITY, STATE,	ZIP CODE		0,2010
MOORH	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	4		
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F 554	any assessment of his own medications these medications medications inside. When interviewed director of nursing medications remo admitted and subs R31's physician with medicating with medicating with medicating with medicatified by the stanceded to "talk to as he has been for since his admission assessed for self however, DON additionally however, by the mear future. Since the mear future. Since the mear future was looking to the near future. Since the mear future of the mear future of the mear future of the mear future. The mear future of skin, scalp and care Area Assess 2/28/18, indicated cancer and gastro initial care plan into on staff for activitic during an observation of the medications.	ord was reviewed and lacked of R31's self administration of ins, including his sourcing of its, despite being found to have the his room several times before. I on 3/7/18, at 1:47 p.m. the incomply (DON) stated R31 had its ved from his room when he first sequent times since then in as notified regarding him self arcotics and antibiotics as surveyor. DON stated staff him about the self medicating in its would be beneficial as its discharge the nursing home in the stated an assessment of make sure he's administered in its make sure he's	F 5	they self-administered rasking if they have used documenting use of the Policy and Procedure for self-administration of mareviewed. 4. Effective 4/4/2018, a comport of the direct monitor resident self-admedication. The direct designated quality-assure representative will perfor systematic changes: rangesidents who are approximated to approximate the monthly and the findings of the content of the monthly quality-assurementation. The Documentation of the complete 2 audits per without the findings of the content of the monthly quality-assurementation. The Don will be respected to the monthly quality-assurementation of the complete committee meeting. 5. The Don will be respected.	d to ensure numedication. medication was edication was edication was equality-assurated under the tor of nurses of ministering or of nurses of nurses of nurses of the following check oved to DN or designed week x 4 week months Any ected on the squality-assuranted and submissurance	ursing The S ance eto or ring king ee will ks, spot, ance nitted	

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F 554	R107 regularly remorphine). RN-A physician change oxycodone from of for better pain rel noted that R107 rover the counter on resident's bed R107's family broresident. During further obp.m. it was obser (1) tube of OralGasked, R107 gesnods, indicated h compared to the subsequent interv(LPN)-I stated shrelief with the me R107 still had fand In review of the mevidence that a shad been completed in the complete of the subsequent interview of the mevidence that a shad been completed in the complete of the subsequent interview of the mevidence that a shad been completed in the complete of the subsequent interview of the mevidence that a shad been completed in the complete of the subsequent interview of the mevidence of nursing medical record, cassessed for self and stated R107 his ability to self and stated facility medications policity is capability in the complete of t	quested oxycodone (form of stated recently, R107's and the dosing time for the every 6 hours, to every 4 hours, ief. While observing care, it was nad two (2) tubes or OralGel (an lidocaine gel used for oral pain) side stand. RN-A stated that bught the medication in for the every at the medication in for the every to the servations on 3/09/18, at 12:32 and R107 continued to have one el on his bedside stand. When turing with hands and head en was getting relief with OralGel, gel the nurses provided. In a view licensed practical nurse efelt R107 was getting better dication dosing time change, but nily bring in OralGel for self-use. The dical record, there lacked elf-administration assessment atted by the facility. In 3/12/18, at 8:30 p.m. the grown in	F 5	554		

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F 554	however, lacked an administration asse	are found at bedside, ny guidance or direction on self essment after this occurs.	F 554			
	Request/Refuse/Dic CFR(s): 483.10(c)(6) The discontinue treatment to participate in expromulate an advars §483.10(c)(8) Noth construed as the rithe provision of meservices deemed in inappropriate. §483.10(g)(12) The requirements special spart I (Advance (i) These requirements concerning medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable Star (iii) Facilities are preentities to furnish the	right to request, refuse, and/or ent, to participate in or refuse perimental research, and to not directive. Ing in this paragraph should be ght of the resident to receive edical treatment or medical nedically unnecessary or e facility must comply with the iffied in 42 CFR part 489, Directives). ents include provisions to written information to all adult not the right to accept or refuse treatment and, at the ormulate an advance directive. written description of the implement advance directives	F 578			4/4/18
	time of admission a information or artic has executed an a may give advance	s section are met. idual is incapacitated at the and is unable to receive ulate whether or not he or she dvance directive, the facility directive information to the t representative in accordance				

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F 578	with State Law. (v) The facility is a provide this informor she is able to a Follow-up proced the information to appropriate time. This REQUIREM by: Based on intervite facility failed to enemergency care a ensure resident was correctly in an emersidents (R7) revisited for the facility failed to enemergency care and the facility failed to enemer facil	not relieved of its obligation to mation to the individual once he eceive such information. ures must be in place to provide the individual directly at the ENT is not met as evidenced ew and document review, the asure conflicting directives for and treatment were clarified to vishes would be implemented are negent situation for 1 of 2 viewed for advanced directives. Provider Orders for Life nent (POLST) signed 11/29/16,	F 578	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists cone was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1.It is the policy of the facility to proadequate supervision and assistant advance directives. One of the mar that this has been achieved for resi #7 is by reviewing the advance direction file and ensuring with resident a POA correct code status on file. R7 previous POLST in chart and a diffeorder which was not determined to been reviewed with resident. The corder in place for DNR is now clarif noted in EMAR. The chart has been corrected and R7 profile updated. It case, after the surveyor reported the contradictory advance directives on the staff was reminded to notify SW find any orders that are not clear arensure resident and POA are active involved in determining their wishes policy to be reviewed at next reside council meeting and with all new accouncil meeting and with all new accounters.	the ssion or that of and vide ce with my ways dent ctive and a crent have cerent ied and a file, if it is a file, if it is a file, or if they are in this e if it is a file, if it is a file, if it is a file, or if it is a file,	

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F 578	status, and review "quarterly." R7's most recent dated 12/28/17, ic conference had be member and seve worker (SW)-A. It documentation R7 directives had been R7's medical record any evidence the subsequent order the correct proced R7 in an emerger When interviewed licensed practical found to be unresshe would "look a implement treatm reviewed R7's corwas listed as a DI responsible to ma paperwork. On 3/7/18, at 3:06 coordinator LPN-lexplained the profimplementing a real threatment of the profimplement of th	Care Conference Summary Identified R7 as "DNR." The care een attended by R7, his family eral staff including the social However, the summary lacked 7's wishes for advance en discussed. ord was reviewed and lacked conflicting POLST and s had been clarified to ensure dures would be implemented for	F 578	ensuring understanding of facility All hard charts have been reviewe 4/5/2018. 2.Because all residents are require have advance directives on file all potentially affected by the cited de 4/3/2018, the SW printed new POI from MN.GOV and is initiating a pireview to update over next quarter as ensure all are current up to dat. Orders will be signed, reviewed ar chart. In addition, all new residents updated on policy and ensure curradvance directives are admitted we resident and reviewed for accurace Charts immediately were audited for discrepancies of which 4 were not compliant and updated immediate other residents were affected. The Policy and Procedure for advance directives was also reviewed and a 3.To enhance currently compliant operations and under the direction director of nurses, on 4/4/2018 intraining for admissions, social services and ensuring consistent documentation in hard chart with of from physician and listed on profile training emphasized the importance ensuring all residents come in with advance directives, POLST on har initiated for chart and reviewed wit resident and POA to ensure right schosen. 4.Effective 4/4/2018, a quality-ass program was implemented under supervision of the SW to ensure	d as of ed to are ficiency, LST an to as well e. d in s will be ent ith y. for ly. No anced updated. of the service vice and state nce order e. The ce of n proper nd or h status is urance	

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F 578	order to ensure the respected, and to "an emergent situation of the commence of the respected, and to "an emergent situation of the commence of the respected of th	hould have been clarified in "patient wishes" were avoid any confusion if there is on that comes up." Care Planning/POLST policy entified guidelines which current Health Care Directive g "located in the chart under ctive tab." The provided policy in or guidance on how to d made or implemented to), nor any procedure to ensure are clarified. Injury/Decline/Room, etc.) 14)(i)-(iv)(15) iffication of Changes. Imediately inform the resident; ident's physician; and notify, or her authority, the resident then there isolving the resident which I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a alth, mental, or psychosocial threatening conditions or	F 578	compliance of advance directives. SW or designated quality-assuran representative will perform the foll systematic changes: randomly che resident charts for current and cur advanced directives. The SW or dwill complete 2 audits per week x weeks, then 1 audit weekly x2 modeficiencies will be corrected on the and the findings of the quality-assurance checks will be documented and su at the monthly quality-assurance committee meeting. 5.Admissions and SW will be respond to the second the second to the second to the second the second the second to the second	oce owing ecking rent lesignee 4 nths Any ne spot, urance ubmitted	4/23/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 580	(14)(i) of this secticall pertinent inform is available and prophysician. (iii) The facility muresident and the rewhen there is- (A) A change in rocas specified in §48 (B) A change in restate law or regula (e)(10) of this sect (iv) The facility muupdate the addres phone number of trepresentative(s). §483.10(g)(15) Admission to a conthat is a composite §483.5) must disclits physical configures.	contification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the est also promptly notify the esident representative, if any, or or roommate assignment 3.10(e)(6); or sident rights under Federal or tions as specified in paragraph on. Set record and periodically is (mailing and email) and the resident	F 58	30			
	its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the physician was notified of recurring, worsening pressure ulcers for 1 of 3 residents (R13) reviewed for worsening pressure ulcers, and for 1 of 1 resident (R41) reviewed with active yeast infection. Findings include:			This Plan of Correction const written allegation of compliant deficiencies cited. However, s of this Plan of Correction is not admission that a deficiency ex one was cited correctly. This Correction is submitted to meer requirements established by s federal law. 1.It is the policy of the facility to	ce for the ubmission of an clists or that Plan of et tate and		

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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00	
MOODU	AD DELLA DIL ITATIC	AN & HEALTHOADE OFNITED		2810 SECOND AVENUE NORTH			
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		MOORHEAD, MN 56560			
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F 580	Continued From p	age 15	F 580				
				notification of changes to provider			
		mum Data Set (MDS) dated		family. One of the many ways that			
		d R13 had severe cognitive		been achieved for resident #13 is	by		
		nd diagnoses which included		reviewing wound and current			
		restless leg syndrome and		documentation of wounds. R13 w			
		DS identified R13 required		to have L unstageable are to heel			
		ce with activities of daily living		increased in size and area now de			
		ped mobility, transfers and		on previously healed area on R he			
		The MDS identified R13 was at		Resident has prevalon boots which			
		lcer development, had no healed pressure ulcers. The		not used appropriately - wound ca documentation did not address re			
		fied the following skin		heels and interventions were not f			
		re relieving devices for chair		Care sheets and care plans update			
		S did not identify R13 was on a		wound consult received for possib			
		tioning program. Further, the		incision and drainage. Daughter u			
		3 had no behaviors of rejection		on heels and treatment. R41 note			
		14 day look back period.		have had yeast infection and staff	did not		
		·		respond timely to resident concert			
	On 3/9/18, at 8:12	a.m. R13 was seated in a		they did notify MD took over 24 ho	ours to		
		oom, her stocking clad		get response then pharmacy didn			
		lirectly on the footrests of the		facility they would not fill the OTC			
		time, the surveyor requested		suppositories. Resident has since			
		sing (DON) to come to R13's		resolution of yeast infection and s			
		ntered R13's room with a		educated on timely follow up on m			
		nd pen and immediately		symptoms and expecting no less			
		els should be offloaded at all		hours to get response from MD or			
		R13 had a current pressure		again. If still no response update r			
		eel. She removed R13's left foot which revealed thick,		director. Pharmacy assumed OTC were ordered through different versions.			
		which covered R13's heel. DON		DON and regional director met wi			
		ring tape on R13's left heel, and		pharmacy and sent list of stocked			
		stated, "God that hurts when		meds and agreed if order sent pha			
		DON reassured R13 she would		will now always send OTC timely			
	3	id measured the pressure ulcer		base with DON if issue.			
		revealing the following		2.Because all residents count on	staff for		
		5 centimeters (cm) in length		timely and appropriate care all are			
		h. DON stated R13's heel was		potentially affected by the cited de			
		(dead or devitalized tissue that		wound documentation has been re			
		exture: usually black, brown, or		interventions for prevention are in			

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NAME OF I	PROVIDER OR SUPPLIE	₹		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
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F 580	She confirmed Raulcer on her left he the DON visualized DON removed the which revealed he R13's heel. She control of R13's right heel and pressure ulcers at 1.7 cm. DON contain unstageable per R13's stockings and R13's feet back of wheelchair. -At that time DON heel pressure ulce looked at it on 2/2 history of unstaged visualized due to eschar. Slough; in green or brown tis stringy and mucin adherent to the bactumps throughout dead or devitalized texture; usually blimay appear scab are usually firmly wound and often to she was aware Right pressure ulcers. Strings under the pressure ulcers of she was aware Right pressure ulcers.	nay appear scab like) tissue. Is had an unstageable pressure eel. The surveyor requested at R13's right heel at that time. It is stocking from R13's right foot, ard, thick, brown tissue covered onfirmed she had not assessed and measured the right heel at that time as follows: 2.0 cm by firmed R13's right heel also had ressure ulcer. DON then donned and Prevalon boots, placed anto the footrests of the I stated R13's unstageable left er had worsened since she last able (wound bed cannot be the presence of slough or on-viable yellow, tan, gray, asue; usually moist, can be soft, ous in texture. Slough may be ase of the wound or present in at the wound bed. Eschar tissue; d tissue that is hard or soft in ack, brown, or tan in color, and like. Necrotic tissue and eschar adherent to the base of the the sides/edges of the wound.) In both heels. The DON stated and an unstageable left heel the confirmed R13's 2/15/18, at stated she was not aware R13	F 58	,	en reviewed ensure no and are followed urn call from is we been unitoring uny bruises, rashes. All d for a residents d Procedure also reviewed liant ection of the 8 all staff egarding ts for a dition and ent further d R41 is rewas noted d treatment ently. The ortance of eriously, llow up, effective f changes in		
	nurse for recomm	e would contact a wound clinic lendations and further stated if R13's physician had been		program was implemented un supervision of the director of monitor new orders, change i	nder the nurses to		

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F 580	notified of either or ulcers. DON state be off loaded at all boots or a pillow. Sexpected staff to crecord anytime sh DON stated she wound assessmer wound measurem pressure ulcer re-created staff to crecord anytime sh DON stated she wound assessmer wound measurem pressure ulcer re-created staff to crecord anytime she wound assessmer wound measurem pressure ulcer re-created staff to create staff	f R13's unstageable pressure d she expected R13's heels to I times either with the Prevalon She further indicated she document in R13's medical e refused to offload her heels. As responsible for the facility's and had completed weekly ents when R13's left heel occurred in February 2018. Form titled, Wound Evaluation of on 12/15/17, the DON stored and written flow sheet with wound measurements. The deal of the control of t	F 58	and residents with impaired The director of nurses or de quality-assurance represent perform the following syster the DON or designee will er done weekly to monitor char condition and new orders for 1 week, then 6 residents weeks, then on 3 residents weeks and residents with post altered skin integrity 6 residweeks and 3 residents for 4 ensure compliance. Any deside be corrected on the spot, and the quality-assurance committed quality-assurance committed further review or corrective and 5.DON will be responsible for the first provided the sponsible for the sponsib	esignated tative will matic changes: nsure audits nge of a large and a week for 2 weekly for 4 patential for ents for 2 weeks to efficiencies will not the findings ecks will be at the monthly e meeting for action.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE B10 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 SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 580	purple. The form list the heel open to air. -2/21/18, revealed measured 1.8 cm is were defined, surroform listed an intento air. -2/28/18, revealed measured 1.8 cm is were defined, surroform listed an intento air. R13's wound evaluated identification of R13 measurements and relieving intervention. Review of R13's word found in the electron R13 had an unstagating in the electron R13 had an unstagating in the electron in the electron in the following of 100% skin, periwous surrounding skin wound in the follow were in place; R13 on both heels every redistribution mattre electronic Wound Electronic Wound Electronic Wound Electronic words.	R13's left heel pressure ulcer by 2.0 cm, wound margins bunding skin was intact. The vention to leave the heel open R13's left heel pressure ulcer by 2.0 cm, wound margins bunding skin was intact. The vention to leave the heel open ation flow sheet did not include 3's right heel ulcer, did not include any pressure ons for her heels. Sound evaluation flow sheet, onic record, 12/15/17, revealed eable pressure ulcer on her is identified on 12/15/17. The low sheet identified R13's right measured 1 cm by 1 cm. The dentified R13's pressure ulcer haracteristic: wound bed was and margins were defined, as intact. The flow sheet ing treatments/interventions is was to have a foam dressing of 72 hours, pressure ess and heel protectors. The Evaluation flow Sheet did not ulcer on R13's left heel.	F 5	80				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245052	B. WING _		03	/13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 580		_	F 58	0			
		ed documentation of the left heel pressure ulcer.					
	Review of R13's pr 3/9/18, revealed th	rogress notes from 7/17/17, to e following:					
	- 7/17/17, R13's he open to air.	els were scabbed over and left					
	physician (MD)-A a to apply foam dres every 3 days and a	s seen by her primary and new orders were obtained sing to both heels and change as needed. The note revealed ressure sore precautions in					
	-12/29/17, R13's bi open to air.	ilateral heels were to be left					
	identify risk for pre-	assessment (tool used to ssure ulcer development) listed of for skin breakdown.					
	measured 2.3 cent had no redness or revealed R13's left no redness or drain was purple in color measurements of I	R13's left heel and indicated boots (pressure relieving					
	with scab intact wit the border of the w noted, with surrour to touch. Right hee	neel measured 2.5 cm by 2 cm h 20% eschar noted around round, no redness or drainage nding skin intact and blanched el measured 2 cm by 1.7 cm ness or drainage noted, and					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245052	B. WING			03/-	13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	recommendations of physician office corwith resident's heel Prevalon boots to be On 3/9/18, at 9:03 a reviewed with the Description of the Descrip	tact. Call placed for for resident's heels and hacted in regards to concerns s. R13 agreed to allow be applied without difficulty. a.m. R13's medical was DON. She confirmed R13's identified R13 had developed ageable pressure ulcer on her l17. The DON confirmed R13's identified R13 had an are ulcer on her left heel. The as not aware a wound in completed on 12/1/5/17, for the DON confirmed R13 had ulcers on both of her heels. Id R13's medical record lacked when R13's bilateral are ulcers had healed. The 3's medical record lacked any sessments of R13's bilateral are ulcers. She confirmed	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		2810	EET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE NORTH DRHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 580	8/30/17 to 12/15/ -8/30/17, skin hee examination10/24/17, R13 ha (pressure) ulcer of the control of the cont	and a past history of decubitus of the left heel. Yas seen at the facility for a seen denote identified R13 had a secubitus ulcer of the left heel. If acility staff to start dressing the hours and to implement	F 5	580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		03	/13/2018	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	YEAST INFECTIO R41's quarterly Mir 2/5/18, identified R current infections. When interviewed explained she had (fungal infection of membranes) which reported having revagina to a nurse to would "be back late. The following day, different nurse, how anything about it." finally looked at it a yeast infection," how done about it. R41 nothing still had be don't think they cor. "I think it's because R41's progress not dictations: On 3/1/18, "[R41] habout vaginal discoute briefs could a discharge of any king the	N: nimum Data Set (MDS) dated 41 had intact cognition and no on 3/6/18, at 2:23 p.m. R41 developed a yeast infection the skin or mucous was left untreated. R41 dness and itching on her he week prior who told her they er" and then never returned. R41 reported it again to a wever, they also "never did R41 stated a night nurse and stated "[i] think you have a wever, again nothing was was frustrated and expressed en done to help her adding "[i] nmunicate with the doctor," as	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245052	B. WING			03/	13/2018	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			, 557.157.25.15	
(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 SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	OULD BE COMPLÉTION		
F 580	been notified via fa On 3/6/18 (four day order] from [physic anti-fungal used to EMAR updated and Resident made aware and the sident made aware another nurs about the developed symptor evidence there had notify R41's physicial director which resure for treatment order When interviewed clicensed practical masked her "last wee infection. R41 had nurses" to help her anything had been aware another nurs about the develope had heard back so physician on 3/2/18 explained the phys without a clinic apprecord lacked any 6 3/2/18, adding "not doctors" for orders.	x. awaiting [sic] response." ys later), "Received [telephone ian's nurse] for Monistat [an treat yeast infections] d order faxed to pharmacy. are of new Rx [prescription]." Telephone Orders Audit sheet fied a telephone order was tat vaginal suppositories. A d for vaginal candidasis (a ne vagina). ord was reviewed and lacked a physician had reviewed the or been notified of R41's ms. Further, the record lacked been ongoing attempts to an or consult with the medical lted in R41 waiting four days	F 5	80				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245052	B. WING_		03	/13/2018	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 584 SS=D	symptoms if they we contact the primary. During interview on director of nursing (the nurses had contact the developed sympresponse back." Direcord lacked any eattempts to notify a infection. Further, I "hiccups" with not gaddressed when the medical director in the A facility policy for requested and none Safe/Clean/Comfor CFR(s): 483.10(i)(1) \$483.10(i) Safe Environmental to the supports for daily like the facility must prospossible. (i) This includes enserged and sephysical layout of the independence and	orders for R41's developed eren't able to immediately physician. 3/8/18, at 1:39 p.m. the (DON) stated she was aware tacted R41's physician with otoms, however, "didn't get a ON verified R41's medical evidence of subsequent physician of R41's developed DON stated she felt the retting orders timely would be a facility changed their the near future. Inotification of change was a were provided. Itable/Homelike Environment ()-(7) Invironment. It is developed considered in the result of the physician of change was a were provided. Itable/Homelike Environment ()-(7) Invironment. It is developed considered in the physician of change was a were provided. Itable/Homelike Environment ()-(7) Invironment. It is developed ()-(1) with the physician of change was a were provided. Itable/Homelike Environment ()-(7) Invironment. It is developed ()-(1) with the physician with the physic	F 58			4/23/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	245052		B. WING			03/13/2018	
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	10/2010	
MOORHEAD REHABILITATION & HEALTHCARE CENTER				2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)	
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE	
F 584	Continued From por theft.	page 25	F 5	84			
		sekeeping and maintenance ry to maintain a sanitary, orderly, nterior;					
	§483.10(i)(3) Clean bed and bath linens that are in good condition;						
	§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);						
	§483.10(i)(5) Adequate and comfortable lighting levels in all areas;						
	levels. Facilities in	nfortable and safe temperature nitially certified after October 1, nin a temperature range of 71 to					
	sound levels. This REQUIREME	the maintenance of comfortable ENT is not met as evidenced					
	review, the facility services for a clear resident with odor refused assistance	ation, interview and document failed to ensure housekeeping an environment for 1 of 1 s in the sample (R9) who e with personal hygiene.		This Plan of Correction constitution written allegation of compliance deficiencies cited. However, subset of this Plan of Correction is not admission that a deficiency existence was cited correctly. This Plan of Correction is not a deficiency existence.	for the omission an that		
	indicated R9 had dementia without anxiety. R9's urina 12/20/17, listed R of bladder, able to	eport print date of 3/12/18, diagnoses of bipolar disease, behavioral disturbance, and ary incontinence CAA, dated 9 was occasionally incontinent of feel urge to void at times, went adependently and was able to		Correction is submitted to meet requirements established by sta federal law. 1.It is the policy of this facility to clean and comfortable environments make it safe and homelike. Some many ways that this has been a for resident #9 is by working wit family and ombudsman to assis	promote a lent to ne of the chieved n resident		

F 584 Continued From page 26 obtain his own fluids. The CAA did not address his interventions for his incontinence and did not address his odors or personal hygiene. R9's care plan, revised 2/3/18, did not include interventions to address R9's incontinence or ongoing personal TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 584 working on resident refusal for cares. R9 was noted to have strong urine odor. Resident appears disheveled and dirty. Refuses to let staff clean his room. Care plan did not mention urinary incontinence	(X3) DATE SURVEY COMPLETED	
MOORHEAD REHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE	2018	
MOORHEAD, MN 56560 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 584 Continued From page 26 obtain his own fluids. The CAA did not address his interventions for his incontinence and did not address his odors or personal hygiene. R9's care plan, revised 2/3/18, did not include interventions to address R9's incontinence or ongoing personal MOORHEAD, MN 56560 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 584 Working on resident refusal for cares. R9 was noted to have strong urine odor. Resident appears disheveled and dirty. Refuses to let staff clean his room. Care plan did not mention urinary incontinence		
MOORHEAD, MN 56560 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 584 Continued From page 26 obtain his own fluids. The CAA did not address his interventions for his incontinence and did not address his odors or personal hygiene. R9's care plan, revised 2/3/18, did not include interventions to address R9's incontinence or ongoing personal MOORHEAD, MN 56560 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 584 Working on resident refusal for cares. R9 was noted to have strong urine odor. Resident appears disheveled and dirty. Refuses to let staff clean his room. Care plan did not mention urinary incontinence		
F 584 Continued From page 26 obtain his own fluids. The CAA did not address his interventions for his incontinence and did not address his odors or personal hygiene. R9's care plan, revised 2/3/18, did not include interventions to address R9's incontinence or ongoing personal F 584 Continued From page 26 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 584 working on resident refusal for cares. R9 was noted to have strong urine odor. Resident appears disheveled and dirty. Refuses to let staff clean his room. Care plan did not mention urinary incontinence		
obtain his own fluids. The CAA did not address his interventions of personal hygiene. R9's care plan, revised 2/3/18, did not include interventions to address R9's incontinence or ongoing personal working on resident refusal for cares. R9 was noted to have strong urine odor. Resident appears disheveled and dirty. Refuses to let staff clean his room. Care plan did not mention urinary incontinence	(X5) MPLETION DATE	
During supper observations, on 3/6/18 at 5:27 p.m., R9 was sitting at a dining room table, alone. R9 had a very strong urine odor, with the odor noticed approximately 5 feet away. At 9:40 a.m., R9 was served his evening meal, quickly consumed the meal, then returned to his room and laid on his back in bed. It was noted there was a very strong urine smell in the entire room. When asked R9 refused an interview at that time. On 3/07/18 at 2:44 p.m., R9 was observed walking the halls with a 4 wheeled walker, wearing clothes different than 3/7/18. However, R9 continued to have a noticeable urine odor. On 3/8/18 at 8:30 a.m., R9 was observed in the dining room having a strong urine smell eminating from self. After the meal, R9 returned to his room, and again a strong drafting of warm, very strong urine odor emminated from the room. On an environmental tour on 3/12/18, 11:25 a.m. the environmental director (ED) and the facility administrator (ADM) stated they were both aware of R9's room having a strong urine odor. Both the ED and ADM stated R9 was incontinent of bladder, refused his clothing to be laundered, and would hang up soiled clothes to dry in his room. Neither staff members knew if the facility had reached out to family or the ombudsman for assistance with this concern. The ADM stated the previous administrator directed staff to go in and take R9's clothes to be laundered, which had		

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		245052	B. WING _		03/	13/2018	
NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COI		10/2010	
		ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 584	During an intervienursing assistant room cleaned so then stripped the attempted to reme R9 got upset toda and slammed the before she left R9 soiled pants she was pants in his close. During an intervience social worker (SW personal odor, and R9 had been refunded the facility ombudsman for a odors and room of the stated the facility ombudsman for a odors and room of the state of the facility of the state of th	ow on 3/12/18, at 12:10 p.m. (NA)-I stated R9 did not like his she waited until he left for lunch, bed, wiped down mattress, and ove soiled clothing. NA-I stated by, yelled at her, told her to leave door. NA-I further stated that o's room, he grabbed a pair of was carrying and hung up the t. I w on 3/12/18, at 12:19 p.m. the o'l was aware of R9's room and dattempted conversation with sed by resident. SW further has not reached out to family or assistance with R9's personal dors. I w on 3/12/18, at 12:49 p.m. I w on 3/12/18, at 12:49 p.m. I w on 3/12/18, at 12:49 p.m. I w or sistance in helping with R9's fusal for clothes to be further stated, "It was awful the ere (at the facility)." I w titled Deep Cleaning Rooms, or, indicated residents rooms daily and a deep clean would have on 3/12/18, at 8:30 a.m. the g (DON) stated that the facility loped interventions to assist R9	F 58	cleanup of room when resider room which he does prior to be day. Encouraged to speak wit regarding care issues. Son are in law prefer resident go back psychiatric unit again for inparas they feel he is not reasonal exhibiting an increase in PTS becoming too aggressive. When any residents refusing cares to SW who will meet with residetermine cause and plan. If continues to refuse will update ombudsman for support. Also have other staff approach residents. Current reside audited by clothing and room appearance to ensure no othe had same issues with non-conduse the ensure most of the same issues with non-conduse the ensure of the same issues with non-conduse the ensure of the same issues with non-condusted by clothing type appear of the residents were affected and Procedure for comfortable environment was reviewed. 3. To enhance currently complement of the director of nurses, on 4/4/201 staff received in-service trainic clean homelike environment addressing rooms with reside refuse cares. The training enthe importance of understand facility is the residents home and the importance of understand facility is the residents home and the importance of understand facility is the residents home and the importance of understand facility is the residents home and the importance of understand facility is the residents home and the importance of understand facility is the residents home and the importance of understand facility is the residents home and the importance of understand facility is the residents home and the importance of understand facility is the residents home.	unch every th SW and daughter to VA tient services able and D and anen staff note they will refer dent to resident e family and o, will try to sident to try ions with dents were smells and er residents mpliance. ating as well we strong urance. No . The Policy le liant ection of the 8 all nursing ng regarding and ents that apphasized ling this and often orking with ors. Staff to work with		

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		245052	B. WING _		03/	13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLÉTI		
F 584	Continued From pa	age 28	F 58	have extreme behaviors – hando given with options and staff role prefusal situations. If any resident the same pattern immediately interdisciplinary team will determine and how to address the situation gets out of control. Residents with behavioral concerns that impact the facility will immediately get psycheto assist with behavior managem 4. Effective 4/4/2018, a quality-assigneous program was implemented under supervision of the SW to monitor requiring additional assistance with grooming, room cleaning and over resistance to compliance. The States designee will complete 2 audits pix 4 weeks on room order, odor and resident cleanliness, then 1 audit for 4 weeks ensure staff able to waround resident refusal to keep of minimum. Any deficiencies will be corrected on the spot, and the find the quality-assurance checks will documented and submitted at the quality-assurance committee mental further review or corrective actions 5.SW and housekeeping will be responsible for this POC.	played exhibits ne needs before it in high he entire consult ent plan. surance the resident the er all work and weekly work dors at a element of the er monthly eting for		
F 607 SS=D	CFR(s): 483.12(b) §483.12(b) The faci implement written	at Abuse/Neglect Policies (1)-(3) cility must develop and policies and procedures that: nibit and prevent abuse,	F 60	7		4/23/18	
	neglect, and explo	itation of residents and fresident property,					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/	13/2018	
NAME OF F	PROVIDER OR SUPPLIE	R	1	STREET ADDRESS, CITY, STATE, ZIP			
MOORHE	EAD REHABILITATI	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From	page 29	F 6	07			
	to investigate any	tablish policies and procedures v such allegations, and slude training as required at					
	This REQUIREM by: Based on intervi- facility to implement ensure the State timely manner for	ew and document review, the ent policies and procedures to agency (SA) was notified in a fallegations of neglect with njury for 1 of 2 residents (R22)		This Plan of Correction co written allegation of compli deficiencies cited. Howeve of this Plan of Correction is admission that a deficiency one was cited correctly. The Correction is submitted to the correction of the correctio	ance for the r, submission s not an y exists or that nis Plan of		
	12/23/17, identifice safe, comfortables which included supatient abuse and every employee of mandated reported "Failure to provide to avoid physical illness." An "Intellisted which includes "During the shift or unexplained in mandated reported initial report to the will immediately reported will immediately reported in the same provided and the same	rable Adult policy reviewed ed a statement of providing a environment for all residents apporting "Zero Tolerance" for d/or neglect. The policy directed of the care center was a er and defined neglect as, e goods and services necessary harm, mental anguish, or mental rnal Reporting Procedure" was ded the following steps: at that the alleged abuse/neglect jury is first observed, a er will immediately make an eir Supervisor the Supervisor eport to the House Supervisor ort it to the Director of rator."		requirements established to federal law. 1. It is the policy of this facili incidents and do timely folk incident that result in injury R22 was noted to have but footboard during transfer be Hoyer that resulted in a fracomplained of pain, staff diwhich confirmed the fractureport was filed nor follow with Hoyer. In this case, as surveyor reported the faulty Hoyer lift was assessed on staff educated on incident the policy regarding incider accidents. Nursing and SW educated on importance of vulnerable adult cases to the (office of health facility comincidents and accidents are reviewed immediately for a abuse or neglect. A resider	ity to report all ow up on any. In this case mped butt on y staff with cture. Resident id get an x-ray re. No incident up on transfer fter the y system, the 4/4/2018 and reporting and its and / were also reporting all ne OHFC inplaints). All is to be inty potential		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/	13/2018	
NAME OF F	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CO			
				2810 SECOND AVENUE NORTH			
MOORHE	EAD REHABILITATION	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 607	investigation of the reported allegation or incident." This statement listed components of the investigations which may include interviews of		F 6	stations and educated to all sensure the components of all neglect are identified and im-	ouse and		
	determine if the ir criteria for 'Repor deemed reportab submitted to [SA] System within the	Nursing or Administrator shall neident/allegation meets the table Incident'. All incidents le under MN statute are via the on-line Reporting 2 hour period."		followed up on. 2.Because all residents rece assistance are potentially aff cited deficiency and all reside considered vulnerable all are affected to potential for abus 4/4/2018, the director of nurs transfers with staff and reviet therapy the need for Hoyer tr	ected by the ents are potentially e/neglect. On ing reviewed wed with aining. PT		
	nursing (DON) or incident or allegat reporting under th "the [DON] of adn in writing on the li	·		observed that all resident tra involving Hoyer lifts were cor safely. Since survey all incid accidents are reviewed, and sustaining injury has been re reported immediately. No oth were affected. The Policy and	ents and ents and any resident viewed and er residents d Procedure		
	12/22/17, identified required extensive bed mobility, and hallucinations, or R22's care plan rewas at risk for aboundable adult (common entry por R22 required a horse	inimum Data Set (MDS) dated at R22 had intact cognition, a eassistance with transfers and displayed no delusion, rejection of care behaviors. Eavised 1/23/18, identified R22 use due to his decreased ted staff to follow the facility VA) policy and file reports to the int (CEP) as needed. Further, over lift (mechanical body lift) for f should "care in pairs."		for abuse/neglect was review updated. 3.To enhance currently compoperations and under the director of nurses, on 4/4/20 staff received in-service train minimizing accidents. The tremphasize the importance of mechanical lifts safely. Also abuse/neglect policy and safeducated on following plan of appropriate interventions, times.	oliant ection of the 18 all nursing ing regarding aining will f using all reviewed was ety. Staff f care, neliness of		
	was questioned a the facility. R22 s how staff transfer was, "not sure if y stated when staff	d on 3/6/18, at 7:16 p.m. R22 bout his care and treatment in stated he had a concern about him in the hoyer lift adding he rou'd call it abuse or not." R22 had transferred him a week ago it him on the bed and were		reporting to OHFC. Nurses we reminded to chart once an oruntil the result of the order is continue to follow up on residentiation, incident and where the follow up is until resolved residents were affected. 4. Effective 4/4/2018, a quality	der is taken, in place and dent e in process . No other		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/	13/2018	
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	·		
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F 607	aware they had dor careful" with him. If management had foccurred. R22's progress not identified the follow -10/10/17, at 2:05 p [due to] hitting butto of bed while being to 2:20 p.m. the nurse PPX (professional R22's lumbar, sacr. There were no doc pain or any potentia warranted requesti if the administrator (DON) had been not injured while transformation or the same that it is a spine and pelvis residentified R22 had a spine and pelvis residentified several his last CT scan who fracture left 12th rite.	ne so. The staff just "weren't Further, R22 stated no staff or ollowed up with him since this es were reviewed and ring entries: o.m. R22 " wants an x-ray ocks, lower back on foot board transferred in hoyer[.]" At edocumented a call was out to portable x-ray) for an x-ray on al, spine and pelvis regions. umentation regarding R22's al injuries sustained which and an x-ray, nor any indication and/or director of nursing offied of R22 being potentially erred in the hoyer lift. a.m. a late entry was recorded px came at 6:30pm last night [s.]" There was no further cumented to ascertain the fany injury had been e provision of care as 17. eport signed 10/10/17, an x-ray obtained of his lumbar lated to "pain in butt area after dboard during a lift." The all findings when compared to nich included, "Acute displaced	F6	program was implemented unde supervision of the director of nur monitor resident transfers requirilifts. PT will perform the followin systematic changes: randomly call residents who require mechantransfers to be completed immed Audits will be completed on 4 residents will be completed on 6 thorough documentation of all or initiation to completion to ensure follow up. will be audited. All incide immediately reported to DON further discussed daily at stand undeficiencies will be corrected on and the findings of the quality-as checks will be documented and sat the monthly quality-assurance committee meeting for further recorrective action. 5.DON and PT will be responsible POC.	ses to ng Hoyer necking necking nical lift liately. idents for onths. nsuring ders from adequate dents will and up. Any the spot, surance submitted		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		281	EET ADDRESS, CITY, STATE, ZIP CODE 0 SECOND AVENUE NORTH ORHEAD, MN 56560			
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 607	(approximately 20 injury occurred) wh resident involved we reported as, "Physi including, "Conduct pain/injury or rough as having sustaine and time of incident at 9:30 a.m. The sereported injury on a when interviewed worker (SW)-A state failure to provide physical or mental would be caused, we sustained during the incident on 10/10/1 The prior administrand conducted the longer present, and locate an incident restruck into the bed was unaware when notified of this allegallegations of negles sustained should be SW-A stated R22's have been reported. During interview or current DON stated actions were taken recorded allegation previous administrate the record and stated located in their traceneglect of care workers.	hours after the incident with ich identified R22 as the with an allegation being cal Abuse," with defined text to intended to produce a handling." R22 was identified do a rib fracture with a "date to being recorded as 10/11/17, ummary did not identify R22's 10/10/17. In 3/12/18, at 8:14 a.m. social ted neglect of care would be be goods and services to avoid harm adding "any harm that we would report," if injury was be provision of care. R22's 7, was reviewed with SW-A. Fator and DON who reported investigation for R22 were not a SW-A was unable to even the eport regarding R22 being during care. SW-A stated she in the administrator had been gation. SW-A stated potential tect with injuries being the reported "within 2 hours." In potential allegation "should"	F6	07				

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245052	B. WING		03/	13/2018
ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
ECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
jury should not be lift to transfer as aware they had thought they did should of been eviewing the record is allegation, she ed to the SA within grations of abuse, atment, the facility atment, the facility lleged violations of unknown for the sident property, not later than 2 ade, if the events we abuse or result in er than 24 hours if lation do not involve ous bodily injury, to and to other Survey Agency and the state law provides e facilities) in ough established				4/23/18
	ER/SUPPLIER/CLIA ICATION NUMBER: 245052 ACARE CENTER DEFICIENCIES ECEDED BY FULL ING INFORMATION) Vere using proper adjury should not be a lift to transfer as aware they had a should of been eviewing the record as allegation, she and to the SA within a day after it. Gations of abuse, atment, the facility Illeged violations of the events are abuse or result in the events are facilities) in the events are facilities are facilities in the events are facilities are f	A. BUILDII 245052 B. WING GEFICIENCIES ECCEDED BY FULL NG INFORMATION) F 60 Vere using proper aligner should not be lift to transfer as aware they had a should of been eviewing the record as allegation, she led to the SA within a day after it Gations of abuse, atment, the facility Illeged violations of unknown after than 2 and to involve ous bodily injury, to and to other Survey Agency and the state law provides are facilities) in ough established ID PREFIX TAG F 60 F 60	245052 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 BEFICIENCIES GEOEDE BY FULL GINFORMATION) PREFIX TAG PREFIX TAG F 607 F 607 F 607 F 609 gations of abuse, atment, the facility filleged violations oit attor or so of unknown of resident property, not later than 2 ade, if the events are abuse or result in er than 24 hours if pation do not involve ous bodily injury, to and to other Survey Agency and a state law provides re facilities) in bugh established ts of all ator or his or her	245052 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 EFFICIENCIES ECCEDED BY FULL MG INFORMATION) PREFIX TAG F 607 F 607 F 607 F 609 gattons of abuse, atment, the facility alleged violations of abuse, atment, the facility for exident property, not later than 2 adde, if the events we abuse or result in er than 24 hours if gatton do not involve ous bodily injury, to and to other Survey Agency and e state law provides e facilities) in bugh established ts of all ator or his or her

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D REHABILITATI	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE
ccordance with a curvey Agency, who ident, and if the ppropriate correlation his REQUIREM by: Based on interviewed in the period of the period	State law, including to the State within 5 working days of the e alleged violation is verified ctive action must be taken. ENT is not met as evidenced ew and document review, the acognize and ensure an ect with sustained bodily injury ely to the State agency (SA) for 1 (22) whose allegations were dinimum Data Set (MDS) dated ed R22 had intact cognition, a eassistance with transfers and displayed no delusion, rejection of care behaviors. evised 1/23/18, identified R22 use due to his decreased eted staff to follow the facility VA) policy and file reports to the point (CEP) as needed. Further, every lift (mechanical body lift) for ff should "care in pairs." d on 3/6/18, at 7:16 p.m. R22 about his care and treatment in stated he had a concern about thim in the hoyer lift adding he you'd call it abuse or not." R22 had transferred him a week ago	F 6	This Plan of Correction conwritten allegation of complia deficiencies cited. However of this Plan of Correction is admission that a deficiency one was cited correctly. The Correction is submitted to requirements established be federal law. 1. It is the policy of this facil incidents and do timely following incidents and do timely following incident that results in injuring R22 was noted to have bur footboard during transfer by Hoyer that resulted in a fraction complained of pain, staff diwhich confirmed the fractur report was filed nor follow with Hoyer. In this case, af surveyor reported the faulty Hoyer lift was assessed on staff educated on incident in the policy regarding incider accidents. Nursing and SW educated on importance of vulnerable adult cases to the (office of health facility com 2. Because all residents are affected by the cited deficients.	nstitutes my ance for the r, submission s not an v exists or that his Plan of meet by state and wity to report all low up on any y. In this case mped butt on y staff with cture. Resident and y staff with cture. Resident up on transfer fter the y system, the 4/4/2018 and reporting and his and y were also reporting all he OHFC aplaints).	
	SUMMARY S (EACH DEFICIENT REGULATORY OF SECONTINUED FROM FROM PROCESS OF THE PROC	DREHABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 ccordance with State law, including to the State durvey Agency, within 5 working days of the incident, and if the alleged violation is verified perioriate corrective action must be taken, this REQUIREMENT is not met as evidenced by: Based on interview and document review, the incident incident in the incident in the incident in the incident is not met as evidenced by: Based on interview and document review, the incident incident in the in	DENTIFICATION NUMBER: 245052 B. WING DYIDER OR SUPPLIER D REHABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Fontinued From page 34 coordance with State law, including to the State survey Agency, within 5 working days of the incident, and if the alleged violation is verified ppropriate corrective action must be taken. his REQUIREMENT is not met as evidenced by: Based on interview and document review, the acility failed to recognize and ensure an illegation of neglect with sustained bodily injury was reported timely to the State agency (SA) for 1 f 2 residents (R22) whose allegations were eviewed. Indings include: E22's quarterly Minimum Data Set (MDS) dated 2/(2/21/17, identified R22 had intact cognition, allucinations, or rejection of care behaviors. E22's care plan revised 1/23/18, identified R22 was at risk for abuse due to his decreased nobility, and displayed no delusion, allucinations, or rejection of care behaviors. E22's care plan revised 1/23/18, identified R22 was at risk for abuse due to his decreased nobility and directed staff to follow the facility ulnerable adult (VA) policy and file reports to the ommon entry point (CEP) as needed. Further, 122 required a hoyer lift (mechanical body lift) for ansfers and staff should "care in pairs." When interviewed on 3/6/18, at 7:16 p.m. R22 was questioned about his care and treatment in the facility. R22 stated he had a concern about ow staff transfer him in the hoyer lift adding he was, "not sure if you'd call it abuse or not." R22 tated when staff had transferred him a week ago or better," they hit him on the bed and were ware they had done so. The staff just "weren't	Dentification Number: 245052 245052 STREET ADDRESS, CITY, STATE, ZIPY 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 coordance with State law, including to the State urvey Agency, within 5 working days of the cident, and if the alleged violation is verified porporpriate corrective action must be taken. his REQUIREMENT is not met as evidenced y; Stated on interview and document review, the acility failed to recognize and ensure an llegation of neglect with sustained bodily injury as reported timely to the State agency (SA) for 1 12 residents (R22) whose allegations were sviewed. 122's quarterly Minimum Data Set (MDS) dated gluz2/17, identified R22 had intact cognition, required extensive assistance with transfers and ed mobility, and displayed no delusion, allucinations, or rejection of care behaviors. 122's care plan revised 1/23/18, identified R22 tas at risk for abuse due to his decreased nobility and directed staff to follow the facility ulnerable adult (VA) policy and file reports to the formmon entry point (CEP) as needed. Further, 122 required a hoyer lift admign he ansfers and staff should "care in pairs." When interviewed on 3/6/18, at 7:16 p.m. R22 tasted when staff had transferred him a week ago or better," they hit him on the bed and were ware they had done so. The staff just "werent"	A BUILDING 245052 B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FROM TAG CONTINUED FROM THE PROPERTY OF THE APPROPRIATE CONTINUED FROM THE APPROPRIATE CONTINUED FROM THE APPROPRIATE DEFICIENCY) FROM DEPICIENCY This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is not an admission that a deficiency exists or that one wa

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F 609	identified the follow -10/10/17, at 2:05 p [due to] hitting butto of bed while being t 2:20 p.m. the nurse PPX (professional p R22's lumbar, sacra There were no docu pain or any potentia warranted requestir if the administrator (DON) had been no injured while transfer -10/11/17, at 6:39 a which identified, "pp for resident's x-rays progress notes doc x-rays results, nor in sustained during the recorded on 10/10/ R22's PPX Final Re identified R22 had a spine and pelvis rel hitting back on head report listed severa his last CT scan wh fracture left 12th rib A completed Incide submitted to the SA (approximately 20 h injury occurred) whi	es were reviewed and ing entries: o.m. R22 " wants an x-ray ocks, lower back on foot board transferred in hoyer[.]" At recorded a call was out to cortable x-ray) for an x-ray on al, spine and pelvis regions. Lumentation regarding R22's al injuries sustained which and an x-ray, nor any indication and/or director of nursing officed of R22 being potentially erred in the hoyer lift. I.m. a late entry was recorded box came at 6:30pm last night off.]" There was no further umented to ascertain the frany injury had been be provision of care as 17. Export signed 10/10/17, an x-ray obtained of his lumbar atted to "pain in butt area after dboard during a lift." The I findings when compared to sich included, "Acute displaced	F 6	09	manual was created to educate star components of the abuse program program further educates staff on vereport and what to report to ensure this type of situation does not occur. The program also has an incident reguide to assist staff to determine we reportable and who to notify when, discussed was the proper procedurincident and accidents and the notiprocess to ensure DON and SW are aware of any situation for immediate follow up. Policy and procedure for reportable events was reviewed. Not residents were affected. 3. To enhance currently compliant operations and under the direction director of nurses, on 4/4/2018 all restaff received in-service training regardless of how small or if no injuit DON needs to be informed immediated as well as doctor, family/POA and documented accordingly in point clicare. Documentations must include up nurses notes and appropriate notification made to POA, MD, DOI and OHFC is necessary via DON of 4.Effective 4/4/2018, a quality-assurprogram was implemented under the supervision of the SW to monitor at incidents to ensure anyone with injuits uspected abuse is reported immediated of the SW to monitor at incidents to ensure anyone with injuits uspected abuse is reported immediated of the SW to monitor at incidents to ensure anyone with injuits uspected abuse is reported immediated of the SW to monitor at incidents to ensure anyone with injuits uspected abuse is reported immediated of the SW to monitor at incidents to ensure anyone with injuits uspected abuse is reported immediated injuries will be logged to ensure followed to the SW to monitor and investigation log. The SW or designated guality-assurance.	The when to that again. eport hat is Further for fication e e o other of the nursing garding nts. Incident arely the ately of the follow N, ED r SW. rance ne ll ury or diately and ow up	

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NAME OF I	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CO		13/2010	
MOORH	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 609	reported as, "Physincluding, "Conduction pain/injury or roug as having sustained and time of incided at 9:30 a.m. The reported injury on When interviewed worker (SW)-A state failure to proviphysical or mental would be caused, sustained during the incident on 10/10/The prior administrand conducted the longer present, and locate an incident struck into the bedwas unaware when notified of this alled allegations of negligibles and state of the sustained should be recorded allegations were taken recorded allegations were taken recorded allegations were taken recorded allegations were taken recorded in their trained appropriately," adoptocedures and procedures and procedures and procedures and procedures.	sical Abuse," with defined text of intended to produce h handling." R22 was identified and a rib fracture with a "date nt" being recorded as 10/11/17, summary did not identify R22's 10/10/17. on 3/12/18, at 8:14 a.m. social ated neglect of care would be de goods and services to avoid harm adding "any harm that we would report," if injury was the provision of care. R22's 17, was reviewed with SW-A. Trator and DON who reported a investigation for R22 were nown of SW-A was unable to even report regarding R22 being a during care. SW-A stated she in the administrator had been gation. SW-A stated potential ect with injuries being the reported "within 2 hours." is potential allegation "should"	F 60	representative will perform the systematic changes: the DC conjunction with SW will man immediately if any abuse/ne was suspected. All incidents suspected abuse/neglect sit reviewed at stand up daily. It designee will complete 6 aux 2 weeks then 4 audits week then 2 audits per month for the ensure compliance in this arrespond to the findings of the qualification committee weeting for further corrective action. 5.DON, ED and SW will be this POC.	ON in ke report glect or injury s/accidents or uations will be The DON or dits per week ekly x 2 weeks 2 months to rea. Any don the spot, sy-assurance and submitted ance er review or		

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reported the incide this as the situation reported." DON stand information rel felt it should have to two hours and not a occurred. The facility Vulnera 12/23/17, identified a safe, comfortable and supported "zer neglect. Further, the determined to be reto the SA "within." Comprehensive As CFR(s): 483.20(b)(s) §483.20 Resident A The facility must coa comprehensive, a reproducible assess functional capacity. §483.20(b) Compre §483.20(b)(1) Res A facility must mak assessment of a regoals, life history a resident assessme by CMS. The asset the following:	ated she was aware they had nt, however, thought they did nt he record ated after reviewing the record ated to R22's allegation, she been reported to the SA within the following day after it with able Adult policy dated at the facility desired to provide the environment for all residents to tolerance" for abuse and/or the policy directed all incidents the 2 hour period." It is sessments & Timing (1)(2)(i)(iii) Assessment the provided they are a sament of each resident's each resident's each resident's needs, strengths, and preferences, using the ent instrument (RAI) specified the ent instrument (RAI) specified the sesment must include at least and demographic information ine.	F 609			4/23/18

CENTERS FOR MEDICARE & MEDICARD SERVICES				U	IVID IVO.	0930-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 636	(vi) Mood and beha (vii) Psychological v (viii) Physical functi (ix) Continence. (x) Disease diagnos (xi) Dental and nutr (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications. (xv) Special treatmo (xvi) Discharge plar (xvii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation assessment. The ainclude direct observith the resident, as licensed and nonlice members on all shirt (xiii) Salar (xiii) Within 14 calenders (xiii) of this sprescribed in §413. apply to CAHs. (i) Within 14 calenders (i) Within 14 calenders (ii) Within 14 calenders (iii) Within 14 calenders (iii) Within 14 calenders (iiii) of this sprescribed in salar (iiiii) of this sprescribed in salar (iiiii) of this sprescribed in salar (iiiiii) of this salar (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	well-being. oning and structural problems. sis and health conditions. itional status. s. ents and procedures. nning. on of summary information onal assessment performed riggered by the completion of Set (MDS). on of participation in assessment process must rvation and communication s well as communication with ensed direct care staff fts. on required. Subject to the oed in §413.343(b) of this sust conduct a comprehensive sident in accordance with the ed in paragraphs (b)(2)(i) section. The timeframes 343(b) of this chapter do not lar days after admission, sions in which there is no on the resident's physical or for purposes of this section, has a return to the facility ary absence for hospitalization	F6	036			

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/1	3/2018
NAME OF F	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 636	This REQUIREME by: Based on intervier facility failed to ensessments (CA analysis of a residhistory and prefere reviewed for worse resident (R17) rev 1 of 1 resident (R2 pain and 1 of 1 resident and 1 of 1	age 39 ENT is not met as evidenced w and document review the sure resident Care Area A) included a comprehensive ent's needs, strengths, goals, ences for 1 of 1 resident (R13) ening pressure ulcer, 1 of 1 iewed for decline in ambulation, 207) reviewed for unmanaged sident (R28) reviewed for walk resident (R1) reviewed for falls. mum Data Set (MDS) dated d R13 had severe cognitive ad diagnoses which included restless leg syndrome and DS identified R13 required nee with activities of daily living ped mobility, transfers, personal ment of urine and frequently el. The MDS identified R15 ssure ulcer development, had ntly healed pressure ulcers. dentified R13 received ication and had frequent pain 10 on a numeric scale. Further R13 had no behaviors of uring the 14 day look back e Area Assessment (CAA) entified ten care areas had data entered into the MDS the following areas were	F 636	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility to en residents are assessed correctly viassessments and MDS to coordina appropriate care plans. Some of the many ways that this has been achifor R1 is by ensuring mats off floor bed in low position and next to bed activates of distraction are available needed, and daily walks to stretch and strengthen gait. R13 had wour assessed, interventions correctly pon care plan and sheet and referre wound specialist to further evaluate R17 has been seen by prosthetic cand is having it sized, therapy will vusing prosthetic and staff aware of importance of following plan of care listed on walk to dine program; stafencouraged to walk regularly, follow sheet and update nursing or therap any noticeable declines. R207 had unmonitored pain and pain assess not clear nor documentation. In this after the surveyor reported all resic listed above the care area assessmer were inaccurate based on docume and MDS. All care plans have beer reviewed and updated, MDS nurse	the ssion or that of and sure all a te ne eved unless de laced do to e heels. linic work on e. R 28 ff w care by for ment s case, lents nents not in	

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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
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F 636	triggered; Cogitative Functional/Rehabili Incontinence and In State, Falls, Nutritic Psychotropic Drug -Cognitive Loss/De area was an actual cognitive impairmen non-Alzheimers der multiple pre-popula data entered on the neurological factors additional assessm cognition. The CAA analysis of the afore checkmarks which functioning. The CAA analysis of the afore checkmarks which functioning from resident and/or fam considerations. -ADL Functional/Rerevealed the care a R13 related to requirem facility staff for multiple pre-popula included; pain, inco CAA lacked a compaforementioned preimpacted R13's AD any other considerations. -Urinary Incontinence.	e Loss/Dementia, ADL tation Potential, Urinary ndwelling Catheter, Mood anal Status, Pressure Ulcer,	F 6	36	taken a CAA training and is aware to properly document on CAA's. 2.Because all residents are assess determine their appropriate plan of based on their assessments all are potentially affected by the cited defi on 4/4/2018, the MDS nurse review accuracy of CAA's and MDS that surveyors noted to be inaccurate. A resident CAA's will be reviewed for timeliness and accuracy. Furthermore, CAA's being created as of 4/5/2018 double checked by regional reimbursement coordinator prior to submission to ensure compliance. on MDS/CAA was reviewed. No otheresidents were affected. 3.To enhance currently compliant operations and under the direction director of nurses, on 4/4/2018 all serceived in-service training regarding state and federal requirements for documentation, assessments and proposed for the MDS nurse to follow up on ite that are not being addressed during assessment period and ensuring careas are complete. 4.Effective 4/4/2018, a quality-assurpogram was implemented under the supervision of the MDS nurse to the residents will be reviewed at time of admission or annual to ensure CAA being completed thoroughly and completely. All triggers will be care planned and communicated to staff care sheets and communication to staff care sheets and communication to staff care sheets and communicated to staff care sheets and communicated to staff care sheets and communication to staff care sheets and communication to staff care sheets and communicated to staff care sheets and communication to staff care sheets and communicated to staff care sheets and communication	ed to care ciency, red all other ore, all swill be policy ner to s. The tance tance ems care rance ne at all f s's are	

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MOORHI	EAD REHABILITATIOI	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
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F 636	problem for R13 reineed for assist with multiple pre-popula included pain, envir need for assistance lacked a comprehe aforementioned preimpacted R13's included any other corresponding consumpacted R13's urinary incomposervation and rescare planning consumpacted R13's urinary incomposervation and rescare planning consumpacted R13's modern and problem for lacked a compaforementioned preimpacted R13's modern and/or family input considerations. -Falls CAA revealed problem for R13 rein with transfers, bed revealed multiple plareas which included medications and incomprehensive and pre-populated checked risk for falls. The Caconsiderations that from resident observations of the considerations that from resident observations of the considerations that from resident observations.	lated to incontinence and toileting. The CAA revealed ted check marked areas which conment, urinary urgency and with toileting. The CAA insive analysis of the e-populated checkmarks which continence. The CAA further considerations that could affect tinence from resident sident and/or family input for iderations. Evealed the care area was an R13 related to diagnosis of the CAA revealed multiple of the CAA revealed multiple of the CAA revealed multiple of the change and medications. The pain and medications. The prehensive analysis of the e-populated checkmarks which and the CAA further lacked ations that could affect R13's tobservation and resident	F 6	336	new interventions in place. Audits of CAA's will be completed for accuratimeliness; they will be completed to nurse 2 audits per week x 4 weeks audit weekly x 2 months to ensure compliance in this area. Any deficient will be corrected on the spot, and the findings of the quality-assurance of will be documented and submitted monthly quality-assurance committed monthly quality-assurance committed monthly quality-assurance committed monthly provided in the prov	cy and by MDS then 1 encies ne necks at the ee ctive	

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F 636	-Nutritional Status was an actual probindicated the reaso pre-populated checincluded arthritis, demony. The CAA analysis of the afor checkmarks which CAA further lacked could affect R13's observation and recare planning conservation and recare planning conservatio	CAA revealed the care area plem for R13, though did not on. The CAA revealed multiple ck marked areas which dementia, anxiety and poor lacked a comprehensive rementioned pre-populated impacted R13's nutrition. The lany other considerations that nutrition from resident sident and/or family input for siderations. AA revealed the care area was for R13 related to need for bility and incontinence. The iple pre-populated check ch included; altered mental d intrinsic risk factors. The prehensive analysis of the e-populated checkmarks which k of pressure ulcers. The CAA other considerations that could r pressure ulcers from resident sident and/or family input for	F6	36			

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F 636	medications. The considerations that using psychotropic observation and rescare planning cons - Pain CAA reveale problem for R13 re and routine use of revealed multiple pareas which include may cause pain surosteoporosis. The canalysis of the afor checkmarks which CAA further lacked could affect R13's pand resident and/or considerations. On 3/12/18, at 12:2 coordinator (MDSC completed R13's MMDSC-A confirmed comprehensive and did not address any affect R13's affected RAI manual dated were triggered by that indicate the ne based on problem in "triggered care are abetween the MDS aplanning. The RAI in process provides gkey issues identifie MDS assessment as	CAA further lacked any other could affect R13's risk of medications from resident sident and/or family input for iderations. d the care area was an actual lated to complaints of leg pain medications. The CAA re-populated check marked ed disease and conditions that ch as arthritis and CAA lacked a comprehensive ementioned pre-populated impacted R13's pain. The any other considerations that cain from resident observation family input for care planning to p.m. the facility MDS s)-A confirmed she had alysis of each care area and y considerations which may	F 6	36			

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F 636	manual identified actual or potentia provides for furth areas by guiding confounding factor documentation in factors for decline addition the RAI rinstructed to iden current and grour of practice and w of sound clinical practice and w of sound clinical practice and working skills were CAA process. R17 R17's Admission 10/13/17, identified impairment and hepneumonia, below chronic obstructive and diabetes. The independent with including transfer occasionally incorrevealed R17 did limited range of note The MDS identified therapy (PT.) occaservices. The MD anti-anxiety mediata entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated R17 in the MDS identified at a entered into following areas w Loss/Dementia, Associated	whereas the MDS identified I problems, the CAA process er assessment of the triggered staff to look for causal or ors and was important the CAA cluded the causal or unique risk er or lack of improvement. In manual indicated facilities were tify and use tools that were nided in current clinical standards then applied to practice, the use problem solving and decision er imperative in completing the Minimum Data Set (MDS) dated and R17 had moderate cognitive and diagnosis which included by the knee amputation (BKA,) are pulmonary disease (COPD,) are MDS identified R17 was activities of daily living (ADL's) are, bed mobility and was not ambulate, had one sided notion of the lower extremity. The MDS not ambulate, had one sided notion of the lower extremity. The R17 had received physical supational therapy (OT,) and R17 had received physical cation and had frequent pain. Assessment (CAA)dated and eight had triggered from the the MDS requiring analysis, the erer triggered; Cognitive ADL Functional/Rehabilitation and Indwelling	F6	36			

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F 636	Catheter, Falls, N Dehydration/Fluid Psychotropic Drug -Cognitive Loss/D was an actual promoderate cognitive recall 1 of 3 object pre-populated cheentered on the MI neurological factor requiring additionations. The Cognition. The Cognition. The Cognition. The Cognition of the affect of the considerations of the affect of the considerations of the considerations. -ADL Functional/Frevealed the care R17 related to rigit and prosthesis. The pre-populated cheincluded; pneumonand underlying cognition of the consideration of R1 lacked a comprehaforementioned programment of R1 lacked a comprehaforementioned programment of R1 lacked a comprehaforementioned programment of the considerations. -Urinary Incontine	utritional Status, Maintenance, Pain and	F6	36			

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F 636	problem for R17 prostate hypertro always know who revealed multiple areas which incluand medications. comprehensive a pre-populated ch continence. The considerations th function from res and/or family input considerations.	page 46 related to diagnosis of benign phy (BPH,) and R17's inability to en he needed to void. The CAA pre-populated check marked ided pain, diabetes, depression The CAA lacked a inalysis of the aforementioned eckmarks which impacted R17's CAA further lacked any other at could affect R17's urinary ident observation and resident ut for care planning	F6	36			
	problem for R17 and a right prosth pre-populated ch included medicat The CAA lacked aforementioned p impacted R17's r lacked any other R17's risk for falls	related to antianxiety medication nesis. The CAA revealed multiple eck marked areas which ions and internal risk factors. a comprehensive analysis of the pre-populated checkmarks which isk for falls. The CAA further considerations that could affect is from resident observation and amily input for care planning					
	was an actual prothe nature of the several pre-populincluded function diabetes and respected a compression of the compacted R17's rany other consider nutrition from respected R17's rany other consideration from respected R17's range R	s CAA revealed the care area oblem, though did not indicate problem. The CAA revealed lated check marked areas which al problems, poor memory, piratory disease. The CAA hensive analysis of the pre-populated checkmarks which nutrition. The CAA further lacked erations that could affect R17's ident observation and resident ut for care planning					

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F 636	considerations. -Dehydration/Fluithe care area was indicated the naturevealed several areas which inclumedication use. To comprehensive a pre-populated chrisk for dehydration other consideration for dehydration for dehydration for dehydration for resident and/or faconsiderations. Psychotropic Druarea was an actude depression and a (Xanax.) The CA pre-populated chrincluded anti-anx consequences of CAA lacked a coraforementioned proposed impacted R17's right that could affect for use from resident and/or family input considerations. -Pain CAA reveal problem related to CAA revealed semarked areas who contractures and CAA lacked a coraforementioned problem related to CAA revealed semarked areas who contractures and CAA lacked a coraforementiones.	d Maintenance CAA revealed s a potential problem and did not ire of the problem. The CAA pre-populated check marked ded depression, diabetes and	F6	36			

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F 636	impacted R17's painother consideration from resident obse family input for care On 3/12/18, at 12:2 she had completed CAA dated 10/13/1 CAA lacked a completed care area and did rowhich may affect R RAI manual dated were triggered by that indicate the nebased on problem "triggered care area between the MDS aplanning. The RAI process provides gkey issues identified MDS assessment a evaluate triggered manual identified wactual or potential provides for further areas by guiding st confounding factors documentation inclifactors for decline addition the RAI mainstructed to identificurrent and ground of practice and when of sound clinical process.	in The CAA further lacked any is that could affect R17's pain revation and resident and/or explanning considerations. If p.m. the MDSC-A confirmed R17's admission MDS and T. MDSC-A confirmed R17's prehensive analysis of each not address any considerations. The additional assessment identification, known as as," which form a critical link and decisions about care manual identified the CAA uidance on how to focus on diduring a comprehensive and directed facility staff to care areas. Further the RAI whereas the MDS identified problems, the CAA process assessment of the triggered aff to look for causal or and was important the CAA uided the causal or unique risk or lack of improvement. In anual indicated facilities were and use tools that were ed in current clinical standards an applied to practice, the use oblem solving and decision imperative in completing the	F 63	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 636	R207's Admission I dated 2/27/18, iden intact and had diag surgical past of a ri (surgical procedure depression, anxiety identified R207 was daily living and was therapy (PT) and oservices. The MDS constant pain and I medication for pain received psychotro R207's Care Area A 2/27/18, identified sentered into the ME following areas wer Functional/Rehabili Nutritional Status, Psychotropic Drug -ADL Functional/Rerevealed the care a R207 related to recein (infection/inflamma and had a history or revealed several prareas which included depression and cor CAA lacked a compaforementioned preimpacted R207's Alany other considera ADL function from in the considera ADL function from in the consideral consideration consideral consideral consideral consideral consideral consideral consideration consideral consideration consideral consideral consideration consideral consideral consideration consideral consideral consideral consideral consideral consideration consideral consideral consideration consideral consideration consideral consideration consideration consideral consideration consideral consideration	Minimum Data Set (MDS) tified R207 was cognitively nosis which included recent ght knee arthroscopy (TKA) to repair knee damage,) and schizophrenia. The MDS independent in all activities of receiving both skilled physical ccupation therapy (OT,) further identified R207 had had received as needed . The MDS identified R207 pic medications. Assessment (CAA)dated six had triggered from the data DS requiring analysis, the re triggered; ADL tation Potential, Falls, Pressure Ulcer and Pain and	F 63	6		

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F 636	-Falls CAA revealed problem for R207 mobility and toileting medications. The compre-populated cheincluded medication pain. The CAA lact of the aforemention which impacted R2 further lacked any affect R207's risk to observation and recare planning constructional Status was an actual problem the nature of the proposition of the proposition. To other consideration	ed the care area was an actual related to supervision with bed and and receipt of psychotropic CAA revealed several ck marked areas which ons, anxiety, depression, and ked a comprehensive analysis ned pre-populated checkmarks 207's risk for falls. The CAA other considerations that could for falls from resident esident and/or family input for siderations. CAA revealed the care area olem, though did not indicate roblem. The CAA revealed ated check marked areas which I problems, poor memory, and in the CAA lacked a realysis of the aforementioned ckmarks which impacted the CAA further lacked any and the could affect R207's dent observation and resident	F 630	5		
	an actual problem mobility. The CAA check marked are factors, medication CAA lacked a comaforementioned primpacted R207's r CAA further lacked could affect R207's	AA revealed the care area was related to supervision with bed revealed several pre-populated as which included extrinsic risk as and newly admitted. The prehensive analysis of the e-populated checkmarks which isk for pressure ulcers. The d any other considerations that is risk for pressure ulcers from on and resident and/or family				

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F 636	-Psychotropic Drug area was an actual depression, bipolar The CAA revealed marked areas which medication and adverse proposed the comprehensive and pre-populated check R207's risk of psychotropic drug to comprehensive and pre-populated check R207's risk of psychotropic drug to comprehensive and affect R207's risk of resident observation input for care planting and compain rated 6/10 on a compain rated 6/10 on a compain medication. Pre-populated check included arthritis are lacked a comprehensioned presimpacted R207's part of the considerations. On 3/12/18, at 12:3 she had completed CAA's dated 2/27/CAA lacked a compare area and did residue.	Use CAA revealed the care problem related to anxiety, disorder and schizophrenia. several pre-populated check h included anti-anxiety verse consequences of use. The CAA lacked a alysis of the aforementioned exmarks which impacted hotropic drug use. The CAA other considerations that could f psychotropic drug use from n and resident and/or family ing considerations. If the care area was an actual R207's frequent complaints of a numeric pain scale and use The CAA revealed several ex marked areas which and contractures. The CAA nsive analysis of the e-populated checkmarks which ain. The CAA further lacked ations that could affect R207's observation and resident	F6	536			

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F 636	had severe cognitive diagnoses which in and agitation. The I extensive assistant (ADL's) including lo incontinent of both identified R28 had a or more in the last ridentified R28 had and was at risk for R28's Care Area As 1/16/18, identified fentered into the MD following areas wer Loss/Dementia, Uri Indwelling Catheter Pressure Ulcer. -Cognitive Loss/De area was an actual severe cognitive im non-Alzheimers der multiple pre-popula data entered on the neurological factors additional assessm cognition. The CAA analysis of the afore checkmarks which functioning. The CAC considerations that functioning from resident and/or fam considerations.	dated 1/16/18, identified R28 re impairment and had cluded dementia, restlessness MDS identified R28 required as with activities of daily living comotion and was always bowel and bladder. The MDS a significant weight loss of 5% month. The MDS further no falls within the last quarter pressure ulcer development. Seessment (CAA)dated ive had triggered from the data DS requiring analysis, the retriggered; Cognitive nary Incontinence and reference an	F 6	36			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
F 636	CAA revealed the oproblem for R28 reneed for assist with multiple pre-popular included environme for assistance with comprehensive and pre-populated checincontinence. The Considerations that incontinence from resident and/or famonsiderations. -Falls CAA revealed problem for R28 rewith transfers, bed revealed multiple pareas which include medications and incomprehensive and pre-populated checinsk for falls. The Considerations that from resident obserfamily input for care. -Nutritional Status (was an actual probindicated the reaso pre-populated checincluded physical limemory. The CAA analysis of the aforcheckmarks which. -Pressure Ulcer CA an actual problem for the care.	are area was an actual lated to incontinence and toileting. The CAA revealed ted check marked areas which ent, urinary urgency and need toileting. The CAA lacked a alysis of the aforementioned exmarks which impacted R28's CAA further lacked any other could affect R28's urinary resident observation and ally input for care planning. The CAA re-populated check marked and difficulty with balance, continence. The CAA lacked a alysis of the aforementioned exmarks which impacted R28's AA further lacked any other could affect R28's fall risk revation and resident and/or explanning considerations. CAA revealed the care area lem for R28, though did not	F 6	36			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 636	CAA revealed multi marked areas which status, extrinsic and CAA lacked a compa aforementioned primpacted R28's risk for observation and recare planning constant of the care planning and the care and did not at which may affect for the care and the care are between the MDS planning. The RAI process provides of the care and identified which may affect of the care and provides for further areas by guiding structural or potential provides for further areas by guiding factor documentation incompation the RAI minstructed to identification to identification the RAI minstructed to identification.	iple pre-populated check ch included; altered mental d intrinsic risk factors. The prehensive analysis of the e-populated checkmarks which k of pressure ulcers. The CAA other considerations that could r pressure ulcers from resident sident and/or family input for	F 63	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 636	of practice and w of sound clinical	page 55 hen applied to practice, the use problem solving and decision e imperative in completing the	F 6	36			
	11/11/17, identified had diagnoses will disease, dementing restlessness and R1 required total assistance with between total assistance with between total assistance with prior to admission. The language of the two distance with a state of the two distance with the	Minimum Data Set (MDS) dated ed R1 had intact cognition, and hich included Parkinson's a, anxiety, glaucoma, weakness, agitation. The MDS identified assistance for eating, extensive ed mobility, transfers, dressing, Il hygiene, and did not walk. The ed R1 had a fall in the last mission, a fall in the last 2-6 dmission, and no falls since MDS did not identify R1's fall on was ambulating, refused in activity of daily living (ADL) or bative with staff on 11/8/17. Care Area Assessment (CAA) dentified eight care areas had e data entered into the MDS is, the following areas were Function, ADL bilitation Potential, Urinary					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		03	/13/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 636	Nutrition, Pressur and Pain. -Visual Function (an actual problem glaucoma. R1 sta was "ok". The CA pre-populated che entered on the MI and conditions of and diabetic retine that could cause of dementia. and movision marked for antipsychotics. The analysis of the affect checkmarks whice functioning. The CI glasses, input from resident or family consideration. -ADL Functional/Frevealed the care R1 related to severe	Indwelling Catheter, Falls, e Ulcer, Psychotropic Drug Use CAA revealed the care area was a for R1 related to a diagnosis of ted as of that moment his vision A revealed multiple eck marked areas (from data DS), which included: diseases the eye marked as glaucoma opathy, diseases and conditions visual disturbances marked as edications that could impair antidepressant and the CAA lacked a comprehensive orementioned pre-populated in impacted R1's visual CAA further lacked R1's use of the resident observation and input for care planning Rehabilitation Potential CAA area was an actual problem for the present times which	F 63	,			
	dressing, bathing, and eating. The Copre-populated cheincluded: recent hincontinence, depproblem evaluation considerations, at the aforementions which impacted Refurther lacked any	o require assistance with grooming, transfers, toileting AA revealed multiple eck marked areas which pospitalization, vision problems, ression. The CAA lacked ADL on, R1's locomotion and a comprehensive analysis of ed pre-populated checkmarks and the considerations that could inctioning from resident					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 636	-Urinary Incontiner CAA was requeste -Falls CAA reveale problem for R1 rela Parkinson's diseas receiving psychotronumerous falls at prevealed multiple pareas which includ seated balance, intransitions, medica anti-depressants a pre-populated intellacked a comprehe aforementioned primpacted R1's risk lacked any other cR1's fall risk from resident and/or fanconsiderationsNutritional Status was an actual probmultiple pre-popula included dementia CAA lacked a comaforementioned primpacted R1's nutrany other consider nutrition from residand/or family input considerations.	iderations. Ince and Indwelling Catheter d, however not provided. Ind the care area was an actual ated to a diagnoses of the eard glaucoma, was currently opic medications and had previous living facility. The CAA pre-populated check marked ed: difficulty maintaining apaired balance during attions including anti-psychotics, and anti-anxiety agents and anal risk factors. The CAA ensive analysis of the e-populated checkmarks which for falls. The CAA further considerations that could affect resident observation and anily input for care planning CAA revealed the care area of the e-populated checkmarks which and Parkinson's disease. The prehensive analysis of the e-populated checkmarks which and Parkinson's disease. The prehensive analysis of the e-populated checkmarks which intion. The CAA further lacked ations that could affect R1's lent observation and resident	F 63	6			
	an actual problem	for R1 related to requiring Ls. urinary incontinence and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED	
		245052	B. WING		03	/13/2018	
	PROVIDER OR SUPPLIE	R ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 636	was at risk for de CAA revealed mu marked areas wh status, immobility R1 was newly ad comprehensive a pre-populated chrisk of pressure u any other considerisk for pressure observations and care planning cor-Psychotropic Dru area was an actudiagnoses of dep R1 was currently (anti-depressant) Ativan (anti-anxierevealed multiple areas which inclutaking, adverse canxiety, sedation lacked a comprehaforementioned pimpacted R1's rismedications. The considerations the psychotropic medications and reare planning cor-Pain CAA reveal problem for R1 rerated 4 out of 10 occasionally mad The CAA reveale marked areas when the case when the	veloping pressure ulcers. The ultiple pre-populated check hich included; altered mental rediabetes, dementia and that mitted. The CAA lacked a nalysis of the aforementioned eckmarks which impacted R1's alcers. The CAA further lacked erations that could affect R1's ulcers from resident resident and/or family input for insiderations. The CAA revealed the care all problem for R1 related to ression, anxiety, dementia and receiving Remeron, Seroquel (anti-psychotic) and bety) medication. The CAA pre-populated check marked ded; medication classes R1 was onsequences of depression, disturbance of gait. The CAA pre-populated checkmarks which is of using psychotropic. CAA further lacked any other at could affect R1's risk of using dications from resident resident and/or family input for	F6	36			

(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLÉTION	
F 63	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submi of this Plan of Correction is not an admission that a deficiency exists of	the ssion or that	
	A. BUILDIN B. WING _ ID PREFIX TAG F 63	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) F 636 This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245052	B. WING_		03/	13/2018	
NAME OF F	PROVIDER OR SUPPLIE		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		13/2010	
		•		2810 SECOND AVENUE NORTH	-		
MOORH	EAD REHABILITATION	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560			
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IAG			17.0	DEFICIENCY)			
F 637	Oznika wad Engaga		F 00	-			
F 03/	Continued From p	page 60	F 63				
	living (ADL's).			Correction is submitted to mee			
				requirements established by s	ate and		
	Findings include:			federal law.			
	DOOL	in in the Data Cost (MDC). In the I		1.It is the policy of this facility t			
		inimum Data Set (MDS) dated		consistent quality care to ensu			
		ed R28 had severe cognitive ad diagnoses which included		with significant changes are ap assessed and necessary inter			
		sness and agitation. The MDS		in place and that care plan is a			
		uired extensive assistance with		Some of the many ways that the			
	activities of daily living (ADL's,) of bed mobility,			been achieved for R28 is to ge			
	transfers and toileting. The MDS identified R28			ordered, dietary consult and u			
		in locomotion, eating and did		sheets to ensure staff adequate			
		e MDS revealed R28's weight at		for resident to prevent further			
		OS was 135 pounds (lbs.)		this case, after the survey dete			
		identified R28 was frequently		R28 showed a decline in statu			
		h bowel and bladder.		4/6/2016 such as needing mor			
				assistance with cares, is incon			
	R28's annual MD	S dated 1/16/18, identified R28		has been having less of appet			
		tive impairment and had		significant change was initiated			
		included dementia, restlessness		Assessments done and care p			
		MDS identified R28 required		created based on needs after			
		nce with activities of daily living		has closed.			
	(ADL's) including	locomotion and required limited		2.Because all residents have of			
	assistance with ea	ating. The MDS identified R28		changing needs all are potenti	ally affected		
	ambulated with pl	nysical assistance. The MDS		by the cited deficiency, on 4/4/	2018, the		
		eight at the time of the MDS was		MDS nurse reviewed criteria for			
		eight loss since R28's last MDS.		changes. All residents were a			
		dentified R28 was always		determine others needing sig			
	incontinent of both	h bowel and bladder.		Other residents determined to			
				changes have been identified			
		ove assessments indicated a 10		significant change assessmen			
		rease need for staff assistance		been initiated. Policy and proc			
		, locomotion and ambulation		significant change was review	ed and		
	and a decline in b	owel and bladder incontinence.		updated.			
	0 0/40/40 4 45	54 (1 6 111 1150		3.To enhance currently compli			
		:51 p.m. the facility MDS		operations and under the direct			
		C)-A confirmed she had		director of nurses, on 4/4/2018	_		
		f R28's aforementioned MDS's.		staff received in-service trainir			
	мизс-A stated s	he usually only completed SCSA		changes in resident's condition	ı. The		

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F 637	when a resident whospice services. current process ir in residents status. On 3/12/18, at 3:0 (DON) stated she completed when with decline were obse confirmed the factor process in place of except when in a discharged from the A facility policy was completion of resignificant changes a resident's status. The Resident Assidated 10/17, inclusing significant changes a resident's status. Will not normal intervention by statistical intervention by statistical intervention of the call the status; and 3. Requires interdirectly interdisciplinary to significant changes should document significant changes decision regarding decision regarding decision regarding decision in the status in the significant changes and the status of the significant changes are significant changes are significant changes and the significant changes are significant changes and significant changes are significant changes are significant changes and significant changes are significant c	was admitted or discharged from She stated she did not have a place for monitoring changes is. 14 p.m. the director of nursing would expect a SCSA to be when two or more areas of erved with a resident. She ility did not have a current for capturing resident decline resident was admitted or Hospice services. It is requested for recognition and ident SCSA MDS's, none were resemble to the definition of a reas a decline or improvement in a sthat: Ity resolve itself without aff or by implementing standard linical interventions, the decline "self-limiting"; han one area of the resident's lisciplinary review and/or	F6	training emphasized the impronitoring ADL's both improdecline. 4. Effective 4/4/2018, a quali program was implemented usupervision of the DON and monitor residents having chacare. The MDS nurse or dequality-assurance represent perform the following system MDS nurse will pull the ADL change analysis report and see who has had changes in full audit will be done by MD audits per week x 4 weeks tweekly x 2 months to ensure in this area and initiate sig coneeded. All residents will be time of quarterly or annual to significant change. Any define be corrected on the spot, and of the quality-assurance chedocumented and submitted quality-assurance committed further review or corrective a 5.MDS nurse will be responsible.	ty-assurance under the MDS to anges in their signated ative will natic changes: significant review data to a status and S nurse 2 hen 1 audit e compliance hange if reviewed at the ensure not a ciencies will ad the findings ecks will be at the monthly e meeting for action.	

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F 637	MDS assessments temporary variatio Qrtly Assessment	T. The manual clarified that sare not required for minor or ns in resident status. at Least Every 3 Months	F 6			4/23/18	
SS=D	§483.20(c) Quarter A facility must assign quarterly review in and approved by Conce every 3 month This REQUIREME by: Based on intervier facility failed to condinimum Data Sedays for 2 of 2 (R2 late quarterly MDS Findings include: "Quarterly Review '87-required, non-that must be comprofollowing the previetype. It is used to between comprehencitical indicators or resident's status at R 23's annual MDS was cognitively intincluded congestive depression and an was independent in	rly Review Assessment ess a resident using the strument specified by the State CMS not less frequently than ths. ENT is not met as evidenced w and document review, the mplete required quarterly t(s) (MDS) at least every 92 t3, R1) residents reviewed for the Assessment" is an OBRA comprehensive assessment bleted at least every 92 days ous OBRA assessment of any track a resident's status ensive assessments to ensure of gradual change in a		This Plan of Correction conswritten allegation of compliar deficiencies cited. However, of this Plan of Correction is radmission that a deficiency one was cited correctly. This Correction is submitted to marequirements established by federal law. 1. It is the policy of this facility quarterly assessments every ensure correctly assessed an appropriate care plan is deverable. The surveyor report and R1 did not have timely quassessments it was determined to being dropped off the schemes it was determined being dropped off the schemes and R1 did not get correctly census. Both have been assessments. The census is every day in stand up and so double checked to ensure an back from a leave are back in	nce for the submission not an exists or that is Plan of eet state and y to provide y quarter to indeloped. In this orted that R23 uarterly ned it was due eduler. These y and upon y added to the essed and neir is reviewed cheduler by residents		

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F 638	Review of R23's a a quarterly MDS on 11/7/17. On 3/12/18, at 12 was reviewed with She confirmed R2 missed and was a coordinator stated schedule resident stated a Quarterly for R23 with an at 3/7/18. The MDS were over 120 day reference dates. R1's admission MR1 had intact cogniculated Parkinson glaucoma, weakn The MDS identified for eating, extensionant did not walk. Review of R1's clauraterly MDS as reference date (A 116 days between 11/11/17, and curron 3/13/18, at 100 on 3/13/18	record lacked documentation of completed after the annual MDS 2:39 p.m. R23's medical record in the facility MDS coordinator. 23's quartely MDS had been not completed timely. The MDS dist MDS's 90 days apart. She y MDS was currently in progress seessment reference date set of coordinator confirmed there by between assessment assessment. MDS dated 11/11/17, identified antion, and had diagnoses which on's disease, dementia, anxiety, ness, restlessness and agitation. Bed R1 required total assistance ive assistance with bed mobility, ag, toileting, personal hygiene, inical record revealed R1 had a seessment with an assessment with an assessment assessment and progressing and personal of the R1's admission ARD of the R1's a.m. registered nurse	F 6	2.Because all residents ar quarterly all are potentially cited deficiency, on 4/5/20 nurse reviewed process of accurate census with adm business office manager. procedure on quarterly as been reviewed. 3.To enhance currently cooperations and under the director of nurses, on 4/4/2 staff received in-service traimportance of quarterly an assessments. All residents reviewed at time of admission to ensure are off the scheduler and are athoroughly and completely 4.Effective 4/4/2018, a quaprogram was implemented supervision of the MDS nuall residents are assessed annually. The MDS nurse census with point click car ensure no resident is out of over next 3 months. Any doe corrected on the spot, and of the quality-assurance cladocumented and submitted quality-assurance committed further review or corrective 5.MDS nurse will be response.	r affected by the 18, the MDS f ensuring issions and Policy and sessments has impliant direction of the 2018 all nursing aining regarding id annual is will be sion or enthey do not fall assessed in a sessed in		
	Minimum Data Se	et coordinator (MDSC)-A stated ts should have no more than 90					

` /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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F 638	days between assedepended on an elethe electronic healt residents' MDS assassessments could	essments. MDSC-A stated she ectronic scheduler, built in to h record, for tracking when sessments were due so the d be schedled. MDSC-A sassessments and confirmed	F 638			
F 641 SS=D	Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accuracy The assessment management in resident's status. This REQUIREMED by: Based on interview facility failed to ensure accurately reflected (MDS) for 1 of 1 reworsening pressure failed to accurately (MDS) for 1 of 1 reworsening pressure dental care, and 1 incontinence. Findings include: The Centers for Me Long-Term Care Fall Instrument (RAI) 3.10/2017, identified be completed with risk, presence, appressure ulcers." Find the several coding instrument instrument cappressure ulcers." Find the several coding instrument instrument cappressure ulcers." Find the several coding instrument cappressure ulcers.	cy of Assessments. It is not met as evidenced It	F 641	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide accurate assessments on all residents. R13 MDS did not note any pressure areas, R38 MDS did not properly indicated that issues, and R9 did not properly state incontinence. In this case, after the survey indicated the incorrect informatic immediately the documentation was reviewed on these residents. R13 has he wound information updated, care plan updated and interventions in place. R38 was noted to have poor oral hygiene ar	te e on nad	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/13/2018	
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE COMPLÉT	
F 641	including skin care tracking forms, nurisk assessments. nurse and direct of conclusions from observations of the R13's annual Mini 12/26/17, identified ulcer development healed pressure uldentified the follower identified the office, a hard spaces for weekly following was listed to the following was listed to the follower identified pressure ulcer was were defined. The revealed the current dressings to both the follower identified pressure ulcer was were defined and were defined and were defined and the follower identified pressure ulcer was were defined and the follower identified the follower iden	e flow sheets or other skin rses' notes, and pressure ulcer Speak with the treatment are staff on all shifts to confirm the medical record review and e resident." mum Data Set (MDS) dated d R13 was at risk for pressure t, had no current or recently lcers. The MDS further wing skin treatments: pressure or chair and bed. The MDS did as on a turning and ram. orm titled, Wound Evaluation d on 12/15/17, the DON stored and written flow sheet with wound measurements. The d: d an unstageable ulcer of her asured 0.5 cm by 0.5 cm. The ed R13's skin surrounding the s intact and the wound margins wound evaluation flow sheet ent intervention was foam	F 64 ⁻²	been updated. R9 had new bowel as bladder assessment completed and plan updated. 2. Because all residents receive the of care based on their assessment are potentially affected by the cited deficiency, on 4/5/2018, the MDS in reviewed how information is gather importance of doing hands on reviewed to ensure accurate inform In addition, nursing staff were eduction importance of documenting appropriately on residents and revicare sheets to ensure staff providir correct cares. All current resident were reviewed for accuracy and resubmitted when necessary or if determined to need significant chan Through this process 3 discrepance were noted and addressed immediatensure proper documentation; MDS corrected. No other residents were affected. 3. To enhance currently compliant operations and under the direction director of nurses, on 4/4/2018 all restaff were in-serviced training requirements for assessments and MDS/care plans. MDS nurse was educated on importance of seeing residents they assess and ensure accuracy. All residents will be reviewed to staff via care she data. All triggers will be care planse communicated to staff via care she	d care ir level is all urse ed and ew with nation. ated ewing g MDS's of the nursing ewed athering ed and	
	measured 0.3 cm	R13's left heel pressure ulcer by 0.3 cm, wound margins the surrounding skin was intact		and communication book if new interventions in place. 4.Effective 4/4/2018, a quality-assu		

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F 641	and was open to a Review of R13's was found in the electron R13 had an unstaright heel which wound evaluation heel pressure ulcour flow sheet further had the following 100% skin, periwous surrounding skin was indicated the followere in place; R1 on both heels ever edistribution mat electronic Wound identify a pressure On 3/12/18, at 12 coordinator confir 12/26/17, did not ulcers. The MDS process for obtair included; reviewir record and paper the assessment record.	wound evaluation flow sheet, ronic record, 12/15/17, revealed ageable pressure ulcer on her vas identified on 12/15/17. The flow sheet identified R13's right er measured 1 cm by 1 cm. The identified R13's pressure ulcer characteristic: wound bed was bund margins were defined, was intact. The flow sheet wing treatments/interventions 13 was to have a foam dressing ery 72 hours, pressure tress and heel protectors. The Evaluation flow Sheet did not e ulcer on R13's left heel. 32 p.m. the facility MDS med R13's MDS dated identify R13 had any pressure coordinator stated her usual hing data to enter into the MDS of R13's electronic medical chart, going back 7 days from eference date. She stated she 8 had any pressure ulcers at the	F 64	program was implemented und supervision of the MDS and DC monitor residents MDS and ensaccurate and correct. The MDS designated quality-assurance representative will perform the financial systematic changes: after correspondetermined, audit of all MDS's financial factorial systematic changes after correspondetermined, audit of all MDS's financial factorial factorial for the guality per week x 4 weeks the weekly x 2 months to ensure continuous in this area. Any deficiencies with corrected on the spot, and the financial factorial fa	N to ure data in nurse or ollowing otions or IDS nurse on 1 audit inpliance I be indings of II be ine monthly eeting for on.		
	Long-Term Care I Instrument (RAI) identified Section with an intent to re present during the	Medicare and Medicaid (CMS) Facility Resident Assessment 3.0 User's Manual dated 10/17, L: Dental was to be completed ecord any dental problems e look-back period. The manual ing dental status can help					

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F 641	aspiration, malnut and poor control of provided several a "Conduct exam of cavity. Visually obtaincluding lips, gurrand cheek lining. tissue, abnormal gums. Oral exam uncooperative and oral exam may remissed. Referral toonsidered for the	who may be at risk for trition, pneumonia, endocarditis, of diabetes". Further, the manual assessment steps including: If the resident's lips and oral serve and feel all oral surfaces as, tongue, palate, mouth floor, Check for abnormal mouth teeth, or inflamed or bleeding ination of residents who are do not allow for a thorough sult in medical conditions being for dental evaluation should be	F 6	41			
	diagnoses which dementia and any required total ass which included br Oral/Dental Status broken natural tee was seen, was ur gums: if gums ap bleeding, was unthe resident's more demandable.	nitively impaired and had included Diabetes Mellitus, siety. The MDS indicated R38 istance with personal hygiene ushing teeth. R38's MDS is, obvious or likely cavity or eth: if any cavity or broken tooth imarked. Inflamed or bleeding pear irritated, red, swollen, or marked. Unable to examine: if uth cannot be examined, was of the above, was marked yes.					
	provider note from 8/11/16, indicating and areas of likely	clinical record revealed a n Apple Tree Dental dated n R38 had many broken teeth n decay. No other dental nere received from the facility.					
	multiple broken to mouth. The right to	2 p.m. R38 smiled revealing seth on the top, right front of front tooth was half decayed colored matter attached to the					

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F 641	teeth at the gumlin upper right side to inflamed with multiple of the inflamed of the	page 68 ne. R38's gums around the eeth were reddened and tiple other teeth showing decay. If a.m. nursing assistant (NA)-A combative with cares which teeth. NA-A stated staff was the oral cares often, due to the orted it to the nurse. If a.m. NA-I stated R38 was eith cares which included A-I stated R38 had not let teeth in a long time, but staff eals, reported refusals to the labelation and the labelation of the labelation of the labelation of the labelation of the labelation and confirmed R38 and decaying teeth. 28 a.m. registered nurse MDS	F 64	,			
	coordinator (MDS section on Oral/D the resident's clini notes, and review charting complete MDSC-A stated if questions she wo staff. MDSC-A sta physically assess she completed R3 including the Oral recall if she physic of the assessment	C)-A stated, to complete the ental Status she would check ical record, review progress activity of daily living (ADL) and by nursing assistants. She had any follow upuld go out to the floor and ask atted she did not usually residents. MDSC-A confirmed 88's MDS dated 1/17/18, Dental status. She could not cally assessed R38 at the time t. MDSC-A reviewed the Apple der note dated 8/11/16, and					

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F 641	accurate assessment the time of the assection of the assection of the assection of R38's dental would cause the de (CAA) to not trigger assessment of his obeen completed. On 3/12/18 at 12:32 (DON) stated she will date to be accurate was what drove the for the resident. DOR R38's current dental MDS. An MDS policy was and one was not prutilized the instruction Assessment Instruction Assessment Instruction 3.0 dated Centers for Medical (CMS). CMS's goal information broadly effective resident along-term care facil R9's Diagnosis Regindicated R9 had didementia without be anxiety. R9's quarte indicated R9 did no indicated R9 was a	above" would not be an ent of R38's dental status at essment. MDSC-A stated I section "none of the above" ental Care Area Assessment and a comprehensive dental status would not have dental status would not have 2 p.m. director of nursing would expect resident MDS and the MDS assessment eresidents care plan and care DN stated she would expect al status to be reflected on the estatus to be reflected on the estatus to be reflected on the ment (RAI) Manual for MDS are Facility Resident ment (RAI) User's Manual for 10/17, was published by the re & Medicaid Services was to disseminate at to facilitate accurate and essessment practices in lities. Fort print date of 3/12/18, lagnoses of bipolar disease, ehavioral disturbance, and erly MDS dated 12/20/17, at exhibit any behavior and liways continent of bladder.	F 6	41			
	During supper obse	ervations, on 3/06/18 at 5:27					

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F 641	R9 had a very strenoticed approxim. R9 was served hi consumed the me and laid on his bawas a very strong. When asked R9 ron 3/07/18 at 2:4 walking the halls wearing clothes drown and a strength of the stren	ong at a dining room table, alone. Ong urine odor, with the odor ately 5 feet away. At 9:40 a.m., is evening meal, quickly eal, then returned to his room ock in bed. It was noted there urine smell in entire room. Fefused an interview at that time. A p.m., R9 was observed with a 4 wheeled walker, ifferent than 3/7/18. However, ave a noticeable urine odor. On im., R9 was observed in the ing a strong urine smell self. After the meal, R9 returned again a strong drafting of warm, odor emminated from the room. In won 3/12/18, at 12:10 p.m. (NA)-I indicated she was aware into furine and stated R9 did not need so she waited until he left ipped the bed, wiped down empted to remove soiled the R9 got upset today, yelled at ave and slammed the door. NA-I is before she left R9's room, he soiled pants she was carrying orants in his closet. In won 3/12/18, at 8:30 a.m. the go (DON) confirmed R9 was cated R9's quarterly MDS, dated are incorrectly coded for his	F 64	11			
F 656 SS=D		nt Comprehensive Care Plan)(1)	F 65	56		4/23/18	

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F 656	§483.21(b) Compre §483.21(b)(1) The implement a compre care plan for each resident rights set f §483.10(c)(3), that objectives and time medical, nursing, a needs that are ident assessment. The odescribe the follow (i) The services that or maintain the resiphysical, mental, an required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, included the service provide as a result recommendations. findings of the PAS rationale in the resident's represent (A) The resident's redesired outcomes. (B) The resident's pfuture discharge. F whether the resident community was as local contact agencentities, for this pur (C) Discharge plan	chensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable reframes to meet a resident's and mental and psychosocial diffied in the comprehensive omprehensive care plan must ing - it are to be furnished to attain ident's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required as.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized res the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)- goals for admission and oreference and potential for acilities must document int's desire to return to the sessed and any referrals to sies and/or other appropriate	F 6	56		

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NAME OF F	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2010
MOORHI	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 656	requirements set section. This REQUIREMI by: Based on observ review the facility comprehensive conceived for prostalled to ensure and developed for act of 1 resident (R1) Findings Include: R17's Admission 10/13/17, identified impairment and hypneumonia, below chronic obstructive and diabetes. The independent with including transfers revealed R17 did limited range of matching transfers revealed R17 di	forth in paragraph (c) of this ENT is not met as evidenced ation, interview and document failed to develop an accurate are plan for 1 of 1 resident (R17) thesis. In addition, the facilty comprehensive care plan was ivities of daily living (ADL) for 1 reviewed for falls. Minimum Data Set (MDS) dated ad R17 had moderate cognitive ad diagnosis which included by the knee amputation (BKA,) are pulmonary disease (COPD,) and MDS identified R17 was activities of daily living (ADL's) activities of the lower extremity. activitied R17 had received	F 656	This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, submored this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. It is the policy of this facility to pronsistent quality care to ensure in have comprehensive care plans. The many ways that this has been achieved for R1 is therapy complest staff educated on managing reside pisodes, mats off floor, and offer throughout the day. R17 has dete he would like to try prosthetic again company sizing correctly, therapy start with re-training when it is corand staff aware to follow care she encourage walking with training from the therapy regarding prosthetic appliant his case, after the survey determined the survey determined to the survey	or the hission or that of or that of and rovide esidents Some of eted, ent walks rmined in, ready to inpleted ets and om cation.	
	Review of R17's of identified R17 had and indicated he including transfers	the MDS revealed R17 did not not receive PT or OT services. care plan dated 1/19/18, d a right BKA with a prosthesis was independent with all ADL's s. R17's care plan lacked ff assistance with R17's		2.Because all residents are have changing levels of care all are pot affected by the cited deficiency, o 4/5/2018, the MDS nurse reviewe process of ensuring accurate MD formulate comprehensive care pla other resident care plans have be reviewed and updated for accuracy	n d S's to ans. All en	

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F 656	prosthesis or ambound on 3/9/18, at 4:00 electric scooter in on the floor again and the end of his arrived at the faci received both OT approximately 2-3 walk with his prosindicated since he therapy, no other assisted him to all indicated his prosfelt his stump had he did not feel he further indicated his prosthesis to his prosthesis	<u> </u>	F 65	,	ment on sessments riod are ation is ant tion of the all nursing gregarding and L's. The tance of ement and on on care erformed. In the assurance der the DN to sure data S nurse or following ents that on y will be dits per reekly x 2 in this area.		
	therapist (OT)-A of skilled therapy se	20 a.m. certified occupational confirmed R17 had received rvices when he arrived at the aceived 8 skilled OT visits. She		spot, and the findings of the quality-assurance checks will be documented and submitted at quality-assurance committee r	oe the monthly		

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F 656	stated she felt R1 with therapy and hadonn and doff his and ambulation. On to ambulate up to was discharged from confirmed she has staff continue to wand ambulation in potentially improves facility not providing formal or informal services. On 3/12/18, at 9:5 (DON) confirmed direction to assist monitor and assist monitor and assist DON stated the fatype of restorative prevent decline in implementing a rethe areas she was indicated she did The DON stated is maintain his ability she was unaware staff to assist R17 indicated nursing department had covere currently wo	page 74 7 had made significant progress and improved in his ability to prosthesis, balance, transfers DT-A stated R17 had been able 100 feet with CGA when he om therapy services. OT-A direcommended facility nursing work with R17 with his prosthesis order to maintain and e his modified independence. If she had concerns with the agresidents with any type of ADL maintenance/restorative and to the R17 with ambulation and to the R17 with his prosthesis. The acility currently did not have any ero maintenance program to residents ADL's. She stated estorative program was one of a working to develop and the not have a current plan in place. She would have expected R17 to you to ambulate and further stated OT had recommended nursing with ambulation. She further and the contracted therapy ommunication problems and rking on improving or recommendations.	F 6	556	further review or corrective action. 5.MDS nurse will be responsible for POC.	r this	
		inimum Data Set (MDS) dated d R1 had intact cognition, and					

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F 656	had diagnoses where disease, dementiant restlessness and R1 required extern mobility, transfers R1's Care Area As 11/14/17, indicate falls at previous livadmitted from an and worsening of indicated R1 requibathing, grooming and toileting at time was at risk for an ADLs. Review of R1's cura 3/8/18, last revise ADL self-care per impaired balance, tremors. However instructions for staperformance and mobility, transfers Review of R1's pr 11/11/17, revealed 11/10/17, R1 had this shift and had and noted to walk 11/8/17, R1 was refused to wait for out of room.	nich included Parkinson's a, anxiety, glaucoma, weakness, agitation. The MDS identified isive assistance with bed and did not walk. Seessment (CAA) dated d R1 had a history of numerous ving facility and had been acute hospital after multiple falls Parkinson's disease. The CAA ired assistance with dressing, g, transfers, bed mobility, eating nes due to severe tremors and increase in assistance with Irrent care plan printed on d 3/6/18, identified R1 had an formance deficit related to a Parkinson's disease and and argument acked aff regarding R1's self assistance needed for bed and ambulation. Ogress notes from 11/1/17, to di: I frequent muscle movement been up and down from bed	F 68	56			

AND DUAN OF CORRECTION \ \ \ IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 656	11/7/17, and end R1 had diagnose in walking and unbeen discharged variability in his moses. The summ for assist of 1 for supervision while wheelchair due to transfer. Review of R1's O Progress and Disof 11/7/17, and ersummary identifies ignificant weakn the use of Parking required supervision and functional transfety and level of medication scheological medication scheological medication scheological medication with the unevensurfactor of the regular floor on 3/8/18, at 10:10 the re	of care date 12/4/17, revealed s of muscle weakness, difficulty isteadiness in feet. R1 had had from therapy due to significant nobility depending on medication mary included recommendations all mobility tasks and general R1 mobilized on the unit in his or history of attempting to self accupational Therapist (OT) incharge Summary with start date and date of 12/1/17, revealed the ed R1 was a fall risk, had ess/balance concerns without son's disease medications, iton/assist with standing ADLs insfers/ambulation to ensure of assist dependent on dule. Of a.m. R1 was observed to walk in over the fall mat to the closet horoom. To a.m. R1 abruptly stood up from controlled arm movements, an unsteady gait, walked across the fall mats, transitioning or over to his closet. 15 a.m. PT-A stated R1 received hission, but was no longer in ited R1 was a fall risk and due to judgement he should never	F6	56		

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	PROVIDER OR SUPPLIER EAD REHABILITATIO	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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	transfer, walk in his independently or w On 3/8/18, at 10:54 R1 could transfer a On 3/8/18, at 12:25 (DON) stated R1 h fall risk was "really transferred a lot an or walk independer current care plan a lacked transfer and staff. A policy was reque plans, however nor Activities Daily Livin CFR(s): 483.24(a)(§483.24(a) Based assessment of a reresident's needs ar provide the necess ensure that a resid daily living do not do of the individual's of that such diminution includes the facility §483.24(a)(1) A restreatment and servor her ability to carre	coluntary movements, he could be room and go to the bathroom ith supervision. It a.m. LPN-C stated she felt and ambulate independently. It p.m. director of nursing and Parkinson's disease, so his high." The DON stated R1 self d R1 was not safe to transfer notly. DON reviewed R1's and confirmed R1's care plan ambulation instructions for sted for comprehensive care ne were provided. Ing (ADLs)/Mntn Abilities 1)(b)(1)-(5)(i)-(iii) In the comprehensive esident and consistent with the and choices, the facility must ary care and services to ent's abilities in activities of iminish unless circumstances linical condition demonstrate in was unavoidable. This ensuring that: Is dent is given the appropriate ices to maintain or improve his ry out the activities of daily se specified in paragraph (b)	F 6	56		5/7/18
	3 100.24(b) Addivide	o o. dany ning.				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/	13/2018	
NAME OF F	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COL		10/2010	
MOORH	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 676	accordance with activities of daily I state of daily I st	provide care and services in paragraph (a) for the following iving: giene -bathing, dressing, al care, bility-transfer and ambulation, mination-toileting, ing-eating, including meals and mmunication, including al communication systems. ENT is not met as evidenced ation, interview and document of failed to provide enance services to prevent the enability for 1 of 1 resident (R17) defor a decline in ambulation. tual harm when the facility failed	F 6	,	ce for the ubmission of an cists or that Plan of et state and to provide event of the many ved for R17 d for re-fit		
	chronic obstructiv	v the knee amputation (BKA), re pulmonary disease (COPD) litus. The MDS identified R17		this case, after the survey det R17 showed a decline in amb ability and was not using pros	ulation		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245052	B. WING			03/1	13/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER			310 SECOND AVENUE NORTH OORHEAD, 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	was independent w (ADL's) including tr MDS revealed R17 one sided limited ra extremity. The MDS received physical th therapy (OT) service R17's quarterly MD R17 was cognitively and had one sided lower extremity. Th ambulate and did n R17's Care Area As 10/13/17, identified facility from an acut diagnoses which in and anxiety. The Ca BKA and had a pro- R17 was working w strengthening, ende however, did not ide locomotion. The Ca independent in ADL ambulate at the tim the CAA identified facight BKA with a pro- independent with al R17's care plan ide Review of a nursing	ith activities of daily living ansfers and bed mobility. The did not ambulate, and had ange of motion of the lower of further identified R17 had herapy (PT) and occupational es. S dated 1/10/18, identified y intact, independent in ADL's limited range of motion of the e MDS revealed R17 did not ot receive PT or OT services. Sessment (CAA) dated R17 had been admitted to the te care hospital and had cluded pneumonia, depression AA identified R17 had a right esthesis. The CAA identified with PT and OT services for the urance and prosthetic training, entify ambulation or AA identified R17 was 's and indicated R17 did not e of the assessment. Further, R17 was at risk of injury due to	F 6	76	immediate referral sent to get sized re-evaluated for fit. 4/5/2016 R17 vicinic and will need another visit who being worked on as resident is on restrictions with many providers and needs release. Assessments done care plan to be created based on neafter prosthetic is in place. 2. Because many residents have prosthetic devices many are potent affected by the cited deficiency, on 4/4/2018, the DON reviewed all reswith prosthetic devices to ensure utilization is in place and care plan accurate also reviewed all residents need to be walked during the day, and procedure on ADL's has been reviewed including ambulation. All residents with decline according to CASPER and those with walking or plans have been reviewed and eval to ensure compliance or determine No other residents were affected. 3. To enhance currently compliant operations and under the direction of director of nurses, on 4/4/2018 all no staff received in-service training regidecline in ADL's and importance of ambulating residents with care sheet indicate they should be walked with for maintenance. The training emphasized the importance of mon ADL's both improvement and declin Care sheets have been updated to all assistive devices and staff aware must report items omitted, refused effective	vent to ich is d and eeds ially idents that Policy a care uated needs. of the jursing garding ets that staff itoring include ethey	
		a front wheeled walker, had a dutilized a scooter. The care			4.Effective 4/4/2018, a quality-assu program was implemented under the		

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	(X3) DAT	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER EAD REHABILITATIO	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 676	guide lacked any diprosthesis. On 3/7/18, R17 warroom, he indicated services for a coup the facility last fall. had stopped becaustated he had not nor walking with the had a new prosthesis be able to walk if he prosthesis was now On 3/8/18, at 6:21 a stated R17 was use ADL's. She stated I prosthesis. She individed in the did not always with the facility did not he was able to ambut the facility did not he was able to ambut the facility did not he was able to ambut the facility did not he was able to ambut the facility be seen by walking programs. On 3/9/18, at 4:01 pelectric scooter in hon the floor against and the end of his larrived at the facility received both OT a approximately 2-3 walk with his prostrindicated since he therapy, no other strings.	irrection for use of R17's s seated in a wheelchair in his he had received therapy le of weeks when he arrived at R17 stated therapy services se of his insurance. He further eceived any type of exercises facility staff. R17 stated he sis and was unsure if he would e tried. He indicated his new too big for his right stump. a.m. nursing assistant (NA)-C cally independent in all of his ne had a right BKA and had a cicated R17 was independent fing the prosthesis and stated wear the prosthesis. NA-C ambulate and was unaware if oulate. NA-C further indicated have a restorative or am for range of motion or She indicated residents would therapy for any exercise or o.m. R17 was seated in an his room. R17's prosthesis was a the wall, between his closet oned. R17 stated when he first by in October 2017, he had	F6	supervision of the DON ar monitor residents having of care leading to decline in MDS nurse or designated quality-assurance represe perform the following syst residents ADL's to ensure based on ADL significant or report audits and that any having ambulation with stable monitored to ensure actione and documented actionates will be completed be audits per week x 4 weeks weekly x 2 months to ensure at time of quarterly or ann not a significant change. A will be corrected on the sprindings of the quality-assimil be documented and significant change in this area. All residents were time of quality-assimil be documented and significant change. A will be documented and significant change. Significant change in the sprindings of the quality-assimil be documented and significant change. Significant change. A will be responsible to the sprindings of the quality-assimility assimility and the sprindings of the properties.	changes in their ADL's. The entative will ematic audits of no decline change analysis resident listed aff ordered will ctivity is being cordingly. The y MDS nurse 2 is then 1 audit ure compliance will be reviewed ual to ensure any deficiencies bot, and the urance checks ubmitted at the ecommittee or corrective	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		281	REET ADDRESS, CITY, STATE, ZIP CODE 10 SECOND AVENUE NORTH DORHEAD, MN 56560	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 676	indicated his prosfelt his stump had he did not feel he further indicated habout losing his a prosthesis to his prosthes	thesis was too big for him and shrunk. R17 stated at that time would be able to walk. R17 he had voiced his concerns bility to walk and to wear his primary medical doctor as he did rns would be addressed by the progress and discharge ate 10/11/17, and end of care entified R17's progress since his significant and he had all five PT sessions. The d R17 made consistent gains ity strength, balance and had received gait training for attern with prosthesis limb and devices to reduce risk for falls itency of ambulation. The PT ary revealed R17 had ongoing trance deficits, was at high risk bendent mobility, was able to and required contact guard front wheeled walker (FWW). Intified R17 would benefit from the summary revealed R17 was ring in an assisted living facility progress to a handicap and and a home exercise.	F6	776			
	date 11/9/17, ider	itified R17 had made good s start of care and had					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER EAD REHABILITATIO	N & HEALTHCARE CENTER		281	REET ADDRESS, CITY, STATE, ZIP CODE 10 SECOND AVENUE NORTH DORHEAD, MN 56560	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 676	participated in all el summary revealed performance with transfers and ambour safety. Further the identified R17 was educated on a hommaintain gains made R17's current physical revealed an order of evaluation and treasure.	ight therapy sessions. The R17 made gains with ADL ransfers and ambulation. The R17 required supervision to g ADL's and functional ulation with FWW to ensure OT discharge summary at risk for falls, and had been be exercise program to de in OT. Ician orders signed 3/6/18, dated 1/16/18, for PT and OT t as indicated.	F6	76			
	(PT)-A confirmed R therapy services whereapy services whereapy services whereapy services are as a calendar yellow discharged from sk weeks from his adress of ambulation with therapy. She servitting and felt it had on 3/12/18, at 9:20 therapist (OT)-A conskilled therapy servited she felt R17 with therapy and had donn and doff his pand ambulation. Of	A17 had received skilled hen he arrived at the facility. ayor source was from North owed for 15 skilled therapy ar, therefore R17 was illed therapy within a few mission. PT-A stated she felt ments with his mobility in and transfers while working tated R17's prosthesis was a worked well with R17. If a.m. certified occupational infirmed R17 had received rices when he arrived at the leived 8 skilled OT visits. She had made significant progress and improved in his ability to prosthesis, balance, transfers I-A stated R17 had been able 00 feet with CGA when he					

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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 676	was discharged fr confirmed she had staff continue to wand ambulation in potentially improved She further stated facility not providing formal or informal services. On 3/12/18, at 9:5 (DON) confirmed direction to facility ambulation and to prosthesis. The D did not have any to maintenance progresidents ADL's. Serestorative prograwas working on to not have a current she would have eability to ambulate unaware OT had assist R17 with an anursing and the confidence of the communication working on improve recommendations. On 3/12/18, at 10 (LPN)-C stated R mobility with a modulity with a modulity with a modulity with a prosthesindependent with wore his prosthes recall R17 ever ar	om therapy services. OT-A drecommended facility nursing york with R17 with his prosthesis order to maintain and his modified independence. I she had concerns with the agresidents with any type of ADL maintenance/restorative at a.m. the director of nursing R17's care plan lacked any staff to assist R17 with a monitor and assist R17 with his ON stated the facility currently type of restorative or gram to prevent decline in the stated implementing a m was one of the areas she of develop and indicated she did to plan in place. The DON stated expected R17 to maintain his and further stated she was recommended nursing staff to inbulation. She further indicated contracted therapy department on problems and were currently ying communication for	F 6	576			

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		245052	B. WING		03	/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP O 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 676	overall independent felt he could use so grooming. She staft would wear it when R17 was independent would wear independent would wear independent in his scooter and had a indicated R17 had when he arrived at of any therapy received any therapy received and indicated she had indicat	t with his ADL's, though she ome more assistance with ed R17 had a prosthesis and he chose. NA-E indicated ent with his prosthesis and was with his mobility with his She further indicated she had	F 6	76		
	decline in ADL's, so was made for PT-A to ambulate. On 3/12/18, at 2:12 motorized scooters.	nance program to prevent uch as ambulation. A request to assess R17's current ability 2 p.m. R17 was seated in a wearing a tee shirt and dark is rested on the floor between				

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		245052	B. WING _		0	3/13/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		10,2010	
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F 676	his closet and the had not walked si therapy services. moved to gather I was also rested a PT-A indicated sh as R17's was mis that were on the k PT-A immediately another 4 WW. R complete the homindicated he would times a week. R1 no longer fit him a the facility. R17 si cap over his gel li cover an amputat prosthesis.) in ord made several attesock, however, he would turn red an R17 to breath and sock. R17 placed stump. PT-A don't torso and cued hi bed, in an attemphis stump, and in set into place. PT no longer fit and sloose. R 17 indica prosthetics compinsurance would i stated she would company. On 3/12/18, at 2:4 had experienced from his prosthess.	end of the bed. R17 stated he ince he had received skilled PT-A entered R17's room, his prosthesis and 4 WW, which against the wall by his prosthesis. He had to obtain another 4 WW saing one of the two tennis balls back two legs of the 4 WW. If left the room and returned with left the prosthesis a few returned to donn the prosthesis a few returned to use a stocking left the had to use a stocking left for his prosthesis to fit. R17 left to donn the Gel liner PLY left would hold his breath, his face donned the Gel liner PLY left the prosthesis onto R17's right left a gait belt around R17's med a gait belt around R17's med a gait belt around R17's med a gait belt around R17's modicated his prosthesis would not refer to secure his prosthesis would not refer to the prosthesis was too left the	F 6	76			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 676	that time. She furt endurance had de ambulate or transithe facility's usual residents annually confirmed R 17 has she indicated she Review of R17's p 3/8/18, revealed the -10/5/17, R17 was pneumonia. The r BKA and was at the services for streng note revealed R17 was bed mobility and she behavioral issues12/28/17, R17 has prosthesis was no note indicated the appointment for R record lacked any aforementioned confirmed and record lacked any aforementioned confirmed to the services of R17's ability to discharge from skillacked documentations.	ther indicated she felt R17's beclined and he was not safe to fer independently. PT-A stated practice was to screen and quarterly, however, and not recently been screened. Was unaware of R17's decline. Progress notes from 10/5/17, to me following; admitted from the hospital with note revealed R17 had a right me facility to receive PT and OT of thening and endurance. A later was alert and oriented, was needs known. The note independent with transfers, well care ADL's and had no dependent of the property. The writer would set up an 17's prosthesis. R17's medical further documentation of R17's procern.	F 6	776			

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 676	interview, the DON facility staff to moni indicated she felt he donning and doffing she was unaware FON 3/13/18, at 10:3 interview with R17's she stated R17 had had not been walkin concerns with the fastated she had not R17 was no longer prosthesis no longer prosthesis no longer prosthesis no longer not have expected ambulation and stafacility staff to assis progress he had mastated she felt at tin compliant, however not negate R17's no	stated she would expect tor R17's use of his stump and a was independent with ghis prosthesis. She stated R17's prosthesis no longer fit. O a.m. during a telephone sprimary physician (PA)-A, I recently reported to her he and and stated she had ongoing acility's communication. She been notified by the facility able to ambulate or R17's are fit. PA-A stated she would R17 to decline in his ted she would have expected at R 17 to maintain the add with skilled therapy. PA-A nes R17 was not always she stated she felt that did beeds. She further indicated pointed R17 had declined so	F 670			
F 677	identified restorative ambulation would be needs. A policy was request decline and ambulation would be needs.	ment, revised 2/19/18, e nursing, transfers and e offered based on residents sted for prevention of ADL ation, none were provided. for Dependent Residents	F 67	7		4/23/18
	CFR(s): 483.24(a)(2) §483.24(a)(2) A resout activities of daily	ident who is unable to carry y living receives the necessary good nutrition, grooming, and				

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		245052	B. WING		02/4	12/2049
NAME OF I	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE	03/1	13/2018
		` ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	by: Based on observer veview, the facility with grooming and (R7, R22, R13) reliving (ADLs) and for their care. In a provide assistance resident (R28) reversident (R29) rever	ation, interview and document failed to provide assistance d bathing for 3 of 5 residents viewed for activities of daily who were dependent on staff ddition the facility failed to e with ambulation for 1 of 1 viewed for ambulating to meals. NG: inimum Data Set (MDS) dated d R22 had intact cognition and e assistance with transfers and Further, a section labeled do to record the amount of ed during baths and/or showers, tion was completed as "Activity or during the entire period." on 3/6/18, at 7:14 p.m. R22 to be bathed "once a week for was not consistently being done they [staff] overlook it." Hall 4 listing dated 3/9/18, as scheduled for a weekly bath	F 67	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. It is the policy of this facility to proconsistent quality care to residents needing assistance with their ADL's Some of the ways this is done is by gathering data through assessment ensure all residents needing assist with ADL's such as ambulating, growth as a material resident of the survey determined multiple resident's get the assistance they need review of residents was completed had facial hair and needed to have removed. Staff were able to coax a multiple attempts but only some of hair was removed due to R13 refusivest of the care. Staff will continue attempt. R7 is diabetic and needs a clipped it is to be done weekly with and nursing was advised this is a coneed and needs to be completed eweek. At this time nails are trimmeneeds assistance with bathing. It is identified that he needs assistance baths, he often refuses and will accept the supdated and staff educated on	the dission or that of and ovide s. Whats to cance coming, d and e, after idents led a led	

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM			245052	B. WING_		03/	13/2018	
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	MOORHE	EAD REHABILITATION	ON & HEALTHCARE CENTER					
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE	
Continued From page 89 documentation provided to support these entries, nor their meaning in the recorded answers. When interviewed on 3/9/18, at 10:48 a.m. nursing assistant (NA)-K stated the NA staff were responsible to complete their own baths and R22 was a scheduled, evening "bed bath." When questioned about what 'Not Applicable' meant on the charting, NA-K responded it was an example of "the PM staff for you," adding she did not think they did their job(s) consistently. Further, NA-K stated residents have reported to her before about not getting their baths done on the evenings, however, she never followed up or reported these concerns as it was not her task to do. During interview on 3/12/18, at 8:59 a.m. the director of nursing (DON) stated completed baths should be recorded in the electronic charting (ADL - Bathing). DON reviewed the charting for R22 and stated she knew "no reason" why they were charting 'Not Applicable' as a response. Further, the last recorded bath(s) R22 was charted as having in the past 30 days were on 3/9/18, 3/2/18, and 2/12/18. LACK OF GROOMING: R7's quarterly Minimum Data Set (MDS) dated 12/18/17, identified R7 had intact cognition and required extensive assistance with personal hygiene. During observation on 3/6/18, at 1:46 p.m. R7 was laying in bed in his room. R7 had visibly long	F 677	documentation pronor their meaning When interviewed nursing assistant (responsible to conwas a scheduled, questioned about the charting, NA-K of "the PM staff for they did their job(stated residents habout not getting the evenings, however eported these condo. During interview of director of nursing should be recorded (ADL - Bathing). If R22 and stated should be recorded (ADL - Bathing). If R22 and stated should be recorded (ADL - Bathing). If R24 and stated should be recorded (ADL - Bathing). If R25 and stated should be recor	ovided to support these entries, in the recorded answers. I on 3/9/18, at 10:48 a.m. (NA)-K stated the NA staff were implete their own baths and R22 evening "bed bath." When what 'Not Applicable' meant on K responded it was an example or you," adding she did not think as) consistently. Further, NA-K ave reported to her before their baths done on the er, she never followed up or incerns as it was not her task to an 3/12/18, at 8:59 a.m. the grown (DON) stated completed baths and in the electronic charting DON reviewed the charting for the knew "no reason" why they at Applicable' as a response. The ecorded bath(s) R22 was in the past 30 days were on d 2/12/18. MING: MING:	F 67	and R22 stated he doesn't wabath day he will take one whe chooses. R28 is assist of 1 w Some staff prefer 2 to have w Although it was stated she will meals it is noted she hasn't be survey staff have been educated walking and will do short daily to continue with strengthening assess for further goals. Assed done and care plan to be created on needs after assessment he 2. Because all residents have changing needs all are potent by the cited deficiency, on 4/4 MDS nurse reviewed resident assistance with grooming and ambulation. MDS nurse will requarter if resident goals being ensure staff follow through with current review was completed residents with similar ADL neand procedure on AD's has be reviewed. No other residents affected. 3. To enhance currently compoperations and under the direct director of nurses, on 4/4/201 staff received in-service training changes in resident's condition cares and following care sheet training emphasized the improved component of the	en he ith walking. I/c to follow. II walk to een. Since ited on walks in hall g. PT will essments ated based as closed. constantly tially affected i/2018, the is needing if bathing or eview each g met and ith cares. A if of all eds. Policy een were liant ection of the 8 all nursing ing regarding on, dignity in ets. The extrance of rement and anges. Staff reviewed d staff ing care		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	X2) MULTIPLE CONSTRUCTION (X3) 3. BUILDING		X3) DATE SURVEY COMPLETED	
		245052	B. WING _		03/	03/13/2018	
NAME OF	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP C		.0.2010	
MOORH	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 677	having a dark colostated "the nurses was diabetic addinated weeks," since any R7 added he wou cleaner as they ge not all of the staff R7's care plan day an activities of dai and he required ecomplete personal Bath Schedule Haidentified R7 to re Wednesday on the During subsequer p.m. R7 was layin long fingernails with underneath sever did receive a bath not trim or clean have trim or clean have their weekly resident has their available to help to the nurse was the the nails, however	pred substance underneath. R7 "help him clip his nails as he ng it had been "two or three one last helped him clip them. Id like his nails kept shorter and et "dirty from the food," however, are always willing to help him. Ited 1/15/18, identified R7 had Ily living (ADL) self care deficit extensive assist of one staff to Il hygiene. Further, a provided Ill 3 listing dated 3/2/18, ceive a bath every Sunday and the evening shift. It observation on 3/8/18, at 2:12 Ig in bed and continued to have the visible black substance all of them. R7 expressed he Ilast evening, however, staff did ties nails. The extrement Administration Record O18, lacked any identified completed by the nursing staff	F 67	job performance. 4.Effective 4/4/2018, a qual program was implemented supervision of the DON and monitor residents needing a ADL's. The MDS nurse or quality-assurance represent perform the following system random audits will be compourse on overall personal a separate audit for individual for maintenance during ass DON or designee will audit ADL's 6 audits per week x 3 audit weekly x 2 months to compliance in this area. All be reviewed at time of quant to ensure not a significant of deficiencies will be corrected and the findings of the qualic checks will be documented at the monthly quality-assur committee meeting for furth corrective action. 5.MDS nurse will be responded.	under the I MDS to assistance with designated tative will matic changes: leted by MDS ppearance and s with walking essments. staff cares with 4 weeks then o ensure residents will terly or annual hange. Any d on the spot, ity-assurance and submitted ance her review or		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245052	B. WING		03	/13/2018
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		10.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	directed them to on nails and stated Fhis hands in a we was a person who nails should have noticed they were During interview of director of nursing staff to assist with	page 91 do so. LPN-I observed R7's R7 "looks like he hasn't washed ek!" Further, LPN-I stated R7 o "likes to look nice" and his been trimmed when staff long and "full of crud." on 3/9/18, at 8:40 a.m. the g (DON) stated she expected grooming as they required reping nails clean and trimmed.	F 6	577		
	12/26/17, identificing impairment and hidementia, depressyndrome. The Mextensive assista (ADL's) including personal hygiene behaviors including R13's Annual Cardated 12/26/17, identification in the Compairment of the Compa	imum Data Set (MDS) dated and R13 had severe cognitive and diagnoses which included sion, anxiety and restless leg DS identified R13 required note with activities of daily living dressing, grooming and The MDS revealed R13 had not not rejection of care. The Area Assessment (CAA) dentified R13 had severe ent, required extensive actility staff with ADL's including AA indicated R13 was able to known and direct her cares. Evised 2/26/18, revealed R13 efficit and required extensive				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 677	personal hygiened did not identify faneeds. Further the required extensive toileting, however continence. A group one nursing 3/6/18, revealed assistance of one	facility staff for dressing, and nail care. R13's care plan cial hair removal or shaving ne care plan revealed R13 re assistance of two staff with r did not identify urinary sing assistant care guide updated R13 required extensive to total re to two facility staff with ADL's. O a.m. a telephone interview with nber (FM)-A, indicated R13 was cility staff for her grooming and reference for her grooming reference f	F6	577			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 677	her lip. On 3/7/18, at 2:03 wheelchair in her r fingernails continue a brown substance have several chin lidark in color. R13's remained unchang On 3/7/18, at 2:25 (LPN)-E stated R1 assistance from faneeds including dr. On 3/8/18, at 4:48 staff assistance wi On 3/8/18, at 4:48 her back with a bla ankles. R13's facia and above her lip. have chipped nail junderneath. On 3/8/18, at 6:58 required extensive with ADL's which in hygiene. She state	p.m. R13 was seated in a oom, facing the window. R13's ed to have chipped polish and a underneath. R13 continued to hairs varying in length and a facial hair above her lip also red. p.m. licensed practical nurse 3 required extensive cility staff for all of her ADL's ressing and grooming. a.m. NA-J stated R13 required th all cares. a.m. R13 was lying in bed on anket covering her from chin to all hair remained on her chin R13's fingernails continued to poolish, with a brown substance a.m. LPN-C stated R13 respectively.	F 67	,			
	wheelchair in her r several chin hairs in length and dark hair above her lip a to have chipped pi	4 a.m. R13 was seated in a com. R13 continued to have varying in length from 5-7 mm in color. Further R13's facial also remained. She continued nk nail polish on all of her prown substance underneath.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF A. BUILDING	IPLE CONSTRUCTION (X3) DATE S COMPL	
245052 B. WING	03/13	3/2018
MOORHEAD REHABII ITATION & HEAI THCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677 Continued From page 94 On 3/8/18, at 2:41 p.m. R13 was seated in a wheelchair in her room, and her facial hair and fingernails were unchanged/ On 3/9/18, at 8:40 a.m. the director of nursing (DON) confirmed R13's care plan directed facility staff to assist R13 with grooming and incontinence cares. She confirmed R13's care plan did not address her facial hair. The DON confirmed R13's long fingernails had a brown substance underneath them, and R13's facial hair. The DON stated she expected staff to assist R13 with grooming, which included removal of her facial hair and ensuring R13's nails were clean. She stated she was unaware FM-A had reported concerns with R13's assistance with grooming. On 3/9/18, at 12:39 p.m. R13 was seated in a wheelchair in the doorway of her room. R13 continued to have several dark chin and lip hairs varying in length from 5-7 mm. She continued to have chipped nail polish and a brown substance underneath the nail length. On 3/9/18, at 1:09 p.m. NA-C stated R13 required extensive assistance with ADL's including grooming. She further indicated R13 was overall cooperative when assisting with cares. R28's Annual Minimum Data Set (MDS) dated 1/16/18, identified R28 had severe cognitive impairment and had diagnoses which included dementia, restlessness and agitation. The MDS identified R28 required extensive assistance with activities of daily living (ADL's) including	77	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245052	B. WING		03	/13/2018
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 677	1/16/18, identified impairment and re one with ADL's inc mobility. R28's CA of R28's ambulation. Review of R28's crevealed R28 had to assist R28 to an	e Area Assessment (CAA) dated R28 had severe cognitive equired extensive assistance of cluding transfers and bed A's lacked any documentation	F6	77		
	guide sheet updat required extensive including transfers The care guide did status for R28. On 3/6/18, at 5:26 wheelchair while r wheeled her to the wheeled R28 to a dining room, place and left the dining	ed 3/6/18, revealed R28 e assistance with ADL's e with 1-2 assist and a gait belt. d not indicate an ambulation p.m. R28 was seated in a nursing assistant (NA)-G e dining room. NA-G then circular table in the back of the ed a clothing protector on R28 room. NA-G did not offer to 8 to the dining room.				
	wheelchair in the onurse (LPN)-K sat to eat. On 3/6/18, at 6:30 wheelchair, finishe was wheeled back	p.m. R28 remained seated in a dining room. Licensed practical next to R28 and assisted her p.m. R28 was seated in her ed with her evening meal and to her room by LPN-K. She did ate with R28 from the dining room.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	REET ADDRESS, CITY, STATE, ZIP CODE 10 SECOND AVENUE NORTH OORHEAD, MN 56560	,	
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F 677	On 3/7/18, at 9:30 wheelchair in her recently wheeled R breakfast. R28 state requested to lie do her bed with a gait. On 3/7/18, at 9:36 extensive assistant ADL's. She stated locomotion and wa mobility. NA-O state ability to ambulate. On 3/8/18, at 4:27 extensive assistant mobility. NA-J state checking and chanthe night and indicacares. NA-J was unindicated R28 had in her room. On 3/8/18, at 8:10 wheelchair in her rewheeled R28 to the observed to offer R to the dining room. On 3/12/18, at 10:5 required extensive required a wheelch stated she was not status and indicate ambulate with staff had not noticed any. On 3/12/18, at 11:4	a.m. R28 was seated in her com. NA-O indicated she had t28 back to her room from ted she was tired and wn. NA-O assisted R28 into belt. a.m. NA-O stated R28 required ce from facility staff for all R28 used a wheelchair for s dependent on staff for ed she was unaware of R28's a.m. NA-J stated R28 required ce with ADL's, including ed she assisted R28 with ging every two hours during ated R28 was compliant with nsure if R28 ambulated and a four wheeled walker (4 WW) a.m. R28 was seated in a com, at that time NA-E ed dining room. NA-E was not t28 assistance with ambulating	F6	77			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	wheelchair for lock herself short distate unaware of R28's staff assisted R28 On 3/12/18, at 11: wheelchair, at that and wheeled her to meal. R28 was not ambulate. On 3/12/18, at 12: required assistant mobility. NA-C state walked to the dining R28 had not been However, NA-C state dine program. On 3/12/18, at 3:0	She stated R28 used a comotion and was able to wheel comotion and was able to wheel comotion and was able to wheel comotion and was ability to ambulate and stated to transfer with a gait belt. 51 a.m. R28 was seated in a stime, NA-E approached R28 to the dining room for the noon to offered assistance to 23 p.m. NA-C stated R28 we with all ADL's including ted R28 was supposed to be any groom and was unsure why assisted to ambulate. atted R28 was not on a walk to	F6	577			
	(DON) confirmed staff to assist R28 stated she would of followed. The DOI be assisted with a Review of R28's p 3/8/18, revealed the anote dated 5/15 wheelchair and wo the facility. -a note dated 8/5/herself around the dependent on facility.	R28's care plan directed facility to ambulate to all meals. She expect R28's care plan to be N stated she felt R28 needed to mbulation to prevent decline.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	used a wheelchair note did not address a note dated 9/14/extensive assistance a gait belt. The not wheelchair and fur with assistance of R28's medical record documentation of RAn undated facility identified a procedic which included docresident's ADL recordical record." If document and noti resident refuses. An undated facility policy identified guincluded daily clear Having trimmed, si resident from accident themselves. In add which indicated, "Unot trim the nails of with circulatory implisted which directed under them using a Documentation show medical record and to the supervisor, information on how	117, revealed R28 routinely to get around the facility. The ss any ambulation for R28. 117, revealed R28 required ce from staff for transfers using e revealed R28 used a ther revealed R28 could walk one, gait belt and walker.	F 6	77		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION (>	K3) DATE SURVEY COMPLETED
		245052	B. WING		03/13/2018
NAME OF F	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE	
MOORHI	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 677	A facility policy wa plan and providing none was provided	s requested for following care assistance with ambulation,	F 677		4/02/40
F 684 SS=D	S 483.25 Quality of Quality of care is a applies to all treatifacility residents. E assessment of a right treation of a resident resident recordance with practice, the compoure plan, and the This REQUIREME by: Based on observative the facility implement physical primary physician of 1 resident (R17 Diabetes Mellitius.) Findings Include: R17's admission Modiabetes, pneumo (BKA,) and hypertidentified R17 was daily living (ADL's)	a fundamental principle that ment and care provided to Based on the comprehensive esident, the facility must ensure eive treatment and care in rofessional standards of prehensive person-centered residents' choices. ENT is not met as evidenced eation, interview and document failed to routinely monitor and an orders for notification of of elevated blood sugars for 1) reviewed with uncontrolled	F 684	This Plan of Correction constitutes in written allegation of compliance for the deficiencies cited. However, submiss of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet requirements established by state an federal law. 1.It is the policy of this facility to assis with monitoring residents with chronic diseases. Some of the many ways the this has been accomplished by monit BG levels in diabetics, having specific parameters in place and ensuring appropriate follow up with physician interventions are not successful. R17	ne sion that that c nat toring c
	R17's quarterly Mi	ring the assessment period. OS dated 1/10/18, identified ly intact, independent in ADL's		noted to have uncontrolled DM II with elevated BG levels and inadequate for up regarding inconsistent results. In reviewing current treatments noted	

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIE	 R	1	STREET ADDRESS, CITY, STATE, ZIP C		10/20 10
				2810 SECOND AVENUE NORTH		
MOORHI	EAD REHABILITATI	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pand received insulassessment period R17's Care Area 10/13/17, identified facility from an action diagnoses which HTN and received The CAA's did not blood sugars. Review of R17's of 3/6/18, revealed to accurate the subcutact MD (med greater then 350 BS (blood sugar) insulin aspart (Normalliliter,) dated 2 subcutaneously (subcutaneously (subcutaneou	page 100 ulin 7 out of 7 days during the od. Assessment (CAA)dated ed R17 had been admitted to the oute care hospital and had included pneumonia,diabetes, d routine daily doses of insulin. It identify the results of R17's current physican orders signed the following orders: ethod of checking blood sugars ed 1/16/18, three times a day, ical doctor) if blood sugar is or less than 90, DO NOT FAX	F 6	DEFICIENCY)	tions for esults remain d resident often as y of blood ed with physician to monitoring. In changing. BG levels are d prefers to outside of gress note have diabetes d by the cited DON BG monitoring sired range of ucated on of MD orders. resident e change in esidents were pliant rection of the 18 all nursing	
	2/1/18, give 500 r morning for type 2	extended release 24 hour, dated milligram (mg) by mouth in the 2 diabetes. Medication Administration		normal monitoring, reporting physicians and follow up wit It was determined through that often R17 has BG level evening and the regular pro	h BG results. his in-service s >450 in	
	Records (MAR) fi revealed the follo	rom 1/17/18, to 3/12/18,		the office. The on call staff a supportive in being proactive give small coverages without with primary who also has coverefused a process for faxing	are not e and only ut following up urrently	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	46 documented of R17's blood sugar ordered. The MAI had reached 512 - February 2018, sugar reading wa 65 documented of R17's blood sugar ordered. The MAI had reached 565 over 400. - March 2018, 3/1 R17's blood sugar on 9 out of 31 documented R17's blood sugar on 9 out of 31 documented R17's blood sugars had readings over 400. Review of a facility consultation dated R17's primary physlood sugars had 250, and on that of The form revealed a diagnosis of unimellitus, and order metformin 500 midaily, check fastift two hours post (luform further revealed a report indicated R17 had seview of a report indicated R17 had sugars had 250 midaily.	eadings. The MAR revealed ar was not checked 4 times as R identified R17's blood sugar on 1/21/18. MAR identified R17's blood as greater than 350 on 21 out of eadings. The MAR revealed ar was not checked 9 times as R identified R17's blood sugars on 2/5/18, and had 9 readings 1/18 through 3/12/18- identified ar reading was greater than 350 cumented readings. The MAR lood sugar was not checked 3. The MAR identified R17's blood ned 526 on 3/5/18, and had 4 0. ty form titled, report of d 2/8/18, revealed report to ysician which indicated R17's I been running high, greater than date, his blood sugar was 409. Id R17's primary physician listed controlled type II Diabetes ered the following: start g extended release, one tablet ing blood sugars every morning, unch and dinner,) as well. The aled R17 was to have a recheck	F6	further follow up with physicagreed to routine faxes to levels and be able to track 4. Effective 4/4/2018, a quaprogram was implemented supervision of the DON to residents with DMII. The Idesignated quality-assurar representative will perform systematic changes: audit to monitor BG results on 5 DMII for 2 weeks then on 2 weekly for 4 weeks to ensure Any deficiencies will be composed and the findings of the quality-assurance checks documented and submitted quality-assurance committed further review or corrective 5.DON will be responsible	monitor BG trends. ality-assurance d under the monitor DON or nce the following done weekly residents with residents ure compliance. rrected on the ne will be d at the monthly reaction.	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03	/13/2018
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE, ZIP (2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	R17's physician litype II Diabetes Molood sugars untio 0.6 mg for one witwo and increase metformin. Review of R17's 3/6/18, revealed the elevated blood sugars had month. The note changed to a concarbs.) -1/20/18, R17's bland indicated R1 insulin. The note decreased to 473 instructed the lice primary physician on call MD ordered 10 extra units of issugar in an hour. -2/2/18, R17's blood on call MD was not many sugar in an hour. -2/5/18, R17's blood on call MD was not many sugar in an hour. -2/5/18, R17's blood on call MD was not not many sugar in an hour. -2/5/18, R17's blood on call MD was not not many sugar in an hour. -2/5/18, R17's blood on the emergency revealed R17's blood to the emergency revealed R17's blood to the primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's primary physician was to receive his and if R17's physician was to rece	isted diagnosis of uncontrolled Mellitus, wait to check fasting il R17 woke, and started Victoza eek, increase to 1.2 mg week to 1.8 mg week three, stop progress notes from 1/17/18, to the following regarding R17's ugars: In note which indicated R17's I ranged from 99-489 in the last revealed R17's diet was esistent carbohydrate diet (limited lood sugar was 499 at 5:00 p.m. 7 had received his scheduled revealed R17's blood sugar had at 5:30 and indicated R17 had ensed nurse to contact his n. Further, the note revealed an ed R17 to receive an additional insulin and recheck his blood	F6	84		

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG			E SURVEY PLETED
		245052	B. WING			03/ ⁻	13/2018
	ER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPR	BE	(X5) COMPLETION DATE
-2/11 on the physic from - 2/1 fax he notificand - 2/27 notificand R17' R17' elevit Janu Marco On 3 electic diable be continuous state notificand routificand continuous continu	nat date and invision was faxed 2/11/18 and 2 2/18, R17's prinigh blood sugaied via telephorars were greated and notify the case of the ca	d sugars were above 350 twice dicated R17's primary d R17's blood sugar results	F 6	84			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		TE SURVEY MPLETED
		245052	B. WING _		03	/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 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) COMPLETION DATE
F 684	She stated she woo contact R17's phys blood sugars were she felt it was important to poss the stated she felt have routinely high. On 3/12/18, at 10:5 a diabetic and routing checked. LPN-C st with any type of die sugars. She stated supposed to be contabove 350. LPN-C R17's physician was ugars above 350. On 3/13/18, at 10:3 interview with R17's she stated she had facility's communicate been notified by the blood sugars on an she had resorted to facility twice a week She stated she won notify her anytime I above 350. PA-A stated she won always compliated that did not negligible.	sician was routinely contacted. uld expect licensed staff to ician via telephone when his above 350. The DON stated ortant for R17's physician to be sible medication adjustments. it was hard on R17's body to blood sugars. 69 a.m. LPN-C stated R17 was inely had his blood sugar ated R17 was non-compliant et and often had elevated blood R17's primary physician was ntacted if his blood sugar was stated she was not sure if as routinely notified of blood 80 a.m. during a telephone s primary physician (PA)-A, I ongoing concerns with the ation. She stated she had not e facility of R17's elevated routine basis's. PA-A stated of having her nurse contact the k to obtain R17's blood sugars. uld still expect the facility to R17's blood sugars were tated she felt at times R17 was ant, however, she stated she	F 68	34		
	•	Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 68	96		4/23/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	l` '	E SURVEY IPLETED
		245052	B. WING _		03/	13/2018
NAME OF F	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD		
				2810 SECOND AVENUE NORTH		
MOORHE	EAD REHABILITATI	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	\$483.25(b) Skin I §483.25(b)(1) Pre Based on the conresident, the facil (i) A resident receprofessional stampressure ulcers and ulcers unless the demonstrates that (ii) A resident with necessary treatm with professional promote healing, new ulcers from the This REQUIREM by: Based on observative, the facility assess, failed to and failed to implement the facility assess, failed to and failed to implement the facility assess, failed to and failed to implement the facility assess, failed to and failed to implement the facility assess, failed to and failed to implement the facility assess, failed to and failed to implement the facility assess, failed to and failed to implement the facility assess, failed to and failed actual assess her pressure relieving the facility assess the	page 105 Integrity Pessure ulcers. Inprehensive assessment of a sity must ensure that- Peives care, consistent with dards of practice, to prevent and does not develop pressure individual's clinical condition at they were unavoidable; and a pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent		CROSS-REFERENCED TO THE AP DEFICIENCY)	itutes my be for the ubmission of an cists or that Plan of et tate and o provide vent	
	Findings Include:	imum Data Set (MDS) dated		that this has been achieved fo #13 is by reviewing wound and documentation of wounds. R1	r resident d current	
	12/26/17, identificing impairment and hidementia, anxiety psychosis. The Miextensive assista (ADL's) including	ed R13 had severe cognitive and diagnoses which included restless leg syndrome and IDS identified R13 required nee with activities of daily living bed mobility, transfers and The MDS identified R13 was at		to have L unstageable are to have L unstageable are to hincreased in size and area now on previously healed area on I survey noted the R heel and the boots were not used appropriate wound care and documentation address resident's heels and i	neel that w developed R heel. After nat prevalon ately - on did not	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		03/	13/2018	
NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD	=		
MOODIII		ON 6 UEALTHOADE OFNED		2810 SECOND AVENUE NORTH			
MOORHI	EAD REHABILITATI	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE 'ROPRIATE	COMPLETION DATE	
F 686	⁻		F 68	36			
		ulcer development, had no		were not followed all interventi			
		y healed pressure ulcers. The		re-evaluated and put in place a			
		tified the following skin		for R heel were initiated. Care			
		sure relieving devices for chair		care plans updated, wound co			
		S did not identify R13 was on a		received for possible incision a			
		itioning program. Further, the		drainage of bilateral heels d/t r			
		13 had no behaviors of rejection		and unstageable. Daughter up	dated on		
	of care during the	e 14 day look back period.		heels and treatment.	•		
	D401			2.Because all residents have o			
		re Area Assessment (CAA) dated		which could lead to alteration i			
		ed R13 had diagnoses of dementia, depression and		integrity or due to illness have			
		r, had severe cognitive		skin breakdown all are potential by the cited deficiency, wound	any anected		
		ir, flad severe cognitive ired extensive assistance with		documentation has been revie	wed		
		ed mobility, toileting and		interventions for prevention are			
		A identified R13 was able to		and documented clearly on ca			
		known and direct her cares. The		Weekly skin audits are comple			
		3 was at risk for pressure		staff update DON on any new			
		ie injuries and infection. The		immediately including reporting			
		ify Ř13 had a current		bruises, skin tears, skin break			
		sure ulcer and failed to address		rashes. All current resident wit			
		pressure relief for R13's heels.		ulcers were assessed for com			
				assessment along with approp	riate		
		Braden Scale of Predicting		interventions. Implementation			
		sk form, dated 1/18/18,		interventions is reviewed on ro			
	identified R13 wa	s chairfast, had very limited		weekly. Staff to alert DON is re			
		oblem with friction and shear		refuses otherwise. Staff educa			
		dequate nutrition, and listed R13		importance of offloading, repos			
	was at low risk fo	r developing pressure ulcers.		care plan updated, care sheets			
				No other residents were affect			
		Norton Scale for Predicting Risk		policy on wound care has been			
		form, dated 1/18/18, identified		3.To enhance currently complia			
		und, had slightly limited mobility,		operations and under the direct			
		nt of urine, was in fair physical		director of nurses, on 4/4/2018			
		is listed at moderate risk for the		received in-service training for			
	development of p	ressure dicers		skin and pressure areas, to en always use Prevalon boots and			
	No further skip as	ssessments were found in R13's		understand offloading to preve			
	clinical record.	paeaamenta were lunin ili L/192		alterations in skin integrity. The			

CLIVIL	13 I ON MEDICANE	- A MEDICAID SERVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		E SURVEY PLETED
		245052	B. WING			03/	13/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				28	810 SECOND AVENUE NORTH		
MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER			IOORHEAD, MN 56560		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP	RIATE	DATE
					DEFICIENCY)		
E 606	O	107					
F 686	Continued From pa	age 107	F6	86			
	D401	. 10/00/40			emphasizes the importance of follo	owing	
		vised 2/26/18, revealed R13			all interventions for effective skin		
		icit and required extensive			maintenance and reporting of char		
		cility staff for ADL's, transfers care plan revealed R13 had			skin conditions. Education done or importance of comprehensive	ı	
		Is related to a history of			assessment of skin, pressure ulce	re and	
		d immobility. R13's care plan			implementation of appropriate	is and	
	· .	ventions which included to			interventions.		
		amily on causes of skin			4.Effective 4/4/2018, a quality-assu	ırance	
	breakdown including transfer/positioning requirements, importance of taking care during				program was implemented under t		
					supervision of the director of nurse		
	ambulating/mobility			monitor residents with impaired sk	in		
	teach R13 and fam	nily the importance of changing			integrity and updating MD, family a	nd care	
		tion of pressure ulcers,			plans with any changes to ensure		
		equent position changes,			appropriate follow through. The di		
		nift weight in wheelchair every			of nurses or designated quality-ass		
		ver, R13's care plan did not			representative will perform the follo		
		entions for pressure relief for			systematic changes: the DON or d	esignee	
	R13's heels.				will ensure audit all residents with	okly v 4	
	The facility's group	one NA care guide updated			pressure ulcers or those at risk we weeks then on 6 residents weekly		
		13 required extensive to total			weeks to ensure compliance than		
		to two facility staff with ADL's,			residents weekly x 2 months. Any	_	
		two hours and as needed.			deficiencies will be corrected on th	e spot.	
		ected facility staff to float heels,			and the findings of the quality-assu		
		d indicated R13 was confused.			checks will be documented and su		
		ther indicated R13 had			at the monthly quality-assurance		
	behaviors resisting	cares at times.			committee meeting for further review	ew or	
	_				corrective action.		
		p.m. R13 was seated in a			5.DON will be responsible for this	POC.	
		oom, both of her stocking					
		iding her heels, rested directly					
		er wheelchair. R13's					
		s were covered with a thin					
		c. Two Prevalon boots					
		devices used for heels,) were					
	observed on the fic	oor at the end of R13's bed.					
	On 3/7/18, at 8:44	a.m. during a telephone					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03	/13/2018
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		. 10.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	indicated R13 had pressure ulcers. F wound clinic week treatment and ind bilateral heel presapproximately a na history of not we pressure ulcer an any other pressur further stated she routinely checked On 3/7/18, at 2:03 wheelchair in her covered feet, incluon the footrests o	B's family member (FM)-A she did a history of bilateral heel FM-A stated R13 used to go to a kly for routine pressure ulcer icated she had thought R13's usure ulcers had healed month ago. FM-A stated R13 had earing the Prevalon boots for did indicated she was unaware of e relieving interventions. She was unsure if the facility	F 6	86		
	wheelchair in her continued to rest wheelchair. Licen entered R13's root to both of her feet with R13 regardin R13's room. R13's footrests of the wheelchair. R13 stated I she thought they covered feet/heel the wheelchair. LI or heels. LPN-E a	2 p.m. R13 remained seated in a room, both of her feet/heels on the footrests of the sed practical nurse (LPN)-E om and R13 complained of pain and her left leg. LPN-E spoke g her pain and immediately left is heels remained on the heelchair, LPN-E did not offer to R13's heels. It p.m. LPN-E re-entered R13's with R13 about her complaints of oudly to LPN-E her feet hurt and were dying. R13's stocking is remained on the footrests of PN-E did not visualize R13's feet again left R13's room, she did sure relief for R13's feet.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION			E SURVEY IPLETED
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, Z 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 686	room and gave he medication was for R13's feet/heels of the will leave R13's room relief. Two Prevalet towards the end of towar	e.m. LPN-E re-entered R13's er two Tylenol, indicated the or R13's complaints of pain. emained resting directly on the neelchair. LPN-E proceeded to without providing pressure on boots remained on the floor of R13's bed. 5 p.m. LPN-E stated R13 was eff for ADL's. She stated she was current treatments or R13's feet/heels. LPN-E stated of pressure ulcers on her heels the pressure ulcers were still R13 did not use the Prevalon the to refusals and was unaware sure relieving interventions. 5 a.m. NA-J stated R13 wore the reliep pain and indicated R13 in issues. She stated she felt providing cares to R13. NA-J the felt once she had completed	F6	86			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION		E SURVEY IPLETED
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		281	EET ADDRESS, CITY, STATE, ZIP CODE 0 SECOND AVENUE NORTH ORHEAD, 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) COMPLETION DATE
F 686	bad ulcers on both she was not one his were still there. LPI who was responsible and further indicated director of nursing. On 3/9/18, at 8:12 wheelchair in her refeet/heels rested diswheelchair. At that the director of nurs room, and DON en measuring tape an indicated R13's heetimes. DON stated ulcer on her left he stocking from her left hard black tissue with placed the measuring mediately R13 styou touch those!" Due done shortly and on R13's left heel, measurements: 2.5 and 2.0 cm in width covered in eschare is hard or soft in test an in color, and masche confirmed R13 ulcer on her left heethe DON visualized DON removed the which revealed hard R13's heel. She cores are given by the land pressure ulcers at 1.7 cm. DON confirmed R13.	of her heels and further stated undred percent sure if they N-C stated she was unsure the for R13's skin assessments at it could be the facility's	F6	86			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONS			E SURVEY MPLETED
		245052	B. WING			03/	/13/2018
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		2810 SEC	ADDRESS, CITY, STATE, ZIP COI COND AVENUE NORTH HEAD, MN 56560	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	R13's stockings a R13's feet back of wheelchair. - At that time DOI heel pressure ulcollooked at it on 2/2 history of unstage visualized due to eschar. Slough; in green or brown tis stringy and mucin adherent to the body clumps throughout dead or devitalized texture; usually bin may appear scab are usually firmly wound and often pressure ulcers of she was aware R pressure ulcers. Since the progress note and had pressure ulcers of she was unaware notified of either of ulcers. DON states be off loaded at a boots or a pillow, expected staff to record anytime she wound assessme wound measurem	Ind Prevalon boots, placed into the footrests of the N stated R13's unstageable left er had worsened since she last 28/18. She indicated R13 had a rable (wound bed cannot be the presence of slough or on-viable yellow, tan, gray, issue; usually moist, can be soft, rous in texture. Slough may be rase of the wound or present in ut the wound bed. Eschar tissue; in the wound bed. Eschar tissue; in the dissue that is hard or soft in rack, brown, or tan in color, and like. Necrotic tissue and eschar adherent to the base of the the sides/edges of the wound.) in both heels. The DON stated 13 had an unstageable left heel the confirmed R13's 2/15/18, it stated she was not aware R13	F6	886			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION		E SURVEY PLETED
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATIO	N & HEALTHCARE CENTER		2810	EET ADDRESS, CITY, STATE, ZIP CODE D SECOND AVENUE NORTH ORHEAD, 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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Review of R13's for Flow Sheet, started in her office, a hand spaces for weekly following was listed an interference of the started in her office, a hand spaces for weekly following was listed an interference of the started of the	rm titled, Wound Evaluation of on 12/15/17, the DON stored of written flow sheet with wound measurements. The lit. If an unstageable ulcer of her asured 0.5 cm by 0.5 cm. The d R13's skin surrounding the intact and the wound margins wound evaluation flow sheet of intervention was foam seet. If R13's left heel pressure ulcer by 0.3 cm, wound margins he surrounding skin was intact, the current intervention was to R13's left heel pressure ulcer by 0.3 cm, wound margins he surrounding skin was intact r. R13's left heel pressure ulcer by 0.3 cm, wound margins he surrounding skin was intact r.	F 6	86			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY IPLETED
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		281	EET ADDRESS, CITY, STATE, ZIP CODE 0 SECOND AVENUE NORTH ORHEAD, MN 56560	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	were defined, sur form listed an interest to air. R13's wound evaluation of R measurements are relieving intervents. Review of R13's version found in the electronary in the electronary indicated the following 100% skin, periwes surrounding skin indicated the followere in place; R13's electronic Wound identify a pressure documentation of right heel and lactronary in the electronic wound in the electronic wound identify a pressure R13's electronic wound identify a pressure of R13's Review of R13's pay 18, revealed to the presence of R13's pay 18, revealed to the p	rounding skin was intact. The ervention to leave the heel open uation flow sheet did not include 13's right heel ulcer, and did not include any pressure ions for her heels. I wound evaluation flow sheet, ronic record, 12/15/17, revealed geable pressure ulcer on her was identified on 12/15/17. The flow sheet identified R13's right for measured 1 cm by 1 cm. The identified R13's pressure ulcer characteristic: wound bed was bound margins were defined, was intact. The flow sheet wing treatments/interventions 13 was to have a foam dressing try 72 hours, pressure tress and heel protectors. The Evaluation flow Sheet did not be ulcer on R13's left heel. I wound sheet lacked any further monitoring of R13's keed documentation of the selft heel pressure ulcer.	F 6	86			
	open to air. -12/15/17, R13 w	as seen by her primary and new orders were obtained					

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F 686	to apply foam dreevery 3 days and R13 was to have place. -12/29/17, R13's open to air. -1/18/18, a Brade identify risk for pr R13 was at low ri. - 2/15/18, R13's measured 2.3 ce had no redness or drawas purple in colomeasurements or R13 had Prevalor boots) on both of with scab intact with border of the noted, with surrout to touch. Right he scab intact, no resurrounding skin recommendation physician office of with resident's he Prevalon boots to On 3/9/18, at 9:00 reviewed with the medical record has a reoccurring unsurrounding unsurrounding unsurrounding skin recommendation physician office of with resident's he Prevalon boots to On 3/9/18, at 9:00 reviewed with the medical record has a reoccurring unsurrounding unsu	essing to both heels and change as needed. The note revealed pressure sore precautions in bilateral heels were to be left en assessment (tool used to essure ulcer development) listed sk for skin breakdown. right heel had an intact tan scab, ntimeters (cm) by 1.5 cm and or drainage. The note further off heel had an intact scab with ainage and the surrounding skin or. The note lacked f R13's left heel and indicated in boots (pressure relieving	F6	86			

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F 686	medical record had unstageable pression DON stated she were evaluation had be R13's right heel. The polyconfirm documentation of unstageable pression DON confirmed From prehensive a unstageable pression R13's medical recassessment or an unstageable pression would have experinterventions to be to prevent worser Review of R13's 2/16/18, included open to air every Wednesday, and However, the ord relieving interventheels. Review of R13's 8/30/17 to 12/15/15/15/17, R13 had (pressure) ulcer of 12/15/17, R13 had (pressure) ulcer of 12/15/17, R13 we follow up visit. The	ad identified R13 had an issure ulcer on her left heel. The was not aware a wound een completed on 12/1/5/17, for The DON confirmed R13 had e ulcers on both of her heels. Heed R13's medical record lacked f when R13's bilateral issure ulcers had healed. The R13's medical record lacked any issessments of R13's bilateral issure ulcers. She confirmed cord lacked a current my monitoring of R13' s right heel issure ulcer. The DON stated she coted pressure relieving e put into place routinely for R13 hing of both pressure ulcers. Current physician orders signed orders to leave bilateral heels shift, weekly skin check every document findings/refusals. ers lacked direction for pressure tions or treatments for R13's physician progress notes from 17, revealed the following; and a past history of decubitus	F6	86		

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F 686	Continued From pa	age 116	F6	86		
		racility staff to start dressing nours and to implement cautions.				
	interview with R13' MD-A stated she w to have current uns both of her heels in R13 had recurring heels and expected pressure relief for lindicated she expected offloaded, and if R2 boots she expected relief to be attempt aware R13 had esonor was she aware ulcers had increase unstageable pressivery deep and were	p.m. during a telephone s primary physician (MD-A), ras last aware R13 continued stageable pressure ulcers on a December 2017. MD-A stated pressure ulcers on both of her d facility staff to provide R13's feet/heels. MD-A cted R13's heels to be 13 refused to wear Prevalon d other methods of pressure ed. MD-A stated she was not char tissue to both of her heels, the the size of R13's pressure ed. MD-A stated she felt R13's ure ulcers were likely stage 4, e very painful for R13.				
	Treatment, revealed was to provide guide pressure ulcers and pressure ulcers. The guidelines for assect ulcers, pressure ulcers, pressure ulcers, pressure ulcers, interestment and infect definitions and despressure ulcers, interestrategies, documes supervisor any work refusals of interventions and assessment, monital interventions and assessment assessment and assessment assessment assessment and assessment assessment assessment assessment assessment a	policy titled Pressure Ulcer d the purpose of the policy delines for the care of existing d the prevention of additional ne policy identified general ssment of current pressure cer care, interventions, ction control. The policy listed criptions of all stages of terventions and care entation and reporting to sening a pressure ulcer or actions. facility staff to provide ongoing to oring and implement analyze interventions in order to factive pressure ulcers to				

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F 686 F 689 SS=J	of.	ning and/or new development lazards/Supervision/Devices	F 686		4/23/18
	system of accidents \$483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observative review, the facility comprehensive fall effective interventi implement intervention who had a history in laceration and refurther, the facility intervention which resulted in further practice resulted in The immediate jeowhen R1 had not be assessed for the refuse of self transfer and implemented and regional director of director of nursing immediate jeopard immediate jeopard 3/13/18, but nonco	resident environment remains that hazards as is possible; and resident receives adequate esistance devices to prevent entry is not met as evidenced entry, interview and document		This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to ensure environment that remains free of accidence hazards. Some of the many ways that has been done is by identifying hazard and risk(s), monitoring for safe environment and implementing immediate reventions when necessary. 2. When the surveyor noted R1 to have multiple floor mats covering floor surfait was determined that they were not u correctly. Immediate action was taken remove floor mats. It was noted reside had 3 falls 3/8/18 and none were addressed by nursing staff. It was	e an lent this (s) liate e sed to

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F 689	actual harm that is Findings include: R1's admission Mi 11/11/17, identified had diagnoses wh disease, dementia restlessness and a R1 required total a assistance with be toileting, personal MDS also identifie month prior to adn months prior to adn months prior to adn admission. The M 11/8/17. R1's Care Area As 11/14/17, indicated falls at previous liv admitted from an a and worsening of indicated R1 recei anti-anxiety medic disturbances in ba for falls and injury, had fallen since ad R1's Risk For Falls identified as comp R1 had a total risk indicated a total so resident at risk. No further fall asso clinical record nor	age 118 Inimum Data Set (MDS) dated d R1 had intact cognition, and ich included Parkinson's an anxiety, glaucoma, weakness, agitation. The MDS identified assistance for eating, extensive and mobility, transfers, dressing, hygiene, and did not walk. The d R1 had a fall in the last mission, a fall in the last plantsion, and no falls since DS did not identify R1's fall on assessment (CAA) dated d R1 had a history of numerous and facility and had been acute hospital after multiple falls Parkinson's disease. The CAA wed an anti-psychotic and facility, exhibited sedation, alance, depression, was at risk and R1's CAA did not identify he dmission to the facility (11/8/17). It is assessment, undated, ascore of 11. The assessment core of 10 or above deemed dessments were found in R1's provided by the facility.	F 689	determined R1 is high fall risk a interventions not in place to prefurther falls. Also noted no posiup to previous falls. 3.Fall assessment was comple immediately and follow up prodinto place 3/9/18 4.The director of nursing along therapy reviewed the need for a devices by R1 and determined were not safe on floor in reside and agreed based on completion risk assessment by DON on 3/ and OT would re-evaluate R1 for therapy goals and/or intervention ensure safety. 5.Immediately 1:1 put in place evaluation could determine best care. A fall analysis was complimoted most falls between 8:30-Resident states often feels like to do something. Also noted the behaviors increase as do his tractional during this time. Both are belied conversation with resident that tired of sitting. 6.Staff will be encouraging should dining table 3x/day to meals an resident sit in regular chair as a process allows and until therapic completes working with him to update safe walking guidelines also will encourage after break activities to increase focused sas resident will allow. 7.Falls, bowel and bladder, aim and ADL assessments update 8.To enhance currently compliate operations and under the direction.	event if fall follow ited less put with lessistive floor mats int room on of fall lessistive floor mats int le	

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F 689	high risk for falls redeconditioning, gair unaware of safety monitor for risk of fivarious intervention R1 to call for assist encourage R1 to strunsteady and flailing sit with R1 when has movement and nor up in wheelchair, ereach and encourage as needed, provide requests for assistat transfer and ambult In addition, R1's caself movement to fland expressed suit provide mats to fact while sitting and lying directed to utilize a the floor on either should be decorded and place pathe bed. Further, R1's care pathe bed. Further, R1's care pathe anti-anxiety medication monitor R1 every she anti-anxiety medication with an increased rof balance, and coglooked like dement broken hips and leg monitor for adverse medications which reflexes, confusion	3/6/18, identified R1 was a lated to confusion, t/balance problems and needs, had Parkinson's and alls. R1's care plan listed as which included: encourage cance before getting up, ay in his room when he is ag all over the place, have staff aving involuntary muscle a-compliant, monitor R1 while insure R1's call light was within age R1 to use it for assistance a prompt response to all ance. R1's care plan lacked	F 6	,	3/9/18 on ccident phasized fall, where tance of accidents. ice was ation staff s, analysis entions. All d, ensured has been nitions put niting them was oleted on nt reviewed was nt just ye around. e for better alls will be up for full eviewed by n R1 d bigger nt able to dle of goals for updated eassurance der the ursing to	

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F 689	impulsive behavior Review of untitled nursing assistant of directed staff R1 reassistance and gaistaff for activities of and R1 was alert whowever, the form floor mats, and lace On 3/6/18, at 3:17 his back in bed. Reflead or footboard corner of the room wall and the entire wall. On the wall new was a tan, beveled started just below wall approximately the attached fall meduct tape that had attached to the wabed a second tan, was observed on the fall mat on the flootbath had a second of it, that continue touch the wall, leaver from the bed to the was clipped onto a mounted light approximated light	· •	F6	689	12. The director of nursing or design will audit R1 environment and safe fall reports, ensure post fall comple and care plan up to date; daily on APM shift for 2 weeks, 3x/week for 2 weeks, weekly for 2 weeks and the monthly for 6 months to ensure compliance. R1 has been audited for cares, falls and interventions for saper previous plan of correction. Log been in place to ensure ongoing compliance and correction has been sustained 13. Any deficiencies will be corrected the spot, and the findings of the quality-assurance checks will be documented and submitted at the rough meeting for further review or corrective action. Policy on fall assessments, use of floor mats and have been updated. 14. The DON is responsible for this	ty, all ted M and n or fety gs have an on don	

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F 689	knee when he fel up his pant leg to brown scab to just On 3/6/18, at 3:4: (LPN)-E confirmed the wall light pull LPN-E stated R1 staff also position of R1's room for its of R1's room for its seated in the wheelchair was parts facing the toclipped to a pillow R1 stood up from closet and then warm. R1 walked owheelchair and s	ell. He stated he landed on his I, lifted his right leg and pulled or reveal a golf ball sized dry, st below the right knee. 2 p.m. licensed practical nurse ed that R1's call light clipped to string was not in reach for R1. did use call light at times, but need the medication cart outside increased supervision. O a.m. R1 was observed to be elechair in his room. R1's cositioned with wheels next to fall elevision. R1's call light was won his bed, not within reach. In wheelchair and walked to his walked into his bathroom. At 9:35 but of the bathroom to his at down abruptly. He then elechair using his feet, out of his	F6	89			
	his feet to propel back to his room from his wheelch of the fall mat the down on the edge immediately stoot an fall mat and the wooden arm chair maroon fall mat a of the wooden chassistant (NA)-le proceeded to chadid not attempt, r	As a.m. R1 was observed using his wheelchair down the hall after a shower. R1 stood up air and walked over the corner at was closest to his bed. He sat se of the foot end of his bed, d back up, and walked over the hen the maroon fall mats to a fir that was positioned on the and stood holding onto the back rair. At 6:17 a.m. nursing entered R1's room and ange the linen on R1's bed. NA-lator offer assistance with R1's valked on top of the maroon fall					

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F 689	mat to his closet, a bathroom. NA-I lef 6:19 a.m. R1 rema At 6:24 a.m. R1 wa wheelchair and sat At 6:26 a.m. R1 se wheelchair and wa into the bathroom. the bathroom, betworner of his bed, cof his room where positioned on top owater mug off of the mats around the lesat down. At 7:21 a wheelchair, walked over-the-bed table to his wheelchair. Fedge of the maroor forward two steps a using his right arm	Ind then walked to the it R1's room and returned at ined standing in the bathroom. Alked out of the bathroom to his down. NA-I exited R1's room. If transferred from his liked to his closet, and walked At 6:30 a.m. R1 walked out of ween his wheelchair and the onto the fall mats to the corner an over-the-bed type table was of a fall mat. R1 grabbed his e table and walked over the fall fit side of his wheelchair and a.m. R1 stood up from his lover the fall mats to the and then starting walking back R1's left foot caught on the floor mat and R1 stumbled and then caught his balance to brace on the back of his ked around the side of the	F6	589		
	supervision for trantoilet independently bathroom with R1, NA-I stated R1's arkind of day R1 was a good day he coul a bad day he requistated she felt R1 stated the fall mats to prevent injury why gray duct tape attabed used to hold a stated when R1 ha	a.m. NA-I stated R1 required asferring. NA-I stated he could y, but she stood in the because he could get "jittery." abulation depended on what having and indicated if it was ad walk on his own and if it was red extensive assistance. NA-I was having a good day. NA-I were on the floor in R1's room then R1 fell, and the looped ched to the wall above R1's nother fall mat to the wall. She d a bad day he would be on throw himself onto the floor				

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F 689	on the mats. NA- once a week. NA instructed staff to and a gait belt. N been on the floor Continual observe from 8:42 a.m. to -At 8:42 a.m. R1 of his low bed wit along side his boy backwards onto t up an down unco medication aide (doorway by the m R1's room or offe had offered R1 a he refused. TMA- needed Ativan (and -At 8:47 a.m. R1 arms continued to walked past R1's kiosk. NA-A brieff turned and looked immediately return continued to ente sporadically turn the kiosk. -At 8:49 a.m. R1 with the same un stopped charting, room again. TMA past R1's room, lo	le movements and flop around I stated R1 had "bad days" about a stated R1 had "bad days" about a confirmed R1's NA care sheet transfer R1 with one to two staff A-I stated R1's floor mats had "all the time." ations was conducted on 3/8/18, 9:20 a.m.: was seated on the foot end edge h his arms flailing up and down dy. R1 abruptly threw himself he bed, and arms were moving ntrollably. NA-I and trained TMA)-A stood outside R1's nedication cart and did not enter r assistance. NA-I stated she massage to help calm him and A stated she gave R1 an as ntianxiety medication) just prior. Temained on his back and his or move uncontrollably. NA-A room towards a wall mounted by stepped back from kiosk, dinto R1's room and and to using the kiosk. NA-A r data into the kiosk, and and look at R1, and then using continued in the same position controllable movements. NA-A turned and looked into R1's -A pushed the medication cart booked into R1's room as she er NA-A or TMA-A entered R1's	F6	89				

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F 689	-At 8:51 a.m. R1 s leaned back with the floor, as his al uncontrollably. NAR1's room, briefly exited the room wassistance and reserved the room wassistance and reserved the uneven fall on the floor mats, reached out with I wooden arm chair the floor onto his wooden chair. NAR1's fall. NA-A wastated R1 fell ofter mats are there." Not the wall kiosk. I uncontrollable morocked his trunk be wooden chair and arm movements a proceeded to star fall mats to the formal mats are the formal mats are the formal movements in his and forth on his benefity entered R1R1 stood up again walked back to the sufficient of the fall with uncontrolled and an unsteady surface of the fall	sat on the edge of mattress, legs straight, with his feet flat on the continued to move A-A left the wall kiosk, entered visualized him and immediately without offering or providing turned to wall kiosk. Stood himself up, walked on top mats, towards the wooden chair turned and lost his balance. He both arms for the back of the rest to steady himself, but fell onto right side holding onto the A-A was immediately informed of alked to R1's doorway, looked in, in and stated, "that's why the NA-A immediately walked back R1 sat up and continued to have evenents of upper arms as he back and forth. R1 grabbed the altipped it back upright with jerky and with an unsteady gait and up and walk over the uneven on the end of his bed and sat down. Continued to have uncontrollable arms and rocked his trunk back ed. NA-A left wall kiosk and "s room and exited the room. In, and with an unsteady gait, e wooden chair on the fall mats. Abruptly stood up from the chair, arm movements, shuffled feet gait, walked on the uneven mats, then onto the floor to his informed R1 was standing	F6	889		

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MOORHI	EAD REHABILITATI	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560				
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F 689	independently. Na asked if he was a bed, and threw hi the mattress, and NA-I walked out on the like it if he the NA-I then entered -At 9:01 a.m. R1 down to the foot with arms moving closest to R1's be an angle, leaving inches. R1 rolled down onto the fall laid down on his in on the floor mats. At 9:0 resident's room a transferred to the from his door way R1 remained sea with his shoulders -At 9:17 a.m. R1 chair, took two states then fell forward, NA-I was present NA-A entered R1 NA-I. R1 kicked if momentum to ge edge of his bed. If mat next to his be wooden arm chaif fall backwards to R1 fell to a seate NA-I braced R1's	page 125 A-I entered R1's room and alright. R1 walked towards his imself onto his bed, bounced on I ended up lying on his left side. Of R1's room and stated R1 did bught she was watching him. I danother resident's room. sat himself up in bed and moved end of his bed. He remained the end and rocked back and forth grup and down. The fall mat end had slid away from the bed at a gap of approximately 6 his hips to the right and sat I mat next to his bed. R1 then right side and rolled side to side and then sat up, seated on the 2 a.m. NA-I exited another and surveyor notified her R1 self afloor mats. NA-I looked at R1 y, but did not go into his room. It do not the floor on the fall mats, as rocking side to side. stood up from the wooden arm the eps forward towards his bed and landing abruptly onto his bed. It in the doorway of R1's room. It doorway and stood next to his legs to get enough to a seated position on the side R1 then stood up on the floor end, started to walk towards the fir, turned around, and started to wards the metal heat register. It doos to keep him from falling seated position and NA-A exited	F6	689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245052	B. WING			03/	13/2018	
	PROVIDER OR SUPPLIEI	ON & HEALTHCARE CENTER		2810	EET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE NORTH DRHEAD, MN 56560	,		
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F 689	the room to updat seated on the flood back facing the classated position whehind him. NA-I supporting his upporting interview of stated she felt R1 not have a set particularly mover days. TMA-A state movements got resit with him one owere to "one to or specific directions for him. TMA-A state when stated she felt R1 purposefully to be on 3/08/18, at 9:5 fall risk and she with the past. and bad (referring She stated R1 had 2-3 days, and state when staff tried to R1's movements then he would sit bed in his room.	or next to his wheelchair with his oset. He braced himself in the lith his arms stretched out was next to R1 on the floor	F6	889				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245052	B. WING		03	/13/2018
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	stated R1 had a I Parkinson's disea abnormal movem discharged from fall risk and due to the should never to PT-A stated R1 cday, and require to stand the next R1 self transferre he was having a do things on his compartment of the movement of the movement of the movements, he cand go to the bat supervision. NA-but he would cate stated the fall mat been down on the On 3/08/18, at 10 R1 could transfer R1 had fall mats for safety. LPN-Ca a lot of involuntar administered the Ativan did not con	as no longer in therapy. PT-A ot of limitations due to his ase and was having more nents and impulsivity so he was therapy. PT-A stated R1 was a o R1's balance and judgement transfer or ambulate on his own. Ould walk independently one maximum assistance of two staff day. PT-A stated she was aware and quite frequently, especially if good day and thought he could own. 2:37 a.m. NA-A stated R1 had ments almost daily, with some ents were constant and other ents were off and on. NA-A was not having involuntary could transfer, walk in his room throom independently or with A stated R1 "almost" falls a lot, ch himself on objects. NA-A its in R1's room had "always" end floor. 2:54 a.m. LPN-C stated she felt and ambulate independently. On the floor and wall next to bed a stated if R1 was noted to have by movement, he was as needed Ativan and if the natrol the movements, a staff with him. LPN-C stated she was	F 6	89		
	R1's Parkinson's	:00 a.m. LPN-I stated she felt disease had been getting experienced a lot of falls at home				

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F 689	had "good days" a on R1's "bad days movements. LPN-be by himself and assist him. She st movements staff t stated R1 utilized not always effective because he would confirmed she was On 3/8/18, at 12:2 (DON) stated R1 If fall risk was "really was aware R1 has sometimes once a supervision with R1 the 1:1 supervision movements began within arms reach himself. The DON and R1 was not sa independently. DO reports, the first reand confirmed a reafter each of R1's incident reports had confirmed a reafter each of R1's incident reports had assess R1's windicated R1 had R1's fall with the of she would expect for R1 right at the	red to the facility. She stated R1 and "bad days." She indicated "he had a lot of involuntary I stated she felt R1 preferred to would get angry if staff tried to ated when R1 had involuntary ry to get him to his room. LPN-I as needed Ativan which was re and used the fall mats I crawl out of bed. LPN-I as not aware R1 had fell today. 5 p.m. director of nursing had Parkinson's disease, so his re high." The DON stated she dinvoluntary movements a week, and staff provided 1:1 at. She stated she would expect the to start when R1's involuntary in and would expect staff being of R1 so he did not fall and hurt stated R1 self transferred a lot afe to transfer or walk DN reviewed R1's fall incident export completed on 12/13/17, export should of been completed falls. She confirmed no fall and been completed for 3/8/18. 1 p.m., during a follow up onfirmed R1's incident reports I did not include a post fall nine the root cause of his falls, whole situation all together. She denied falling this a.m. and felt thair "concerning." She stated staff to initiate 1:1 supervision start of his involuntary continue the entire time he had	F6	89				

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	DDE		
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F 689	there were to be on more on his floor. Scould be considered she maybe would on to the floor in the further was to run in the hall as wheelchair and later report identified R1 went on, alert to se situation and conditusually in that unco time. The report indentificated R1 was on the report indentificated R1 was on the report indentified R1 went on, alert to se situation and conditusually in that unco time. The report indentificated R1 was not following the difficult to redirect. Was wheelchair at all timindicated R1 was occurred very rapid injuring self and oth assistance within the control of the co	indicated she understood e fall mat on R1's wall, and 3 the indicated the fall mats d an added fall risk and stated onsider securing the fall mats ture.	F 68	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245052	B. WING			03/	13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		2810	ET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE NORTH PRHEAD, MN 56560			
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F 689	-12/17/17, at 8:45 a cushion edge in the very sudden, strong movement and fell on his knees. R1 depurple/brown bruise lacked any further i the fall. -12/29/17, at 10:46 pushing his empty and hit his chest on the floor. The reporneeded Ativan at 8: no injuries observe x-ray was ordered rindicated R1 was o to walk with staff. Trugs/carpet, gait im without assistance were predisposing lacked an analysis -12/29/17, at 11:50 walk with R1 in hall as R1 would not all having frequent invand would not sit defour wheeled walke of fire door, the door report indicated R1 right knee, right fifth side by hip. The regincontinent, had ga and Parkinson's dishad improper footw	a.m. seated on wheelchair dining room, when R1 had a ginvoluntary muscle off his wheelchair and landed enied pain and had a large to right knee. The report information, or an analysis of a.m. R1 exited his room wheelchair, stumbled forward a medication cart and fell to to it identified R1 received an as 00 a.m. R1 had no pain and dipost incident, but a chest related to the fall. The report riented and was encouraged the report further indicated balance and ambulating pushing an empty wheelchair factors to R1's fall. The report of the fall. a.m. NA was attempting to way with wheelchair following ow staff to assist. R1 was coluntary muscle movements own in wheelchair or walk with the R1 attempted to grab a hold or closed and R1 fell. The sustained an abrasion to his in finger, right knee and left cort indicated R1 was alert, it imbalance, impaired memory sease. The report listed R1 rear and ambulating without cort lacked an analysis of the	F6	89				

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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ODE			
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F 689	room, fell into the to the wall. R1 had his forehead and report indicated R as needed Ativan agitated and unable movement in his a indicated predisport mats on R1's floor involuntary mover report lacked an analysis of the whole of the wall of the whole of the wall of the whole of the wall of t	m. un-witnessed fall in his corner of the register attached d a red mark on the left side of a scratch to his left knee. The 1 was alert and oriented, had prior to fall because he was let to control involuntary arms and legs. The report osing environmental factors of r, R1 was unable to control ments and gait imbalance. The malysis of the fall. a.m. R1 slide on his buttock air. The report indicated no and R1 was unable to state what was confused most often, did able to explain accurately. The 1 was able to propel himself in and from dining room and walk or mroom to bathroom. The 1 was confused, had gait temory impairment. The report	F6	89				

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F 689	experiencing frequency movements. The fall. Review of R1's pr 3/8/18 revealed the substitution of R1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	inson's disease and was uent involuntary muscle report lacked an analysis of the ogress notes from 11/1/17 to be following: I to facility with diagnoses which on's disease, anxiety and navioral disturbances, mood		689				

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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		2810 S	T ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE NORTH RHEAD, MN 56560			
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F 689	understanding but -12/5/17, 4:50 a.m extremities noted, padded floor, back body against padde evaluation. The note facility at 10:00 a12/12/17, 9:13 a. self ambulating with the same of the self ambulating with the same of the self ambulating with the self ambulating as self ambulating with the self ambulating as self ambulating with the self ambulating with the self ambulating as self ambulating with the self ambulating as self ambulating with the self ambulating wi	and add not follow through. In exaggerated movement of bouncing off of bed onto keep to bouncing on bed, hitting ded walls. R1 sent to hospital for one indicated R1 returned to m. with no new orders. In very agitated this morning, with front wheeled walker (FWW) itent involuntary movements afe. NA attempted to ambulate every angry and started to bang and and attempting to strike in on his bed and was able to in., staff educated him on the him safe and staff needed to atton when his is having any movements. R1 verbalized In R1 in room throwing stuff another, moved bed to another allow staff to go near him, left all as staff ran behind him with the fell on floor 3 times. No injuries in extreme Parkinson shakes as, bouncing on matted floor and all, instructed NA to watch R1 safe. At 12:38 p.m. frequent in movements, combative with lift on bed and kicked staff. In the prediction of	F6	89				

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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, S 2810 SECOND AVENUE I MOORHEAD, MN 565	NORTH			
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F 689	forward with chair he chest x-ray ordered -1/17/18, 9:47 a.m. assistive devices winvoluntary muscle assist to sit in whee and swung self aro injury noted. R1 ediambulating per self under control so he -2/17/18, 12:40 p.m. here and there, unagiven direction, as medication given, s resumed agitation a -3/8/18, 2:18 p.m. r in room he started lowered him to groufirst, R1 had been a uncontrolled mover anti-anxiety medication given of R1's PT Discharge Summan 11/7/17 and end of R1 had diagnoses on walking and unstabeen discharged frowariability in his modoses, at times tare functional moveme bradykinesia limits and at times R1 coincluding walking unwheeled walker with	nitting chest and fell to floor, I, negative for fracture. , ambulating per self with no hile having frequent, moments. Staff attempted to elchair, became very agitated and and fell on buttocks, no ucated on importance of not a until muscle movements a does not fall and hit his head. In agitated, moves his body able to concentrate or focus on needed anti-anxiety seemed helpful for an hour and again. The ported to writer when R1 was to fall and staff caught him and and with butt touching floor anxious this a.m. with lots of ments, received as needed	F 6	89				

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CI 2810 SECOND AVEN MOORHEAD, MN	IUE NORTH		
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F 689	presenting with der recommendations it tasks and general son the unit in his whattempting to self to Review of R1's OT Discharge Summar and end date of 12 included Parkinson The summary listed significant weakness the use of Parkinson required supervisio and functional transsafety and level of medication schedu. On 03/09/18, at 08: of clinical services unsure when the flot the 5 fall mats were not to be used on Felt R1's family was with previous nursing instead of nursing a the "unpreventable On 03/09/18 at 10:: manager (TPM) staffom therapy on 12 up meeting for falls on the wall, removal and dycem in the wind She confirmed ther recommendations is stand up meeting, a	mentia. The summary included for assist of 1 for all mobility supervision while R1 mobilized heelchair due to history of ransfer. Therapist Progress and ry with start date of 11/7/17 /1/17, listed diagnoses which 's disease and repeated falls. d R1 was a fall risk, had ss/balance concerns without on's disease medications, n/assist with standing ADLs afers/ambulation to ensure assist dependent on le. 59 a.m. the regional director (RDCS) indicated she was not mats were placed, but felt are placed on his wall and were read in the choices of making a lot of the choices of home administration and therapy trying to prevent in the placed on his wall and were read at the regional director in the choices of home administration and therapy trying to prevent in the standard therapy trying to prevent in the placed R1 had been discharged in a standard right after that, the floor mats all of head board and foot board wheelchair were placed for R1.	F 6	39			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, Z 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	IP CODE		
(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 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	On 3/9/18, at 10:36 mats on the floor hadmission, and stathe mats and tell the staff "that is not a fisure if finding a resewould be considered. On 03/09/18, at 11 (MW)-A confirmed mats had been plaremembered the semat on R1's floor with the wall in R1's room Christmas." On 03/09/18, at 12 interview, nurse properties, nurse properties, nurse properties, and Aspergers (broom a leads to problems to coordination). She verbalizing his need communication was could be helpful for staff's approach with staff needed to know the had increased to make the facility shown he had increased the facility shown he	age 136 S a.m. NA-N stated R1's fall ad been present since ted staff sometimes find R1 on the nurse, and the nurse tell all." She stated she was not sident on a fall matt on the floor and a fall for the resident. OR a.m. maintenance worker he was aware when the floor ced on R1's wall and stated he econd MW-A standing on a when he had placed 2 mats on m, "sometime before CO3 p.m. per telephone actitioner (NP)-A stated R1 had e, gait disturbance and had utism" and indicated she felt R1 with social skills, behavior, and indicated R1 had a hard time ds and his interpersonal as difficult. NP-A indicated 1:1 rR1, but it depended on the th him. She indicated she felt tow how to interpret R1 and IP-A stated she felt the mats if he was not in lying in bed, and not have a mat on the floor ased involuntary movements SO p.m. a group interview was DON and RDCS. The Parkinson's disease and lewy wever, denied R1 had a n. DON indicated there was no	F 6	89			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 689	the building" and we R1's cognition and felt this was consisted dementia diagnosis unsure when the fa R1's room, but felt to R1's room to pro DON and RDCS codocumentation of a lacked documentat assessments since facility's computer sto remember to cort to a 2 step procedu form. The DON state analysis of R1's fall fall assessments or after each fall. The report his falls consclinical record could of his falls. The DO lack of fall assessments or analysis after each the risk for falls for	s, and stated he fell "all over as impulsive. They verified mobility varied frequently, and tent with his lewy body s. The indicated they were II mats had been placed in that therapy had brought them tect him from the walls. The onfirmed R1's record lacked ny analysis of his falls and ion of any further falls admission. They indicated the system made it difficult for staff inplete a falls assessment due re to access the electronic ted she would expect an after each fall and complete in admission, quarterly and RDCS confirmed R1 did not sistently and confirmed R1's id not be accurate to include all N and RDCS confirmed the nents, completion of post fall and the fall mats increased	F	389				
	to visit R1. He state been on the floor, o	ed he knew the fall mats had covering the area from his bed etty much" since he was						
	3/13/18, at 2:00 p.n	on 11/23/17, was removed on nowhen the facility oval plan which included:						
		prehensive fall assessment ed analysis of patterns for falls						

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(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 C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	and causative factors. Removing the muroom and floor to be lighting; Developing individe which included PT supervision with spreading to a proper medication for agits R1's individual behand use of a bariat working, reachable position at night; Education of staff specific care plan is conduct an appropulation. Implementing audinterventions were staff. On 3/13/18, from 1 staff were interview received education interventions which mats from R1's root 1:1 supervision for medications, the dereport a fall to, and	ualized fall interventions for R1 evaluation, the use of 1:1 ecific directions for how to rision, use of as needed ated episodes, identification of aviors as related to his falls, ric bed in center of room, call light, and bed in low on what a fall was, on R1 interventions, and how to riate 1:1 session for R1; dits to ensure R1's fall consistently implemented by 2:44 p.m. to 1:29 p.m. nursing red and verified they had regarding R1's new care plan included removal of floor om, how and when to conduct R1, use of as needed efinition of a fall and who to changes to R1's bed.	F 6	89		
	1:1 supervision for medications, the dereport a fall to, and Observations were implementation of R1. A facility provided p	R1, use of as needed efinition of a fall and who to				

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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	consultant pharma will seek to identify factors for falls. The record would be reespecially falls in tor periodic bouts of assessment would care. The policy furth medication or combe reviewed that of staff will look for experience to falls be used to identify that may increase staff would evaluate factors that may in ambulation, mobili motor activity, ADI continence and condentify environment of falling and identifications or sequences of modifiable. Bowel/Bladder Inc.	acist, therapy staff, and others of and document resident risk are policy indicated a resident's eviewed for history of falls, the last 90 days and recurrent of falling over time and the fall determine the resident plan of rther indicated a resident's bination of medication would ould relate to falls or fall risk, widence of a possible link of falling and recent changes luate vital signs, medical ory impairments that may. The assessment data would underlying medical conditions the risk of injury from falls. The te functional and psychological crease fall risk, including ty, gait, balance, excessive capabilities, activity tolerance, gnition. The staff would seek to ntal factors that may contribute ify and address modifiable fall erventions to minimize the risk factors that are not	F 6			4/23/18	
99=D	resident who is co admission receive maintain continent	nence. facility must ensure that ntinent of bladder and bowel on s services and assistance to ce unless his or her clinical omes such that continence is					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245052	B. WING		03/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
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F 690	§483.25(e)(2)For a incontinence, base comprehensive assensure that- (i) A resident who indwelling catheter resident's clinical or catheterization was (ii) A resident who indwelling catheter is assessed for rer as possible unless demonstrates that and (iii) A resident who receives appropria prevent urinary traccontinence to the estimated states and (iii) A resident who receives appropria prevent urinary traccontinence to the estimated states and (iii) A resident who receives appropria prevent urinary traccontinence to the estimated states and receives appropriarestore as much no possible. This REQUIREME by: Based on observative the facility follower incontinence assessments.	resident with urinary d on the resident's sessment, the facility must enters the facility without an is not catheterized unless the ondition demonstrates that a necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder the treatment and services to cottinfections and to restore extent possible. The resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel the treatment and services to formal bowel function as NT is not met as evidenced tion, interview and document ailed to accurately conduct a not in order to develop a toileting entinence for 1 of 1 resident	F 690	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submi of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet	the dission or that of
	had severe cognitive	dated 12/26/17, identified R13 ve impairment and had acluded dementia, anxiety,		requirements established by state federal law. 1.It is the policy of the facility to proincontinence care to all residents with the federal law.	ovide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COI		13/2010
		ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	5 L	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 690	restless leg syndridentified R13 requestivities of daily I mobility, transfers identified R13 was on a toileting program R13's annual Car 12/26/17, identified non-Alzheimer's opsychotic disorde impairment, requivant ADL's including by transfers. The CA make her needs and CAA revealed R1's however did not intoileting program. Review of R13's recomprehensive by completed within R13's care plan rehad a self care deassistance from fapersonal hygiene two staff with toile identify R13's uring A group one nursing 3/6/18, revealed Fassistance of one The care guide ditoileting every two two assist.	ome and psychosis. The MDS uired extensive assistance with iving (ADL) including bed and toileting. The MDS s continent of urine and was not	F 69	need it based on bowel and be assessment and offer option program or continence progratis able. One of the many way has been achieved for reside reviewing bowel and bladder cognitive ability to cue or toile functional ability. After survey R13 was confused and consist was determined a new procest be developed to prevent incremoisture to resident with impaintegrity and to meet basic neclean and dry. R13 noted need extensive A2 with toileting and No toileting program was in proposed be developed to determine resid On 4/4/2018 bowel and bladder assessment completed, and staff interview completed, and staff interview completed. Reto have incontinence. Can vere at times to use bedpan due to fluctuations staff to check and every am, after meals and be check at midnight and determany appropriate check and change. Care sheets and care plans used. Because all residents are rehave toileting assessments a re-evaluated regularly, and more changes in overall condition apotentially affected by the cited DON reviewed with staff appropring programs for residents they of find saturated in bed or whee current residents assessed for via bowel and bladder assessed for via bowel and bladder assessed.	of toileting am if resident is that this in #13 is by patterns, it and overall noted the stently wet it is needed to be directly and noted resident and is ident noted resident and is ident noted resident and is ident noted resident and in in it is needed and in in it is not	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		, ,	(X3) DATE SURVEY COMPLETED	
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cility staff for all of her ADL's essing and grooming. LPN-E consistently incontinent and as on a routine check and in incontinence and should be hours. a.m. R13 laid in bed on her toovering her from chin to her sistant (NA)-J entered R13's blanket over R13 and to remove her pajama NA-J stated she was surprised ants on, as she usually did not an endown to her left side, which soaked disposable blue chux ath blanket. R13's buttocks she white and had deep ridges at pad. NA-J then proceeded to bock and peri-area, applied a R13's buttocks, donned a red the two blue urine soaked laced them with three clean ux pads. NA-J covered R13's tand exited R13's room. a.m. NA-J stated R13 required th all cares, including cking and changed every two nec. NA-J stated she was en R13 was last checked and ted R13 was usually and indicated R13 did not	F 69	check and changing have ber place. Care sheets updated a plan. No other residents were The policy on toileting – bowe bladder assessments has be 3. To enhance currently comproperations and under the director of nurses, on 4/4/201 received in-service training for toileting, incontinent care, chechange and importance of cleto prevent alterations in skind training emphasizes the importance of cleto prevent alterations in skind training emphasizes the importance of cleto prevent alterations in skind training emphasizes the importance of cleto prevent alterations in skind training emphasizes the importance of cleto prevent alterations in skind training emphasizes the importance of cleto prevent alterations as they their care but ensure staff interesident unable to complete their own. Educated on approassessing toileting needs and interventions. 4. Effective 4/4/2018, a quality program was implemented unsupervision of the director of monitor residents with impair integrity and updating MD, fare plans with any changes to enappropriate follow through. To find nurses or designated quality representative will perform the systematic changes: the DON will audit 5 residents bowel and program in conjunction with a and interventions 2x per week to ensure toileting plan or checking program appropriate residents. Any deficiencies were sidents. Any deficiencies were sidents.	and care a affected. el and en reviewed. liant ection of the 8 all staff or appropriate eck and ean dry skin integrity The ortance of age residents can with ervene when oasic ADL on opriately diappropriate or assurance inder the nurses to ed skin mily and care sure the director ty-assurance e following or designee ind bladder issessment is for 3 weeks for 3 weeks for 3 weeks eck and for the ill be		
	IDENTIFICATION NUMBER:	A. BUILDIN 245052 N & HEALTHCARE CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 142 Cility staff for all of her ADL's essing and grooming. LPN-E consistently incontinent and as on a routine check and or incontinence and should be hours. a.m. R13 laid in bed on her t covering her from chin to her sistant (NA)-J entered R13's blanket over R13 and t R13 to remove her pajama NA-J stated she was surprised ants on, as she usually did not n. R13's pajama pants and ere both saturated with n-J confirmed was urine. NA-J n to her left side, which soaked disposable blue chux ath blanket. R13's buttocks sh white and had deep ridges at pad. NA-J then proceeded to bocks and peri-area, applied a R13's buttocks, donned a act the two blue urine soaked laced them with three clean ux pads. NA-J covered R13's t and exited R13's room. a.m. NA-J stated R13 required th all cares, including cking and changed every two nce. NA-J stated she was en R13 was last checked and ted R13 was usually and indicated R13 did not	A BUILDING 245052 B. WING STREET ADDRESS, CITY, STATE, ZIP COT 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) F 690 F 690 Check and changing have bee place. Care sheets updated a plan. No other residents were a plan. No other residents and the director of nurses, on 4/4/201 received in-service training fo toileting, incontinent care, che change and importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasizes the importance of cle to prevent alterations in skin it training emphasiz	DENTIFICATION NUMBER: 245052 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		E SURVEY PLETED
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F 690	On 3/8/18, at 6:50 required extensive with ADL's which hygiene and check indicated she check and changunsure if R13 was as usually compounded on 3/9/18, at 8:40 (DON) confirmed staff to assist R13 She confirmed R R13's continence to maintain continexpected staff to included incontine was unlikely R13 brief or her chux checked and chashe did not routing the staff to included incontinexpected staff to included incontinexpected staff to included incontinexpected and chashe did not routing the staff to include t	page 143 8 a.m. LPN-C stated R13 re assistance from facility staff included grooming and personal ck and changed for incontinence. re thought R13 was assisted to re every 2-3 hours but was re ever continent. She stated R13 re ever continent. She stated R13 re plan directed facility re with grooming and toileting. re re plan did not address re or identify R13's toileting needs rence. The DON stated she rence cares. She stated she felt it re would have soaked through her re pads if she had been routinely re resident bladder re was unsure of when R13 was	F6	documented and submitted quality-assurance committed further review or corrective 5.DON will be responsible	ee meeting for action.	
	extensive assista grooming and toil required checking every 2-3 hours.	9 p.m. NA-C stated R13 required nce with ADL's including leting. NA-C indicated R13 g and changing for incontinence She further indicated R13 was we when assisting with cares.	h ADL's including NA-C indicated R13 hanging for incontinence ther indicated R13 was			
	confirmed she had MDS and confirm being continent of program. MDS coresponsible for coquarterly and anni	2:20 p.m. the MDS coordinator and completed R13's most recent need R13 had been identified as f urine and was not on a toileting coordinator stated she was completing facility residents and assessments which would ssessments. MDS coordinator				

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH 100RHEAD, MN 56560		
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F 690	bladder assessme was unaware of ho with toileting and/o	nedical record lacked a recent nt. She further confirmed she ow facility staff assisted R13 r checking and changing.	F 690			
	Nutrition/Hydration CFR(s): 483.25(g) (Section 1984) 483.25(g) Assisted (Includes naso-gast both percutaneous percutaneous endocenteral fluids). Bast comprehensive as ensure that a reside (Section 1984) 483.25(g)(1) Mair of nutritional status desirable body weighbalance, unless that preferences indicated (Section 1984) 483.25(g)(2) Is of maintain proper hy (Section 1984) 483.25(g)(3) Is of there is a nutritional provider orders at the This REQUIREME by: Based on observative review, the facility for the control of the control	Status Maintenance (1)-(3) Ind nutrition and hydration. Instric and gastrostomy tubes, endoscopic gastrostomy and poscopic jejunostomy, and sed on a resident's sessment, the facility must ent- Intains acceptable parameters as, such as usual body weight or ght range and electrolyte the resident's clinical condition this is not possible or resident the otherwise; Intered sufficient fluid intake to dration and health; Intered a therapeutic diet when all problem and the health care	F 692	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists cone was cited correctly. This Plan Correction is submitted to meet	the ssion or that	
		,		admission that a deficiency exists of	of	

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F 692	R50's Admission indicated the diag (inflammation of the surgical colostom Minimum Data Seindicated R50 was used to be a ceeping a protein R50 stated he find days ago. On 2/8/18, the processed recommendation request for "1 oz recommendation post-surgical color (protein). R50 has indicated R50 was on the low end of R9's primary physical recommendations 2/9/18: "1 oz Liquing was entered into with an order data 2/10/18. On 3/8/18, a review medication admir February 2018, rehad been initiated through 2/28/18, The eMAR for Market R50 was entered into with an order data 2/10/18.	Record (print date 3/9/18) gnoses of peritonitis the abdominal lining), and post by placement. R50's admission et (MDS), dated 2/6/2018, s cognitively intact. group meeting, on 3/8/18 at stated that he was to be n drink daily since admission. ally started receiving it about 2 evious registered dietician R50's nutritional needs, making is to R50's primary physician the Liquacel qd (everyday)." This was made by PRD due to R50's estomy, and a low range albumin d follow-up lab on 1/25/18, still is still considered by PRD to be the acceptable albumin range. sican signed the is into orders the following on acel qd (everyday)." The order R50's electronic medical record et of 2/09/18, and a start date of everyday and a start date of everyday and a start date of everyday and a start date of expectation record (eMAR), dated everyday and a start date of expectation record (eMAR), dated everyday and all days on 2/10/18 and all days on 2/10/18 and all days were blank, not given. Earch 2018 for R50, indicated R50 ein supplement only on 6 of the	F 69	federal law. 1.It is the policy of the facility to residents receive proper nutritiensure overall health. One of ways that this has been achie resident #50 was to initially or protein supplementation for hillow albumin levels. After surve R50 had initial orders for increprotein supplement for low albumin lab was ordered, diet notified, and point click care documentation for supplement reviewed to ensure put on MA followed up appropriately to medication error was complet 4/4/2018, albumin level was ordered. At the time correction completed resident went to heack surgery and at this time re-evaluate need for supplementation or dietary ordenhanced nutrition or hydration potentially affected by the cite DON reviewed all residents the supplements to ensure that all supplements are being given. With dietician the report for su and ensuring coded properly dietary. The Policy and Procesupplements was reviewed ar No other residents were affect policy on nutritional supplements been reviewed.	ion to the many ved for der extra s borderline ey noted the eased bumin levels amediately cian ts was R and ursing. ed on rdered and cian a being spital for will entation ceive ders for a many are d deficiency. at had Reviewed plements under dure for ad updated. ed. The		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		03/	13/2018	
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F 692	In an interview on 3 director of nursing (February and March	J/12/18 at 8:23 a.m., the DON), after reviewing R50's at 2018 eMAR's, was uncertain of received his physician uplement.	F 69	operations and under the directic director of nursing, on 4/4/2018 received in-service training for rutrition, hydration, supplement The training emphasizes the im of following all orders and ensuruntritional needs be met and the importance of following up on supplementation and notification updated labs to evaluate necessaupplements for people with ablabs. Dietary will also ensure all admits with supplements get lis supplements, so they can easily with orders and appropriate labs as necessary. 4. Effective 4/4/2018, a quality-a program was implemented undesupervision of the dietary manadesignated quality-assurance representative will complete 2 a residents receiving supplements x 4 weeks, then 1 audit weekly to ensure compliance in this are deficiencies will be corrected or and the findings of the quality-achecks will be documented and at the monthly quality-assurance committee meeting for further recorrective action. 5. The Dietary manager, dieticia DON will be responsible for this	all staff nonitoring s and labs. cortance ing all n of sity of normal new ed under monitor ordered ssurance er the ger or udits on all s per week 2 months a. Any the spot, ssurance submitted eview or n and		
F 696 SS=D		ses sure that a resident who has a ed care and assistance,	F 69	· ·		5/7/18	
	The facility must en	sure that a resident who has a					

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the comprehensive the residents' goals be able to use the This REQUIREME by: Based on observareview the facility faservices and assist prosthesis for 1 of an amputation. This the inability to weat wasting of R17's right (BKA.) Findings include: R 17's admission M 10/13/17, identified impairment and had pneumonia, below chronic obstructive and diabetes. The independent with a including transfers, revealed R17 did not limited range of months of MDS further in physical therapy (Find the MDS further in th	fessional standards of practice, e person-centered care plan, s and preferences, to wear and	F 69	This Plan of Correction conwritten allegation of compliadeficiencies cited. However of this Plan of Correction is admission that a deficiency one was cited correctly. The Correction is submitted to make requirements established by federal law. 1. It is the policy of this facility maintenance with prostheticy prevent unnecessary decline normal quality of life. Some ways that this has been ach is to have prosthetic re-fit are place get PT/OT ordered. In after the survey determined a decline in ambulation ability using prosthesis, immediate to get sized and re-evaluate 4/5/2018 R17 went to clinic determined unable to get apwith current orthotic clinic directriction now needs approximately provider to approve prosthemals of assisting with this process assisting with this process. Assessments will be done as to be created based on need prosthetic is in place, current assessments are current and correct. Resident stated will feels like it and often prefers	ance for the submission not an exists or that is Plan of neet y state and ty to provide devices to e and ensure of the many need for R17 and when in a this case, R17 showed ty and was not e referral sent of for fit. Which opointment ue to eval for tic. Therapy ess. and care plan ds after and care plan use when he	

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diagnoses which in and anxiety. The CABKA and had a prosent R17 was working we strengthening, endual however, did not ide locomotion. The Caindependent in ADL ambulate at the time the CAA identified Facognitive impairment Review of R17's caright BKA with a profindependent with all R17's care plan ide. Review of a nursing dated 3/6/18, reveated with transfers with a right prosthesis and guide lacked any diassistance with R17. On 3/7/18, R17 was room, he indicated services for a couple the facility in the fall had stopped becaus stated he had not reor walking with the had a new prosthesis be able to walk if he prosthesis was now. On 3/8/8/18, at 6:24 usually independent.	te care hospital and had cluded pneumonia, depression AA identified R17 had a right sthesis. The CAA identified with PT and OT services for urance and prosthetic training, entify ambulation or AA identified R17 was and indicated R17 did not e of the assessment. Further, R17 was at risk of injury due to nt. The plan identified R17 had a pethesis and indicated he was all ADL's including transfers. Intified R17 did not ambulate. The gassistant (NA) care guide alled R17 required one assist a front wheeled walker, had a did utilized a scooter. The care irection for use of or	F 6	but is alert and oriented current E 14/15. 2.Because many residents have prosthetic devices some are pote affected by the cited deficiency, of 4/4/2018, the DON reviewed all right with prosthetic devices to ensure utilization is in place and care plate accurate. Other residents determinate declines have been identified significant change assessments been initiated. No other residents affected. 3.To enhance currently compliant operations and under the direction director of nurses, on 4/4/2018 at staff received in-service training in changes in resident's condition. It training emphasized the important monitoring ADL's both improvem decline. Care In conjunction with all staff will be in -serviced on prodonning and doffing and walking when prosthesis in place and important of residents need for exercise, we and maintaining independence we cares. Fitting with dignity and quastaff were educated on important ensuring all residents live in a hoenvironment and can live at their functional status. 4.Effective 4/4/2018, a quality-as program was implemented under supervision of therapy to monitor residents having prosthetics to en being utilized correctly and allowing resident utmost autonomy in self-Therapy or designated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation of the signated quality-as representative will perform the formation	ntially on esidents on hined to do and have were of ent and therapy sthetic protocols fortance alking ith their elity of life the of me like highest or tance of the highest or tance of the highest or t	

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MOORH	EAD REHABILITATIO	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 696	doffing the prosther always wear the prosted and ambulate. NA-C for not have a restorated for range of motion indicated residents therapy for any extended and the end of his arrived at the facility received both OT approximately 2-3 walk with his prostindicated since he therapy, no other assisted him to an indicated his prostfelt his stump had he did not feel he further indicated he further indicated he about losing his all prosthesis to his prost feel his concertacility staff. Review R17's PT summary, start dated 11/3/17, ide start of care was a participated well in summary revealed with lower extremitendurance. R17 he	age 149 sindependent in donning and esis and stated he did not rosthesis. NA-C stated R17 did was unaware if he was able to urther indicated the facility did tive or maintenance program nor walking residents. She is would usually be seen by ercise or walking programs. p.m. R17 was seated in an his room. R17's prosthesis was set the wall, between his closet bed. R17 stated when he first ity in October 2017, he had and PT services for weeks and had been able to chesis and the therapist. He had stopped working with staff member had offered or abulate in the facility. He chesis was too big for him and shrunk. R17 stated at that time would be able to walk. R17 e had voiced his concerns coility to walk and to wear his rimary medical doctor as he did the would be addressed by the progress and discharge the 10/11/17, and end of care intified R17's progress since his significant and he had all five PT sessions. The did R17 made consistent gains the strength, balance and addreceived gait training for attern with prosthesis limb and strength.	F 69	systematic audit of all reside prosthetics 3 per week x 4 w 1 audits weekly x2 months to compliance in this area to en residents with prosthetics are sample and assessment will prosthetic, proper donning/douse and resident satisfaction will be reviewed at time of quannual to ensure not a signif Any deficiencies will be correspot, and the findings of the quality-assurance checks will documented and submitted a quality-assurance committee further review or corrective a 5. The ED, DON and therapy responsible for this POC.	reeks, then ensure ensure all e in the include, fit of offing, actual a. All residents carterly or icant change. ected on the at the monthly e meeting for action.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245052	B. WING		03	3/13/2018
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 696	on safe assistive of and improve efficied discharge summar balance and endur for falls with indep ambulate with PT summary identified further therapy, ho R17 was discharge services. Further the a candidate for living with a potential to accessible indeperovided education program. Review of R17's Commary, start of date 11/9/17, identifying progress since his participated in all esummary revealed assist with standing transfers and amburals with standing transfers and amburals with summary revealed assist with standing transfers and amburals, and had been program to maintal On 3/12/18, at 9:3 (PT)-A confirmed in the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists a calendar years of the stated R17's program to maintal consists and the stated R17's program to maintal consists	levices to reduce risk for falls ency of ambulation. The PT ry revealed R17 had ongoing rance deficits, was at high risk endent mobility, was able to required CGA and FWW. The d R17 would benefit from the summary revealed R17 was ng in an assisted living facility progress to a handicap and a home exercise. To progress and discharge care date 10/9/17, and endutified R17 had made good start of care and had eight therapy sessions. The latter R17 made gains with ADL transfers and ambulation. The latter R17 required supervision to g ADL's and functional culation with front wheeled ensure safety. Further the OT ry identified R17 was at risk for a educated on a home exercise in gains made in OT. 3 a.m. physical therapy director R17 had received skilled when he arrived at the facility. Dayor source was from North llowed for 15 skilled therapy ear, therefore R17 was killed therapy within a few mission. PT-A stated she felt	F 69	6		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 696	R17 made improrareas of ambulat with therapy. She fitting and felt it hoon 3/12/18, at 9:: therapist (OT)-A skilled therapy se facility and had restated she felt R2 with therapy and donn and doff his and ambulation. It to ambulate up to was discharged fronfirmed she has staff continue to and ambulation in potentially improves the further state facility not provide	page 151 vements with his mobility in ion and transfers while working e stated R17's prosthesis was ad worked well with R17. 20 a.m. certified occupational confirmed R17 had received ervices when he arrived at the eccived 8 skilled OT visits. She 17 had made significant progress had improved in his ability to s prosthesis, balance, transfers OT-A stated R17 had been able of 100 feet with CGA when he from therapy services. OT-A and recommended facility nursing work with R17 with his prosthesis in order to maintain and we his modified independence. If she had concerns with the ing residents with any type of all ADL maintenance/restorative	F 6	96		
	(DON) confirmed staff assist R17 wand assist R17 wand assist R17 wand assist R17 wand assist R17 wastated the facility of restorative or redecline in resider implementing a rethe areas she wandicated she did The DON stated maintain his abilitishe was unaware staff to assist R1	52 a.m. the director of nursing I R17's care plan directed facility with ambulation and to monitor with his prosthesis. The DON currently did not have any type maintenance program to prevent his ADL's. She stated estorative program was one of its working to develop and not have a current plan in place, she would have expected R17 to be to ambulate and further stated a OT had recommended nursing with his prosthesis. She nursing and the contracted				

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		245052	B. WING _		03	8/13/2018
	PROVIDER OR SUPPLIE	R ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 696	therapy department and were currently communication of the could use a grooming. She stould wear it when the could use a grooming. She stould wear it when the could use a grooming. She stould wear it when the could use a grooming. She stould wear it when the could use a grooming. She stould wear it when the could use a grooming. She stould wear it when the could use a grooming. She stould wear it when the could use a grooming. She stould wear it when the could use a grooming. She stould wear it when the could use a groom of the could use a	ent had communication problems by working on improving or recommendations. 2:59 a.m. licensed practical nurse 17 was independent with otorized scooter. She stated R is and indicated R17 was the prosthesis and occasionally is. LPN-C stated she did not imbulating since his admission. 2:46 a.m. NA-E stated R17 was ent with his ADL's, though she is some more assistance with lated R17 had a prosthesis and en he chose. NA-E indicated dent with his prosthesis and was with his mobility with his r. She further indicated she had	F 69	96		
	and a gait belt up stated she had no for R17 and was	to approximately 100 feet. PT-A of received any recent referrals unaware of any decline in his personal results. PT-A indicated R17 was given				

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	CODE		
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F 696	a home exercise pr strength. She indica benefited from conta ambulating, howeve have a formal or inta program to prevent ambulation. A reque assess R17's curre On 3/12/18, at 2:12 motorized scooter va- jeans, his prosthesi his closet and the e- had not walked sind therapy services. P moved to gather his walker (WW), whice wall by his prosthesi obtain another 4 W of the two tennis ba- legs of the 4 WW. I and returned with a he did not routinely program and indical prosthesis a few tin the prosthesis no lo first arrived at the fa- use a stocking cap sock used to cover when using a prost prosthesis to fit. R1 donn the Gel liner F hold his breath, his had to stop. PT-A of donned the Gel liner prosthesis onto R1' gait belt around R1 stand. R17 stood fr	ogram to maintain his ated she felt R17 would have tinued assistance with er she stated the facility did not formal restorative/maintenance decline in ADL's, such as est was made for PT-A to not ability to ambulate. p.m. R17 was seated in a wearing a tee shirt and dark is rested on the floor between end of the bed. R17 stated he can be he had received skilled T-A entered R17's room, is prosthesis and 4 wheeled in was also rested against the case. PT-A indicated she had to W as R17's was missing one calls that were on the back two PT-A immediately left the room nother 4 WW. R17 indicated complete the home exercise ated he would donn the case a week. R17 stated he felt onger fit him as it had when he callity. R17 stated he had to over his gel liner PLY sock (a an amputated limb (stump) hesis.) in order for his 7 made several attempts to PLY sock, however he would face would turn red and he can an amputated limb. PT-A donned a 7's right stump. PT-A donned a 7's torso and cued him to om his bed, in an attempt to sis onto his stump, and	F 69	96			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		2810	ET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE NORTH DRHEAD, MN 56560	<u>, </u>	10/2010
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F 696	indicated his pros PT-A confirmed R stated she the proindicated he had recompany but had not cover an adjust follow up with R 1 On 3/12/18, at 2:4 had experienced from his prosthesic confirmed R17 we that time. She furt endurance had deambulate or trans the facility's usual residents annually confirmed R 17 has she indicated she R17's current phy revealed an order evaluation and treorders did not add Review of R17's p3/8/18, revealed to T10/5/17, R17 was pneumonia. The revealed R17 was bed mobility and she behavioral issues	thesis would not set into place. 17's prosthesis no longer fit and osthesis was too loose. R 17 requested to see his prosthetics been told his insurance would stment. PT-A stated she would 7's prosthetics company. 7 p.m. PT-A stated she felt R17 muscle wasting in his stump is not being used routinely. She build not be able to ambulate at their indicated she felt R17's eclined and he was not safe to fer independently. PT-A stated practice was to screen and quarterly, however, and not recently been screened. It was unaware of R17's decline. Is sician orders signed 3/6/18, and and 1/16/18, for PT and OT that as indicated. R17's physical dress R17's prosthesis. It organises notes from 10/5/17, to the following; It is admitted from the hospital with note revealed R17 had a right the facility to receive PT and OT of the grant or the sindependent with transfers, self care ADL's and had no	F 6	96			

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F 696	prosthesis was no note indicated the appointment for Frecord lacked any aforementioned of a comparison of the control of the c	o longer fitting him properly. The ewriter would set up an R17's prosthesis. R17's medical y further documentation of R17's concern. s very active throughout the corized scooter, however, did not	F6	96		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245052	B. WING		03/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
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F 696 F 697 SS=G	identified restorative ambulation would be needs. A policy was request provided. Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mathe facility must end provided to resident consistent with profit the comprehensive and the residents' of the REQUIREMED by: Based on observative review, the facility fassess, failed to desinterventions to mathe resident (R207) state pain. This deficient	sment, dated August 2017, e nursing, transfers and be offered based on residents sted for prosthesis, none were	F 696		
	depressed mood w Findings include: R207's Admission I identified R207's had on 2/20/18, and had	terns and reports of ith pain. Record form, printed 3/9/18, ad been admitted to the facility d diagnoses which included knee, bipolar disorder and		requirements established by state and federal law. 1.It is the policy of the facility to provide adequate supervision and assistance was pain management. R207 had been in facility for therapy r/t TKA. R207 complained of pain on numerous occasions. Staff were not consistent on documenting or administering pain medication. The therapy department did try e-stim for pain and heat without	ith

245052 B. WING 03/1	13/2018
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R207's admission Minimum Data Set (MDS) dated 2/27/18, identified R207 was cognitively intact and had diagnoses which included recent surgical past of a right knee arthroscopy, depression, anxiety and schizophrenia. The MDS identified R207 was independent in all activities of daily living and was receiving both skilled physical therapy (PT) and occupation therapy (OT) services. The MDS further identified R207 had constant pain and had received as needed (PRN) medication for pain. The MDS did not identify R207 received non-pharmacological interventions for pain. R207's Admission ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 2/27/18, identified R207 had a recent right knee arthroscopy in addition to right lower extremity cellulitis (infection and inflammation of the skin). The CAAs identified R207 was cognitively intact and was working with therapies on strengthening and mobility. The CAA facther indicated R207 was expected to return to her own apartment. R207's Admission Pain CAA dated 2/27/18, identified R207 vas cognitively intact and was working with therapies on strengthening and mobility. The CAA facther indicated R207 was expected to return to her own apartment. R207's Admission Pain CAA dated 2/27/18, identified R207 vas cognitively intact and was working with therapies on strengthening and mobility. The CAA facted deficiency and the pain and 10 being the worst pain imaginable) and received Gabapentin (medication for nerve pain), Tylenol, and Oxycontin (extended release opioid analgesic) for pain. The CAA lacked documentation of the location or any characteristics of R207's pain. Further, the CAA did not identify what was a tolerable level of pain for R17. Review of R207's electronic and paper record lacked any further pain assessments completed and appropriate reduced inspector and swelling reduced long-term pain and swelling reduced bong-term pain and swelling reduced long-term pain and swelling reduced long-term pain control would be within more appropriate range. MD as l	

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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
MOODUI	AD DELIADII ITATIC	AN & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH		
MOORHE	EAD REHABILITATIC	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560		
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F 697	R207's hospital too instructions dated -Pain Assessment 2/20/18, listed R20 after surgery. Her rated at a 9 out of pain relief to be a pain relie	tal knee replacement discharge 2/20/18, revealed the following: completed at the hospital on 1/27 had acute pain in right knee current pain level had been 10, with a mutual pain goal for pain level of 2. tructions listed for pain ided: vate your leg periodically. tions approximately 45-60 erapy/activity. e pain, may help to take pain e therapy. ow under the knee. signed physician orders ving orders: //20/18, acetaminophen 650 mouth every 4 hours as ain. //20/18, Tramadol (non-opioid by mouth every 6 hours as ate pain.	F 6	received in-service training of the importance of listening to adequate pain control and of interventions according to calculate and pain monitoring to ensure pain control. The Policy and pain management was review updated. 4. Effective 4/4/2018, a quality program was implemented usupervision of the director of monitor resident self-adminimedication. The director of designated quality-assurance representative will perform the systematic changes: MDS in DON will audit 5 residents the pain based on their assessing interview 2x per week for 3 residents 2x per week for 6 ensure residents with pain a appropriately treated. Any debe corrected on the spot, and of the quality-assurance chedocumented and submitted quality-assurance committee 5. The DON and MDS will be for this corrective action.	emphasizes o the resident, ther are plan. Staff assessment, assessment, aterventions, re adequate Procedure for ewed and ty-assurance under the f nurses to stering nurses or ee he following urse and nat trigger for nent and weeks than 3 weeks to are efficiencies will ad the findings ecks will be at the monthly e meeting.	
	- an order dated 3	/1/18				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 697	tablet by mouth ever to pain, if Tramadol Percocet, maximum R207's current care R207 had acute an and incorrectly identified left knee and in knee arthroscopy (vplan revealed R207 therapy. The care promonitor R207 for particle of pain. On 3/7/18, at 8:02 a her back with a pillo stated she recently due to severe arthrifrequent pain of her pain felt like a burniof her right knee an indicated her pain vmoved her right leg medication would nher pain was not medications. She in facility nursing staff her orthopedic physiaddressed her condangry and often timpain. She stated he approximately 5 our stated at those times	-	F 6	97			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 697	morning. R207 st she had requeste approximately 11 pain medication is stated her pain has she had received been neglected be offered ice packs management. R2 and OT daily and receive pain medicated primary physiciar on 2/20/18, and so not in the area. Review of R207's Treatment form or receiving skilled primary skilled primary physiciar on 2/20/18, and so not in the area. Review of R207's Treatment form or receiving skilled primary skilled primary physiciar on a recent right to a receiving skilled primary skilled prima	rated as recently as last night and pain medication at 100 p.m. and did not receive any until 12:30 am She further ad reached a level of 9 before any medication and felt she had by staff. R207 stated staff had not or warm packs to aid in pain 10:07 stated she received both PT indicated she did not always ication prior to therapy. She she had not been seen by her in since she arrived at the facility stated her primary physician was 15 PT evaluation and Plan of 12:14 lated 2/21/18, revealed R27 was 14:15 plan of 15:16 lated 2/21/18, revealed R27 was 15:16 plan of 16:16 lated 2/21/18, revealed R27 was 16:17 plan of 16:18 lated 2/21/18, revealed R27 was 16:18 plan of 17:18 plan of 18:18 plan of 19:18 plan o	F6	97			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		03	3/13/2018	
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F 697	On 3/8/18, at 5:14 R207 was reliable reported to her she managed. LPN-B she medications and she a level between 7-indicated R207 wo and walk to the nungrimacing in pain. Would often use diadminister pain meshed did not feel R2 managed and had her physician. LPN routinely administed therapy for R207. On 3/8/18, at 5:22 activated at that tir R207 was lying in furrowed, jaw was in her right knee. Note the reported R207's postated she felt R207 had cried in right knee and stated she would be leg with a pillow are no longer used ice. On 3/8/18, at 8:21 chair in the dining against the table of had received pain before, however, sat approximately 5	a.m. LPN-B stated she felt and indicated R207 had had felt her pain was not stated R207 had two PRN pain he often complained of pain at 8 on a numeric scale. LPN-B ould frequently awaken at night rse's station and would be LPN-B further indicated she straction until she could edications for R207. She stated 207's pain was adequately encouraged R207 to speak to I-B stated she was unable to er pain medication prior to a.m. R207's call light was me, NA-I entered R207's room. bed on her back, her brow was tight and stated she had pain NA-I then left R207's room and pain to LPN-B. At that time NA-I of often had pain. She stated the past from the pain in her ted she felt bad for her. NA-I encourage R207 to elevate her not used to offer ice, but R207	F 69	7			

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	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	DE		
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F 697	hand and would g not offered any no interventions such of motion exercise further stated she a "drug seeker" ai when she asked f she wished she ha of pain relief with did not have to as On 3/8/18, at 8:35 chair in the dining hand when she st her lips tightened. walk to therapy. R her gait was shuff weight to her right ambulated down t department. R207 room and the dire indicated it was R proceeded to come evaluation. On 3/8/18, at 8:44 R207 was a reliab stated R207 had	rub her right knee with her right rimace. R207 stated she was on-pharmacological pain as ice or heat therapy, range es or positioning changes. R207 felt the facility thought she was not indicated she felt like one or pain medication. She stated ad better coverage and duration her current medication, so she	F 6	97			
	decrease with me stated she had no R207's pain mana to verbalize her pawas aware R207 prior to therapy se	dicinal pain management. PT-A of met with nursing to discuss agement and felt R207 was able ain to facility nursing staff. She did not receive pain medications essions, and indicated she had to request pain medications					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245052	B. WING			03/	13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	REET ADDRESS, CITY, STATE, ZIP CODE 10 SECOND AVENUE NORTH OORHEAD, MN 56560	1 00.		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 697	-At 8:58 a.m. R207 out of 10 and she ti stood from the cha stated she had new tolerable level of pagoal was. She indic would be tolerable. On 3/8/18, at 9:27 a interview with PT-A recently discussed LPN-C. She indicated level of pain and st non-verbal express was verbally report mental health issue and indicated she was a reliable R207's pain. On 3/8/18, at 3:16 R207 was a reliable R207 did not fabric R207 routinely comencouraged R207 to She stated R207's make any changes and further indicate a practitioner since LPN-C stated R207 she had to wait over medications on the had not informed the R207's report. Review of R207's Maccord (MAR) from the following:	indicated her pain was an 8 ightened her jaw when she ir when cued by PT-A. R207 wer been asked what a ain was for her or what her pain cated a level of less than 5	F 6	97				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/13/2018	
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	DDE .		
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F 697	R207 had reported MAR revealed R20 documented 2 out of identified R207 had three times and had three times. The Marceived Percocet R207 had rated her MAR further reveal Tramadol 12 out of had rated her pain and rated her pain and reported pain 9 revealed R207's rated and Tramadol 10 of Review of R207's F3/8/18, identified R207's F3/8/18, identified R207's p3/9/18, revealed R207's p3/9/18, revealed R207's p3/9/18, revealed the anote dated 2/20 recently hospitalize fatal systemic blood an untreated localized cellulities of right low knee arthroscopy, of The note revealed her right knee follow replacement on 2/1	ted each shift and identified pain 15 out of 26 times. The 7's pain rating was not of 26 times. The MAR I received Tylenol 650 mg d been effective two out of the AR revealed R207 had 11 out of 18 opportunities and repain from 0-9 out of 10. The ed R207 had received 24 opportunities and R207 from a 5-9 out of 10. AR revealed R207's pain level ach shift and identified R207 out of 21 times. The MAR ting was not documented 3 out AR identified R207 had 14 out of a a possible 20 times ut of 22 opportunities. AT discharge summary dated 207 had met her PT goal of ge level of pain a 7 out of 10 progress notes from 2/20/18, to be following: AT (18, revealed R207 was d with sepsis (severe, often d infection usually caused by the cet of the right knee. R207 had a current incision to	F6	97			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 697	rounding physiciar The note listed R2 of various diagnos (current) use of opmethamphetamine lower extremity, starthroscopy. - a note dated 2/22 in bed most of the once during the ship characteristics of Rany non-pharmaco R207. -a note dated 2/22 working with thera walker and receive later note revealed medication. The nucharacteristics of Rany non-pharmacor medication. The nucharacteristics of Rany note dated 2/23 make her needs kand was independent with Awas on PRN pain -a note dated 2/27 PRN pain medicated to the therapies. A later recalled to the therapight knee was wanote indicated R20 clinic for an evaluation and characteristics of the control of the	of during her stay at the facility. O7 had a past medical history es which included longterm plate analgesic, history of eaddiction, and cellulitis of right atus post right knee 1/18, revealed R207 had been day and had a pain medication lift. The note lacked any R207's pain, relief of pain or plogical interventions offered to 1/18, revealed R207 was py, was independent with a ed PRN pain medications. A R207 requested a PRN pain otes did not reveal any R207's pain. 1/18, revealed R207 was able to nown, was receiving therapy ent in ADL's. 1/18, revealed R207 remained ADL's, received therapy and	F 697				

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F 697	received a PRN parequested to estable medications. The rinstructed her pain and further instructed octor appointment. There documentation of I response. The note R207's pain, relief non-pharmacologic R207. -a note dated 3/1/1 provided primary pregarding her conditation to every 6 with daily. -a note dated 3/2/1 requested pain medicated any character pain or any non-phoffered to R207. -a note dated 3/4/1 pain medication two	/18, revealed R207 had ain medication and R207 had alish a routine schedule for pain note revealed R207 was medications were as needed ted R207 to speak to her during her follow up e was no further R207's Orthopedic doctors e lacked any characteristics of of pain or any cal interventions offered to 8, revealed R207's facility hysician was contacted terns with pain management. an order was obtained to ncy of Percocet from every 12 ith a maximum of two doses 8, revealed R207 had edications once. The note teristics of R207's pain, relief of armacological interventions 8, revealed R207 had received rice. The note lacked any	F6	97			
	any non-pharmaco R207. -a note dated 3/9/1 ineffective pain ma	R207's pain, relief of pain or ological interventions offered to 8, revealed R207 had reported inagement with her current further indicated R207's facility					

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F 697	On 3/9/18, at 1:12 R207 was reliable pain was not well medication regim discussed R207's order to attempt to increase the di LPN-I stated she she had spoken y nurse practioner stated the nurse y amount of time R of Percocet. She would benefit fror practitioner. LPN- had not been sch R207 was to be of near future. On 3/9/18, at 3:56 down the hall tow right hand. R207 she did not bear to On 3/12/18, at 9: physician stated I continued compla not met with R200 facility and indica the past couple w expect the facility surgeon first rega R207's orthopedi pain, then he wou He further stated	page 167 oner had been contacted and ake any changes. 2 p.m. LPN-I stated she felt e and indicated she felt R207's managed with her current en. LPN-I stated she had a pain management with her in so establish some type of routine curation of R207's pain relief. felt bad for R207 and indicated with R207's primary physician's regarding R207's pain. LPN-I practioner decreased the 1207 had to wait between doses further indicated she felt R207 and a face to face visit with the 1-I indicated a face to face visit eduled for R207 and indicated discharged from the facility in the 18 p.m. R207 was ambulating vards her room with a cane in her had tight lips, furrowed brow, full weight on her right leg. 17 a.m. R207's primary he was not aware of R207's paints of pain. He stated he had 7 since her admission to the ted he had been on vacation for weeks. He indicated he would to contact R207's orthopedic arding her pain. He indicated if c surgeon did not address her all have expected to be notified. he would expect facility nursing ensively assess R207's pain in	F 6	97			

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F 697	history of infection. On 3/12/18, at 3:01 was reviewed with a R207's medical recognin assessment at R207's pain. The D of ineffective pain reported to her prin R207 should have longoing reports of R207's medical recogning reports of R207's medical recognistence of the With residents and Mathematical strength of the Recognision	p.m. R207's medical record the DON. She confirmed ord lacked a comprehensive and lacked monitoring of ON confirmed R207's reports an agement should have been ary physician and indicated been seen by a physician for pain. The DON confirmed ord lacked any documentation gical interventions attempted an agement, revealed it was policy to help staff identify pain develop interventions that the residents goals. The aral guidelines which included gement was a process of ents pain to a level that was esident based on his or her and established treatment goals. It the following steps of the zing pain, assessing pain, a fpain, defining goals and antions, implementing pain and aned, documentation and	F 69	07		
	Treatment/Service CFR(s): 483.40(b)(§483.40(b)(3) A res		F 74	14		4/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/1	13/2018
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MOORHI	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 744	maintain his or he mental, and psych This REQUIREMI by: Based on observ review the facility interventions for bedementia care to falls. Findings include: R1's admission M 11/11/17, identifie had diagnoses who disease, dementia restlessness and R1 required total assistance with be toileting, personal MDS further ident received a daily a anti-depressant mPRN anti-anxiety seven day look-based R1's Care Area As 11/14/17, identifie from acute hospit worsening of Parkand oriented and CAA indicated R1 (anti-psychotic medicated depressing R1 exhibited sedated in the mental of the mental properties of the medicated R1 (anti-depressant resoluted depressing R1 exhibited sedated R1 included depressing R1 exhibited R1 included depressing R1 exhibited R1 included R1 in	nent and services to attain or in highest practicable physical, nosocial well-being. ENT is not met as evidenced ation, interview, and document failed to provide appropriate behaviors for person centered 1 of 1 resident (R1) reviewed for dinimum Data Set (MDS) dated d R1 had intact cognition, and nich included Parkinson's a, anxiety, weakness, agitation. The MDS identified assistance for eating, extensive ed mobility, transfers, dressing, hygiene, and did not walk. The ified R1 had no behaivors, nti-psychotic medication, daily nedication and had received a medication twice during the	F 744	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of the facility to protreatment and services to residents dementia. R1 was noted to have uncontrolled movements and had formats on floor so staff weren't concabout R1 actions as they felt the floor mats for him to fall safely. Documentations of care plan and of sheets did not indicate how to deal cognitive changes resident had. Cawas updated to ensure resident samats only next to bed when resident bed in low position, if resident becaugitated staff sit with on 1:1 and off walking with resident who is 1 persussist with ambulation. Resident all encouraged to participate in activitic breakfast which appeared to be mocommon time for episodes. 2. Because many residents have did of dementia, signs of cognitive impairments or intermittent confusimany are potentially affected by the deficiency, staff were reminded to deficiency, staff were reminded to deficiency.	the ssion or that of and ovide s with floor erned foor the are plan fety by the informes fer on so es after ost agnosis on e cited	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/30/2018 FORM APPROVED

& MEDICAID SERVICES			<u> </u>	MR MO.	<u>0938-0391</u>
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		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
& HEALTHCARE CENTER					
JUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
plan printed on 3/8/18, last tified R1 had impaired ated to dementia with ce. R1's care plan listed which included: administer red, provide R1 with and return if agitated, cue, se as needed, monitor and al/non-verbal indicators of and follow up as needed. Ited R1 may get anxious and of mobility and this fer calm environment and y frustrated with disease not ve with staff-therefore give standing. However, the care cal behaivors, or what nitions staff would try when stance for safety such as ently or refusing one to one of the company of the	F 7	744	reviewed importance of BIM score conjunction with cares and intervental current residents with dementia reviewed and behaviors, appropriatinterventions No other residents were affected. Toolicy on dementia has been review 3. To enhance currently compliant operations and under the direction director of nurses, on 4/4/2018 all serceived in-service training reminding of immediate 1:1 need for behavior could potentially lead to negative outcome. Staff were educated on assessment of dementia and behavior and appropriate interventions A fall analysis was completed and noted falls between 8:30-10:00 am activitinotified to actively engage resident breakfast. Resident states often feethe needs to do something. Also not his behaviors increase as do his treduring this time. Formulating care blooking possible triggers that might indicate resident is uncomfortable on needing some stimulation. 4.Effective 4/4/2018, a quality-assurance representative will perform audits diversignated quality-assurance representative will perform audits diversignated of the director of nurses designated quality-assurance representative will perform audits diversignated of the director of nurses designated of the director of nurses designated quality-assurance representative will perform audits diversignated to residents with dementions and services to residents with dementions and services to residents with dementions.	tions. e the ved. of the taff ng staff s that viors, most es after el like ted that emors by or rance ne s to k for x was or one ents entia	
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ALL PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245052 8. HEALTHCARE CENTER EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) 1. IDENTIFYING INFORMATION 1. IDENTIFY	AT PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245052 B. WING EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) EN 170 Plan printed on 3/8/18, last tified R1 had impaired ated to dementia with each exist included: administer red, provide R1 with and return if agitated, cue, as needed, monitor and al/non-verbal indicators of and follow up as needed. ted R1 may get anxious and of mobility and this fer calm environment and y frustrated with disease not to we with staff-therefore give standing. However, the care cal behaivors, or what nitions staff would try when stance for safety such as ently or refusing one to one TIM, identified as the facility e sheet, updated 3/6/18, uired one to two staff well for transfers, one to two stailly living (ADL), at fall risk in periods of confusion. cked directions for TIM, INDICATE THE ACT OF	A BUILDING 245052 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 PREPIX TAG TOBERTIFYING INFORMATION) E 170 PREPIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPP DEFICIENCY) F 744 Interventions to redirect behaviors, reviewed importance of BIM score is conjunction with cares and interventions which included: administer ed, provide R1 with and return if agitated, cue, see as needed, monitor and al/non-verbal indicators of sand follow up as needed, ter call meny get anxious and of mobility and this fer callen environment and y frustrated with disease not ve with staff-therefore give standing. However, the care call behaivors, or what nitions staff would try when standing. However, the care call behaivors, or what nitions staff would try when stance for safety such as entity or refusing one to one imperitoring the fort transfers, one to two taily living (ADL), at fall risk no periods of confusion. cked directions for Tag. To provide R1 with and this fer calm environment and y frustrated with disease not ve with staff-therefore give standing. However, the care call behaivors, or what nitions staff would try when stance for safety such as entity or refusing one to one in periods of confusion. Cked directions for Tag. To provide R1 with and the provide R1 with cares and interventions and under the direction of provide R1 with cares and interventions whith cares and interventions whith cares and interventions when conjunction with cares and interventions or reviewed importance of BIM score in conjunction with cares and interventions or reviewed and behaviors, appropriate interventions or reviewed and behaviors, appropriate interventions or reviewed and behaviors and under the direction of interventions or residents with demication and the provide R1 with and the provide R1 with cares and interventions or reviewed importance of BIM score increase and interventions or reviewed and b	(X2) MULTIPLE CONSTRUCTION A BUILDING 245052 8. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 MENT OF DEFICIENCIES AUST BE PRECEIBED BY PULL TAGS DENTIFYING INFORMATION) 19 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 19 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 19 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 19 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 19 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 11 Interventions to redirect behaviors. SW reviewed amportance of BIM score in conjunction with cares and interventions. All current residents with dementia reviewed and behaviors, appropriate interventions No other residents were affected. The policy on dementia has been reviewed. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all staff received in-service training reminding staff of immediate 1:1 need for behaviors, and appropriate interventions A fall analysis was completed and noted most falls between 8:30-10:00 am activities notified to actively engage resident after breakfast. Resident states often feel like he needs to do something. Also noted that his behaviors increase as do his tremors during this time. Formulating care by looking possible triggers that might indicate resident is uncomfortable or needing some stimulation. 4. Effective 4/4/2018, a

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F 744	medication cart a offer assistance. a massage to hel TMA-A stated she (antianxiety medi -At 8:49 a.m. R1 with the same un stopped charting, room again. TMA past R1's room, le passed but, neith room nor offer as -At 8:51 a.m. R1 leaned back with the floor, as his a uncontrollably. Nor R1's room, briefly exited the room vassistance and results on the floor mats, reached out with wooden arm chait the floor onto his wooden chair. Note the state of the uneven fall on the floor onto his wooden chair.	nd did not enter R1's room or NA-I stated she had offered R1 p calm him and he refused. e gave R1 an as needed Ativan cation) just prior. continued in the same position controllable movements. NA-A turned and looked into R1's -A pushed the medication cart poked into R1's room as she er NA-A or TMA-A entered R1's	F 7		ted on the spot, ality-assurance d and submitted urance ther review or		
	mats are there." I to the wall kiosk. uncontrollable mo rocked his trunk I wooden chair and arm movements and a	en and stated"that's why the NA-A immediately walked back R1 sat up and continued to have by the back and forth. R1 grabbed the d tipped it back upright with jerky and with an unsteady gait and up and walk over the uneven					

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F 744	fall mats to the food and an unsteady of surface of the fall closet. NA-I was in independently. NA asked if he was all bed, and threw hir the mattress, and NA-I walked out on to like it if he tho NA-I then entered During interview of stated she felt R1' not have a set pattired days where heverything. She st involuntary mover days. TMA-A state movements got resit with him one or were to "one to or specific directions for him. On 3/08/18, at 9:5 fall risk and she we times in the past, and bad (referring She stated R1 had 2-3 days, and state when staff tried to R1's movements or sit with staff tried to R1's movements or sit with him one or specific directions for him.	age 172 Interest and sat down. Interpolate the defendant sat down. Interpolate the sate of the sate	F 7	44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 744	On 3/08/18, at 11 R1's Parkinson's and had experien he transferred to "good days" and R1's "bad days" I movements. LPN be by himself and assist him. She s movements staff stated R1 utilized needed Ativan whused the fall mats bed.	:00 a.m. LPN-I stated she felt disease had been getting worse, need a lot of falls at home before the facility. She stated R1 had "bad days." She indicated on the had a lot of involuntary I-I stated she felt R1 preferred to distance when R1 had involuntary try to get him to his room. LPN-I as the indicated when R1 had involuntary try to get him to his room. LPN-I as the inch was not always effective and is because he would crawl out of	F 7	744			
	(DON) stated R1 fall risk was "real was aware R1 has sometimes once supervision with I the 1:1 supervision movements bega	25 p.m. director of nursing had Parkinson's disease, so his ly high." The DON stated she ad involuntary movements a week, and staff provided 1:1 R1. She stated she would expect on to start when R1's involuntary an and would expect staff being a of R1 so he did not fall and hurt					
	3/8/18 revealed the -11/1/17, admitted included Parkinson	d to facility with diagnoses which on's disease, anxiety and havioral disturbances, mood					
	-11/8/17, 12:25 a R1 on floor behin injury noted, 1:1 s out of bed on floor	.m., heard a loud sound, found door thrashing around. No supervision initiated. 12:50 a.m., or again, 1:23 a.m., R1 became					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03	/13/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 744	bed, and sent to indicated a previor previous day with -11/23/17, 3:00 a room, found on fl centimeter (cm) of uncooperative, the movements. Order of evaluation at facility with 4 sutu-11/29/17, 2:00 p muscle movements elf transfer multito bed and/or oth Almost fell 2 time by staff back to we Education given a waiting for assists movements were understanding bu-12/5/17, 4:50 a.r extremities noted padded floor, back body against pade evaluation. The infacility at 10:00 a self ambulating with R1, became FWW on the growstaff. R1 sat down calm himself down to staff. R1 sat down calm himself down the growstaff.	page 174 ER for evaluation. The note ous incident of thrashing the other the same symptoms. I.m., heard loud sound from oor, sustained a small (sic) 1.5 out on forehead, resident trashing about with uncontrolled er received to transfer to hospital 10:45 a.m. R1 returned to the trees to area above eye. I.m., very frequent involuntary onto this morning, attempted to italize this morning, attempted to italize the chair without falls occurring. The segarding use of call light and ence for transfers until muscle the less frequent. R1 verbalized at did not follow through. I.m., exaggerated movement of the bouncing off of bed onto the set to bouncing on bed, hitting ded walls. R1 sent to hospital for othe indicated R1 returned to the community of the set of the se	F 7	744			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 744	frequent involunta understanding. -12/13/17, 10:33 a from one place to position, did not a room and ran in h wheelchair and he or bruises noted. -12/21/17, 5:30 a. of large extremitie against padded w. closely and keep l involuntary muscle staff, threw himse Redirection attem staff left room. -12/29/17, 8:00 a. forward with chair chest x-ray ordered assistive devices a involuntary muscle assist to sit in whe and swung self ar injury noted. R1 eambulating per second control so here and there, ur	age 175 ation when his is having ry movements. R1 verbalized a.m. R1 in room throwing stuff another, moved bed to another flow staff to go near him, left all as staff ran behind him with a fell on floor 3 times. No injuries m. extreme Parkinson shakes s, bouncing on matted floor and all, instructed NA to watch R1 safe. At 12:38 p.m. frequent a movements, combative with a movements, combative with a movements, combative with a movements and fell to floor, and, negative for fracture. a., ambulating per self with no while having frequent, a moments. Staff attempted to be elchair, became very agitated bound and fell on buttocks, no ducated on importance of not all until muscle movements are does not fall and hit his head. m. agitated, moves his body hable to concentrate or focus on a needed anti-anxiety	F 7	744			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ¹ A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/13/	2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE 2810 SECOND AVENUE NOR MOORHEAD, MN 56560			
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F 744	-3/8/18, 2:18 p.m., was in room he sta him and lowered hi floor first, R1 had b of uncontrolled move anti-anxiety medical on 3/9/18, at 8:43 a stated R1 was plear when he is not. RN involuntary movemed Parkinson's disease staff when they try and and would hit started having bad of assistance, we caround him when hut sometimes staff physical. On 03/09/18, at 12: interview nurse pra Parkinson's disease "fairly significant Auhad Aspergers(brain de to problems with secondination). She verbalizing his need communication was could be helpful for staff's approach with needed to know ho back off. On 03/09/18, at 12: conducted with the clinical services (RI	reported to writer when R1 rted to fall and staff caught m to ground with butt touching een anxious this a.m. with lots rements, received as needed	F 7	44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		3/13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 744	however, denied R They verified R1's of frequently, and felt lewy body dementian A policy regarding of however none were	1 had a diagnosis of Autism. cognitive and mobility varied this was consistent with his a diagnosis. dementia care was requested, e provided.	F 744			
	S483.40(d) The factor medically-related sometically-related someti	ocial services to attain or st practicable physical, mental well-being of each resident. NT is not met as evidenced tion, interview and record ailed to address behaviors denvironmental concerns for 1 reviewed for behaviors	F 745	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide treatment and services to all residents and follow up on any recommendations sent upon admission on PASARR. One of the many ways that this has been achieved for resident # is by initiating the psych services, involving ombudsman at family in care. After survey noted level II PASARR had not been followed and did not mesh with level I PASARR a referral was made immediately to have resident seen for psych services. The determination was made by not following	of and	

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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MOODU	AD DELIADII ITATIO	N & LIEALTHCARE CENTER		2810 SECOND AVENUE NORTH		
MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER		MOORHEAD, MN 56560		
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F 745	Continued From pa	age 178	F 74	5		
F 745	daily life. R9 did no was the same as the not receive psycho. Review of R9's Cardated 5/1/17, revea activities of daily live nutritional status are CAAs lacked assessymptoms, psycho. R9's care plan, reveal behaviors which interventions which interventions which situations or people to a psychologist/ps. R9 what staff are go cue/reorient/superventions which situations or people to a psychologist/ps. R9 what staff are go cue/reorient/superventions and avergent and orient staff were to reapport change clothes dain nurse. Review of R9's Quaresident Review of was verbally abusing staff and staff was verbally abusing staff was staff staff.	t exhibit any behavior, which he prior assessment and did logical therapy. The Area Assessments (CAA) haled assessments regarding ring, urinary incontinence, and dental care. However, R9's assment of mood, behavioral social well-being or dementia. The Area Assessments (CAA) haled assessments regarding ring, urinary incontinence, and dental care. However, R9's assment of mood, behavioral social well-being or dementia. The Area Assessments (CAA) haled assessments regarding ring, urinary incontinence, and dental care. However, R9's assment of mood, behavioral social well-being or dementia. The Area Assessments (CAA) haled assessments regarding ring, urinary incontinence, and dental care sheet and the care sheet, indicated R9 arterly Interdisciplinary attention of the prior of	F 74	the PASARR appropriate care was likely not followed as R9 has bipola disorder and can become aggressi anxious. Needs extra assistance to able to do basic ADL's. Care plan a behavior assessment also updated 4/5/2018. 2.Because all residents must have PASARR on admission all are pote affected by the cited deficiency, a phas been developed to ensure no PASARR's are missed upon admis All current residents were assessed dementia and behaviors to develop interventions to assist with appropricares. No other residents were affect The policy on PASARR's has been updated. 3.To enhance currently compliant operations and under the direction SW, on 4/4/2018 a review was done SW, admission, medical records, and MDS regarding PASARR's. Medical records will ensure the residents from North Dakota get a PASARR as the are not done in the hospital. The Sensure all admissions have PASAR upon admission. The admissions divill ensure all admission packs are immediately and copy given to SW save for 6 months to ensure all recommendations are in place bas level II PASARR's and the MDS coordinator in doing admission revialso ensure it is on file. All staff were also as a sure it is on file. All staff were applied to the sure in the staff were also ensure it is on file. All staff were applied to the sure and the massion revialso ensure it is on file. All staff were also as a sure it is on file. All staff were also as a sure it is on file. All staff were also as a sure and a staff were also and a sure and a s	ar ve and o be and l a entially protocol esion. d with o other iate ected. of the le with and all oom ey often W will RR lirector e copied to ed on iew will ere	
	dining room table, a urine odor, with the	p.m., R9 was seated at a alone. R9 had a very strong odor noticed approximately 5		educated on the need for social se need for monitoring and assisting v dementia and behavior needs. 4.Effective 4/4/2018, a quality-assu	vith	
DRM CMS-25	667(02-99) Previous Versions	S Obsolete Event ID: VNGR1	1 F	Facility ID: 00938 If continuation	sheet Page	179 of 223

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP			
MOORH	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 745	feet away. At 5:40 evening meal, qui returned to his roo On 3/7/18 at 2:44 walking the halls wearing clothes d R9 continued to ho On 3/7/18, at 3:20 reviewed with the stated the PASRF 4/14/16, and a Le due to mental illne episode depresse II assessment warecommended that to clarify if he has stated she was ur was followed up tracks PASRR recompleted for R9 calling to set up a Review of R9's ps note dated 3/31/1 inpatient psychiatric unit for had a disagreeme slapped her. R9 videpressive episoo function was conduring the interviewed.	p.m., R9 was served his ickly consumed the meal, om and laid on his back in bed. p.m., R9 was observed with a 4 wheeled walker, ifferent than 3/7/18. However, ave a noticeable urine odor. p.m., R9's PASRR Level I was social worker (SW). The SW R Level I was completed on vel II assessment was indicated ess of Bipolar I disorder, current and without psychosis. R9's Level is completed 4/25/16 with a for "Outpatient Psychiatry-It was at he have a psychological test dementia or not". The SW maware if the recommendation on, or who follows up on and	F7	program was implemented supervision of the SW to make review current residents. It performs the following systems of a residents with behavior at weekly for 3 months to ensign services in place and on accensure admitted with PASS deficiencies will be corrected and the findings of the quality committee meeting for furtice corrective action. 5.SW, MDS, Admissions at Records will be responsible.	nonitor Imission and The SW will ematic audits on and dementia sure appropriate dmissions to SAR. Any ed on the spot, lity-assurance d and submitted arrance her review or and Medical		

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F 745	diagnosis. Review of R9's plindicated R9 had R9 was initially acrelated to the san health physician. non-violent, and ractivities of daily depression with a was alert and not examination. R9's more stable, cont physical therapy. by psychiatry. Review of R9's play 3/8/18, revealed to 1-3/1/17, at 12:10 clean pants and slater changed back When asked why yelled and slammaggressive postuthrow his shirt. Reresponded to a care-3/12/17, at 6:35 -5/5/17, at 3:36 pland clothing charmaggressive postuthrow his shirt. Reresponded to a care-3/12/17, at 5:07 plange after much week.	nysician note dated 1/30/18, a history of bipolar disorder and dmitted secondary to violence ne and evaluated by mental R9 remained non-agitated, required a lot of cues to finish his living. R9 had a history of anxiety, but mood was stable. R9 very cooperative during is bipolar I disorder presently inue with nursing care and R9 was presently being followed rogress notes from 3/1/17, to the following: p.m., R9 was noted to have on shirt and was praised for it. R9 ck into usual soiled shirt again. The changed his clothes, he need the door to his room. R9 had are and appeared to want to 9 was reminded to be nice and alm, slow voice. p.m. R9 refused bath.	F 74	15			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 745	changed and cloth cleaned and orgar to curse and yell a violently. Later R9 practical nurse (LF LPN. R9 wanted to and who told them -9/5/17, at 10:11 a changing his clothencouragement to "yepwe'll see" what here about complassessment. Residently assessment. Residently assessment. Residently assessment. Residently at 12/20/17, at 2:55 provered back of shallow staff to assistant when shallow staff to be launded clothes to dimembers knew if the staff to a staff to the staff	les were missing with room hized. R9 got upset and began and slammed the door very came up to the licensed (PN) as if he was going to hit the o know who cleaned his room to do it. Im. R9 continued to refuse the ses despite continued do so. R9's response was hile walking away. Im. R9 was approached times the time of continued to refuse. Im. R9 was noted to have urine hirt and pants. R9 refused to thim getting cleaned. Im. R9 refused bath. Im. R9 refused shower offered wo. He yelled at nursing the attempted to change bedding the series of the series was noted to change bedding the series was noted to have urine the series of the series	F 74:	5		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE	
F 745	concern. The adradministrator directores to be laur. On 3/12/18, at 12 (NA)-I stated R9 she waited until hed, wiped down remove soiled clores a pair of soiled paup the pants in him on 3/12/18, at 12 interview the SW room and person entering R9's roopermission. She	ministrator stated the previous ected staff to go in and take R9's ndered, which had upset R9. 2:10 p.m. nursing assistant did not like his room cleaned, so be left for lunch, then stripped the mattress, and attempted to obthing. NA-I stated while cleaning he returned while she was got upset, yelled at her, told her named the door. NA-I further the she left R9's room, he grabbed ants she was carrying and hung	F 7	'45			
	interview family n facility had not co helping with R9's clothes to be laur	2:49 p.m. during a telephone nember (FM)-B verified the ontacted him for assistance in room odor and refusal for ndered. FM-B further stated, "It t time I was there [at the					
	interview with SW assessments had that R9 had not rowhile a resident of had attempted so	26 p.m. during follow up /, she confirmed no behavioral d been completed for R9 and eccived psychiatric services of the facility. The SW stated she ome other assessments for R9 ed them as well. The SW stated					

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F 745	she was unaware available to comp was aware of R9' she had not atten or Ombudsman for interventions. The working on getting that data would be She stated the lass successful impler behaviors of not sand not getting has successful since two months ago. The psychiatry evaluates be successful in granes. On 3/12/18, at 2:0 (DON) stated she process for PASF would handle it on the admission and malearning the role to able to answer the would expect the followed up on. The behavioral assessand R9's refusals continued to work R9's room was a encouraged him to might reach out to assist with complifacility had to work R9 to get a rappostated the old adriversal and a same couraged him to might reach out to assist with complifacility had to work R9 to get a rappostated the old adriversal assist with cold adriversal and R9 to get a rappostated the old adriversal assist with cold adriversal and R9 to get a rappostated the old adriversal assist with cold adriversal and R9 to get a rappostated the old adriversal	page 183 It of any behavioral assessments oblete for R9, or if R9's physician is refusal of cares. She stated inpted to reach out to the family or assistance with behavioral it is governed by stated the facility is governed by stated for assessments. It is administrator had been the last administrator had been the last administrator left about the SW stated she was hopeful aduation would help the facility to gotting R9 more compliant with the state of the facility is governed by stated she was out today, but the arketing director (AMD) was no take over and she would be at question. She stated she PASRR recommendation be the DON stated R9 had no sment that she was aware of, so of care was something the staff on. She stated the smell from "foul" urea smell and that staff to be compliant and the facility of the family to see if they could fance. The DON stated the k on building a relationship with the with him to do his cares. She ministrator had a good rapport the else has been successful.	F 74	45			

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F 745	not aware of the of still learning the rothealth information. On 3/12/18, at 2:1 responsible for the stated the SW wo Minnesota PASRI On 3/12/18, at 2:2 interview the SW Level I or II was "I SW stated from the responsible for PARI Review of the underlying and behavioral Assess Monitoring, include comprehensive as the resident's usure and behavior. Interview of the underlying castituational and embehavior. Review of the underlying castituational and embehavior. The policy indicated director would be	16 p.m. the AMD stated she was current PASRR process and was ble. AMD stated to talk with the manager (HIM). 19 p.m. HIM stated she was only the North Dakota PASRR and could be the one to follow up on the R Level I and II. 15 p.m. during a follow up stated, tracking any PASRR news to her". At 2:37 p.m. the his point on she would be ASRR in Minnesota. 16 the facility policy titled, The sment, Intervention and ed as part of the essessment, staff would evaluate all patterns of cognition, mood erventions and approaches in detailed assessment of origical and behavioral symptoms uses, as well as potential vironmental reasons for the stated facility policy titled, creening, indicated the policy residents with the appropriate to them to reach their highest and psychosocial functioning. The requirements and if a Level II of the surrender of the requirements and if a Level II.	F 7	45			

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	1 00:10:20:10
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F 755 F 755 SS=D	S483.45 (a)(§483.45 Pharmacy The facility must produge and biological them under an aground support of the personnel to admire	rocedures/Pharmacist/Records (b)(1)-(3)	F 759		4/23/18
	§483.45(a) Proced pharmaceutical set that assure the acc dispensing, and adbiologicals) to mee §483.45(b) Service must employ or ob pharmacist who-	ures. A facility must provide rvices (including procedures curate acquiring, receiving, lministering of all drugs and at the needs of each resident. Consultation. The facility tain the services of a licensed rides consultation on all vision of pharmacy services in			
	the facility. §483.45(b)(2) Esta receipt and disposi sufficient detail to e reconciliation; and §483.45(b)(3) Deteorder and that an a is maintained and This REQUIREME by: Based on interview facility failed to obt	blishes a system of records of ition of all controlled drugs in		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submi	the

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IVAIVIL OF I	NOVIDEN ON OUT LIE			2810 SECOND AVENUE NORTH	ODE		
MOORH	EAD REHABILITATI	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 755	-	_	F 75				
	of 1 residents (R4 infection which waddition, the facili were given per m1 residents (108) potassium supplemedication pass Findings include: ANTIFUNGAL CFR41's quarterly M2/5/18, identified active infections. When interviewed stated she felt state week prior shinfection (a fungal	A1) who developed a yeast as left untreated as a result. In ty failed to ensure medications anufacturer instructions for 1 of observed to receive K-Dur (a ement) during observations of in the facility. REAM: Ininimum Data Set (MDS) dated R41 had intact cognition and no do on 3/6/18, at 2:23 p.m. R41 aff ignored her. R41 indicated e had developed a yeast I infection on the skin or mucous		of this Plan of Correction is admission that a deficiency one was cited correctly. The Correction is submitted to make requirements established by federal law. 1. It is the policy of the facility pharmacy services timely an R41 had yeast infection and order from physician the pharmacy consultant, it was policy was in place not to see counter medications as they supplied by other supply contained by other supply contained the pharmacy consultant, it was policy was in place not to see counter medications as they supplied by other supply contained by other supply contained the prior authorization. R41 whin not receive. R108 had receive by nurse and it was crushed.	exists or that is Plan of neet y state and by to provide and efficiently. If after getting armacy failed ewing with sonoted old end over the y would be ampany and OTC so was all stated need ch facility did ived her K pill is Plan of the plan of t		
	upon timely, desp times to the staff. been done to help R41's progress no identified the follow On 3/2/18, R41 h and a yeast infect [medical doctor] h awaiting [sic] resp On 3/6/18, staff re the MD for Monis antifungal] to be of The note describe faxed to pharmace	ote(s) were reviewed and wing entries: ad complaints of having a UTI tion. The note dictated, "MD has been notified via fax.		medication is not allowed to and given. After survey note concerns immediately DON pharmacy to ensure all OTO be sent when ordered or nu notified immediately if there and all medications to be la appropriately if unable to be 2.Because all residents recomedications from our facility and staff administer most of has potential to affect all resof appropriate meds to crus added to med books on car shared drive with a link to lo medications on. All staff dis will be reviewed to ensure permedication procedures are medications ordered are av	ed these met with C meds would irse would be are questions beled c crushed. eive their y pharmacy f medications it sidents. A list sh has been t as well as on book up pensing meds proper enforced and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/	13/2018	
NAME OF I	PROVIDER OR SUPPLIE	R	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	1012010	
MOORHI	EAD REHABILITATI	ON & HEALTHCARE CENTER	l	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 755	Continued From promitor vaginal at On 3/8/18, R41's and lacked any enhad been implem. When interviewed licensed practical Monistat was ordered however, the facilithe pharmacy, and was frustrated with stated she had ca (3/8/18) and they been notified it was an over-the-count provides through LPN-I stated it was and stated she had happen before. During interviewed director of nursing unaware R41's mobtained or imple that to me." The have ensured the delivered and impleave to "lay in between the country in the c	page 187 rea until resolved." medical record was reviewed vidence this ordered treatment	F 758	DEFICIENCY)	s has cy policy No other n of the I nursing on on tate surance the es to er week months elivery audits onths. veek cies will findings vill be monthly eting for		
	over-the-counter outside source. an order for these us" so it can be fill reviewed R41's re	medications and used an DP stated if the nurses obtained a medications they "need to call lled and delivered. DP stated he accord in their system and they fied in any capacity of the need					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03	/13/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	•	10.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 755	for a Monistat precalled by a nurse responsibility to a medications to the been notified on a have been delive issues like these communication." A facility Medication Pharmacy each physician or medication order on a transfer order pharmacy." Furth how to obtain em lacked any direct	page 188 escription until 3/8/18, when DP stated it was the facility's obtain and provide the eir residents and if they had 3/6/18, the medication could red that same day. DP felt were "all about the on Ordering and Receiving policy dated 5/2012, identified reder should be written on a form, in the resident's chart or er form " and transmitted to the ner, the policy gave procedures ergency medications, however, ion or procedure to order and/or ounter prescriptions.	F 7	755			
	indicated R108 h congestive heart a diuretic (water potassium supple resident's current During a medicat at 8:20 a.m. licen observed dishing (two 20 mEq tabl LPN-B then crush them in chocolate stated she crush	ASSIUM: s Report printed 3/12/18, ad essential hypertension, failure (CHF), and received both reduction medication) and a ement which was documented in a Order Summary Report. ion pass observation on 3/07/18, sed practical nurse (LPN)-J was R108's potassium supplement ets into a medication cup. ned both tablets and placed e pudding. When asked, LPN-J ed R108's potassium because o swallow them whole.					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETED			
		245052	B. WING _		03/	13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 755	3/12/18, physician of Chloride Crystals - by mouth two times potassium in blood, order did not direct. Review of potassium (via www.Drugs.Co. Take K-Dur with a food medicine with food Do not crush, chew Sucking on the table throat. During an interview director of nursing (formulated the same crushed, because it crystals. The DON dissolving the table physician for a liquity of the Medication order appropriate care propolicy directed staff mixed with other medicants unable to safely or need in ot with physician.	er Summary Report printed orders included: Potassium Give 40 milliequivalents (mEq) a day for low amount of start date of 2/22/18. The to crush the medication. In manufacturer's instructions m) included: ull glass of water. Take the or just after a meal. I, or suck a K-Dur tablet. et will irritate your mouth or on 3/12/18, at 1:06 p.m. the DON) stated supplements e as K-Dur should not be twas extended release stated staff should either be to in water or ask R108's d potassium supplement. erapy undated policy included: rs will be supported by occesses and practices. The medications that need to be edications or crushed need to MD (physician), and if swallow meds (medications) ther format it will be discussed	F 75			4/22/49
	Free from Unnec P CFR(s): 483.45(c)(3	sychotropic Meds/PRN Use 3)(e)(1)-(5)	F 75	58		4/23/18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/°	13/2018
	ROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	affects brain activiti processes and beh but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprese resident, the facility §483.45(e)(1) Reside psychotropic drugs unless the medicati specific condition as in the clinical record behavioral intervent contraindicated, in a drugs; §483.45(e)(2) Reside psychotropic drugs unless that medicated diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 da §483.45(e)(5), if the prescribing practitic appropriate for the	cropic Drugs. Archotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following chensive assessment of a must ensure that dents who have not used are not given these drugs on is necessary to treat a s diagnosed and documented di; dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented	F 7	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/	12/2019	
NAME OF E	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COL		13/2018	
		ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	7 <u>C</u>		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI		(X5) COMPLETION	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE	
F 758	Continued From	page 191	F 75	58			
		sident's medical record and ion for the PRN order.					
		N orders for anti-psychotic					
		to 14 days and cannot be ne attending physician or					
	prescribing practi	tioner evaluates the resident for ess of that medication.					
		ENT is not met as evidenced					
	Based on intervie	ew and record review, the facility resident was reassessed for		This Plan of Correction const written allegation of compliance			
		an as needed (PRN) lication, Ativan (anti-anxiety),		deficiencies cited. However, so f this Plan of Correction is no			
		ed 14 days for 1 of 1 residents		admission that a deficiency ex one was cited correctly. This Correction is submitted to me	Plan of		
	Findings include:			requirements established by s federal law.			
	11/11/17, identifie	linimum Data Set (MDS) dated d R1 had intact cognition, and		1.It is the policy of the facility guidelines regarding use of P	RN		
	disease, dementia	nich included Parkinson's a, anxiety, weakness,		psychotropic medications. R1 body dementia with anxious o			
		agitation. The MDS identified assistance for eating, extensive		Ativan was ordered PRN and utilized multiple days in conse			
		ed mobility, transfers, dressing, I hygiene, and did not walk. The		months. On 4/5/2018 MD orderscheduled Ativan and remove			
	MDS further ident	tified R1 had no behaviors, nti-psychotic medication, daily		as resident is determined to h anxiousness. Ativan order upo	ave		
	anti-depressant n	nedication and had received a medication twice during the		MAR staff aware to watch for reactions and monitor target to	adverse		
	seven day look-ba			stated in care plan.			
		ssessment (CAA) dated d R1 was recently admitted		Because many residents ha for PRN psychotropics, many potentially affected by the cite	are		
	from acute hospit	al after multiple falls and		staff were reminded to ensure environments and necessary	safe		
	and oriented and	kinson's disease. R1 was alert able to make needs known. The received Seroquel		to redirect behaviors before u	ilizing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/	42/2049	
NAMEOF	DOWNER OF CHERNIE		D: Wilto	CTREET ADDRESS CITY STATE 71D COS		13/2018	
NAME OF F	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP COL	E		
MOORH	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLÉTION DATE	
F 758	Continued From p	page 192	F 75	8			
		edication), Ativan and Remeron		consistently MD to schedule it			
		medication) for diagnoses which		medications not utilized disco			
		on, anxiety and dementia and		will occur every 14 days. All r			
		ation, disturbances in balance,		have been reviewed for currer			
		at risk for falls and injury.		psychotropic meds for approp	riate use.		
				No other residents were affec			
		are plan printed on 3/8/18, last		policy on PRN psychotropics I	nas been		
		lentified R1 utilized an		reviewed and revised.			
		cation, and directed staff to		3.To enhance currently compl			
		shift for safety due to the use of		operations and under the dire			
		edication, which was associated		director of nurses, on 4/4/201			
		risk of confusion, amnesia, loss ognitive impairment which		staff received in-service training utilizing PRN psychotropic me			
		ntia and increased risk of falls,		that are ordered PRN for more			
	broken hips	illa ana moreasca fisik of falls,		days and the importance of pl			
		e plan directed to monitor for		doing visit to order continued			
		to the anti-anxiety medications		schedule if needed consistent			
		umsiness, slow reflexes,		target behaviors noted in docu			
		ntation, dizziness, impaired		and non-pharmacological app			
		ement, aggression or impulsive		Psychotropic medications will			
	behavior.			at quarterly and annual review determine need, effectiveness			
	R1's physician Or	ders Summary Report, signed		reduction.	o or dose		
		R1 received Ativan 1.0		4.Effective 4/4/2018, a quality	assurance		
		mouth every four hours as		program was implemented un			
		y with an ordered date of		supervision of the director of r			
		an 1.0 mg inject intramuscularly		monitor residents with prn ord			
		urs as needed for anxiety		psychotropic meds. The direct			
		on's disease with an order date		nurses or designated quality-a			
		ever, R1's PRN Ativan orders		representative will perform the			
		e of 14 days after the order start		systematic audits on residents			
		Additionally, there had been no		for prn psychotropics 5 reside			
		ment for ongoing use of the		week x 4 weeks, then 3 reside			
	PRN Ativan.			x2 months to ensure compliar area of PRN use. Any deficier			
	Review of P1's old	ectronic medication		corrected on the spot, and the			
		ord from 3/1/18, to 3/12/18,		the quality-assurance checks			
		received PRN Ativan 6 times.		documented and submitted at			
	sicatos i ti nau	. 222.754 Françairo milios.		quality-assurance committee			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE B10 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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From pa	nge 193	F 7	58			
	3/8/18, revealed: R1 received PRN A (14 days after PRN without documente	gress notes from 1/12/18, to ativan 31 times from 1/12/18 Ativan start date), to 3/8/18, d reassessment for R1's as needed anti-anxiety			further review or corrective action. 5.The Pharmacy, SW and DON wi responsible for this POC.	ll be	
	R1's physician on 1 anti-anxiety medical written for no more necessary beyond responded with "storeassessment". No recommendations of Review of physicial R1 had a history of no depression or an obehaviors. Curre						
	(LPN)-C stated she ambulate independ floor and wall next if R1 was noted to movement, he was	e a.m. licensed practical nurse e felt R1 could transfer and lently. R1 had fall mats on the to bed for safety. LPN-C stated have a lot of involuntary administered the PRN Ativand not control the movements, a sit with him.					
	R1's Parkinson's di and had experience he transferred to the	a.m. LPN-I stated she felt sease had been getting worse, ed a lot of falls at home before e facility. She stated R1 had ad days." She indicated on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03/	/13/2018	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC' ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 758	R1's "bad days" he movements. LPN-be by himself and assist him. She sta movements staff tr stated R1 utilized a needed Ativan white used the fall mats bed. On 3/13/18, at 2:0 (DON) stated R1's monthly by the corprovider on routine order for PRN oral 12/29/17 and was Parkinson's disease	e had a lot of involuntary I stated she felt R1 preferred to would get angry if staff tried to ated when R1 had involuntary by to get him to his room. LPN-I as ch was not always effective and because he would crawl out of 7 p.m. director of nursing medications were reviewed asultant pharmacist and R1's by rounds. DON confirmed R1's and IM Ativan was from used for anxiety related to se. The DON stated she was by requirement for PRN	F 7	58			
	undated, indicated medications shall in the care process in assessment and reassessment and	all decisions related to include appropriate elements of including adequately detailed eview of causes of symptoms. Individual's current in would be reviewed to identify or use, appropriate dose, instration and duration of use id potential side effects present. Hent Nds/Prep in Adv/Followed (1)-(7) and nutritional adequacy.	F 8	03		4/23/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		03/	13/2018	
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 803	§483.60(c)(4) Refireasonable efforts ethnic needs of thinput received from groups; §483.60(c)(5) Be to \$483.60(c)(6) Be to dietitian or other construed to limit apersonal dietary of This REQUIREMED by: Based on observative, the facility were prepared and resident populationall 57 residents residentified to consuproduction kitcher Findings include: A provided Weekly 3/10/18, identified meals. The menumeal for 3/6/18, w	prepared in advance; followed; ect, based on a facility's , the religious, cultural and e resident population, as well as in residents and resident updated periodically; reviewed by the facility's linically qualified nutrition utritional adequacy; and hing in this paragraph should be the resident's right to make hoices. ENT is not met as evidenced ation, interview and document failed to ensure menu items d served as written to the h. This had potential to affect siding in the facility who were me meals from the main h. y Menu dated 3/4/18, to a weeks' period of posted identified a dinner (evening) hich was listed as baked tilapia	F 80	This Plan of Correction con written allegation of complia deficiencies cited. However, of this Plan of Correction is admission that a deficiency one was cited correctly. Thi Correction is submitted to m requirements established by federal law. 1.It is the policy of the facility meal service to all residents alternative option available. will be posted in advance for review. During survey noted	nce for the submission not an exists or that s Plan of eet state and to provide with an These menus resident's that residents		
	meal for 3/6/18, w (fish), wild rice, sli				that residents		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
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MOORHI	EAD REHABILITATIC	ON & HEALTHCARE CENTER		MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 803	During observation on 3/6/18, at 5:19 large pan of apple it on the counter. aide (DA)-A begandowls. DA-A state served tonight for dessert did not get began to remove from the pans which had be for service during of baked squash a which had whole with they did not have a meal, and the supposed to residents. When interviewed read the posted mot served as it was have nothing up." service supplier divere supposed to squash. CK-A expithe dietary staff as direction and one of which weren't supposed to make the advernowever, the dietary on the front station however, this had	n of the evening meal service p.m. cook (CK)-A removed a crisp from the oven and placed Immediately following, dietary to scoop the crisp into smaller d these were going to be the dessert as the banana split made. At 5:38 p.m. CK-C foil from the covered metallic the meal. CK-C exposed a panalong with a separate pain wheat toast inside. CK-C stated any breadsticks to serve for the plier did not deliver any zucchinical squash instead. This meal was as gathered in the dining room. on 3/6/18, at 6:19 p.m. CK-A enu and stated the meal was as supposed to be adding, "we CK-A indicated the food d not deliver zucchini as they so the cooks switched to bressed frustration with some of they did not consistently follow cook was always serving items to be served. CK-A etary staff the previous evening tised banana split bars, ry staff did not make the CK-A stated, "They refuse to them." CK-A explained if the hanged it should be posted up it so residents know it changed,	F 80	2.Because all residents eat for at least 2 meals all are paffected by the cited deficie discussed with dietary manadietician and it is agreed that planned out there is ample ingredients from vendor to are followed. The dietary tesif not available changes to rposted to alert residents of policy on following a following reviewed with department. 3.To enhance currently compoperations and under the didictician and dietary manages 4/4/2018 all staff received in training for menus, meal choptions for residents. 4.Effective 4/4/2018, a qualiprogram was implemented supervision of the dietary manadesignated quality-assurance is served. The dietary manadesignated quality-assurance representative will perform a systematic audits 8 resident to ensure menu is followed residents if their meals were requested. Any deficiencies corrected on the spot, and the quality-assurance check documented and submitted quality-assurance committed further review or corrective 5. Dietary manager & Dietitia responsible for this POC.	otentially ncy. This was ager and at if meals are time to get ensure menus am will ensure menu will be changes. The ng menus was apliant rection of the er, on n-service oices, and ity-assurance under the anager to what is posted ager or ce the following ts for 6 weeks by asking e as e will be the findings of to will be at the monthly the meeting for action.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG		E SURVEY IPLETED
		245052	B. WING _		03/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 803	12/29/17, identified 3/6/18, at 6:49 p.m of food items was R29 stated having frustrating at times On 3/8/18, at 12:58 held with 11 reside service was discus and appearance. The meals being seposted menu adding a service was discussed to the meals being seposted menu adding a service was discussed appearance.	I R29 had intact cognition. On a R29 stated the posted menu not being served "quite often." the menu changed was	F 80	93		
F 807 SS=D	corporate registered facility had been "keresidents were awar any changes being changed, it should residents are "awar A facility policy on preparation was no	et Needs/Prefs/Hydration	F 80	77		4/23/18
	§483.60(d)(6) Drin liquids consistent water preferences and surply hydration. This REQUIREME by: Based on observa	nd drink eives and the facility provides- ks, including water and other with resident needs and ufficient to maintain resident NT is not met as evidenced ation, interview and document failed to honor and implement		This Plan of Correction constitut written allegation of compliance f		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	I \ /	(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		03/	13/2018	
NAME OF F	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO		13/2010	
		ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	<i>3</i> 2		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 807	identified preferer 1 residents (R41) to help her lose with the present of the pr	inimum Data Set (MDS) dated R41 had intact cognition and esistance with eating. on 3/6/18, at 2:17 p.m. R41 anted water during the lunch and he was trying to cut back on her cated she was frustrated with it and staff continuing to serve her meals. R41 showed the slip from the lunch meal she en a couple hours prior which erence to only be served water dinner meal, however, R41	F 80	,	ot an exists or that Plan of eet state and to provide and serve 1 stated ring survey ter was often nted. R41 rd and offer sted. It the facility tentially ey. This was ger and dent's ed and vell staff Diet slips properly list and menu ted, and staff o to give ey choose. Viewed to and diet slips liant ection of the r, on service ces, and were iet orders		

CLIVILI	13 I ON MEDICANE	A MEDICAID SERVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		SURVEY PLETED
		245052	B. WING			03/	13/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				28	810 SECOND AVENUE NORTH		
MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER		N	MOORHEAD, MN 56560		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROFICIENCY)) BE	COMPLETION DATE
F 807	Continued From pa	age 199	F 8	307			
	3/6/18. at 6:13 p.m	. R41 was delivered a room			they are asking for not choosing for	r them.	
		istant (NA)-M. However, the			Reviewed respect and dignity with		
		ss of milk on it; with no water			and personal choices vs mandator		
	provided. R41 stat	ed with a abrupt tone, "Well			choices.		
	there you are, no w	ater, again!" No staff was			4.Effective 4/4/2018, a quality-assu	ırance	
		11 about her choice or			program was implemented under t		
		erages with the meal, despite			supervision of the dietary manager		
	her menu slip ident	ifying she only desired water.			monitor menus and ensure what is		
		0/0/40 1 0 00 NA NA			is served. The dietary manager or	•	
		on 3/6/18, at 6:26 p.m. NA-M			designated quality-assurance		
	explained the process for room tray delivery. The tray(s) were passed around, then staff go back				representative will perform the follo		
					systematic audits of 8 residents re		
		30 minutes and pick them up.			resident preferences weekly for 6 to ensure residents choices are be		
		ages which were passed			honored. Any deficiencies will be	ing	
		ng the trays. NA-M stated			corrected on the spot, and the find	inas of	
		en beverages from the cart and			the quality-assurance checks will be		
		to them. NA-M was unaware			documented and submitted at the		
		noices for beverages are			quality-assurance committee meet		
		d using this process.			further review or corrective action.	J	
					5.The ED, Dietitian, Dietary staff, a	ınd	
	When interviewed	on 3/8/18, at 3:27 p.m.			Nursing staff will be responsible fo	r this	
		d dietician (RD)-A stated the			POC.		
		d to deliver beverages with					
	,	t the way it should go," and					
		ing each resident for their					
		s with each meal. RD-A					
		ation" may be needed as food					
		oly one of the only things they					
	nursing home.	ntrol over" while living in the					
		Food Preferences policy dated					
		a direct interview would be					
		ch resident for their meal					
		admission and these would be					
		clinical record. Further, a					
		be offered choices and allowed					
	to make their own o	decisions regarding meal					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	[`	X3) DATE SURVEY COMPLETED
		245052	B. WING		03/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 807	Continued From pare preferences if optic dietary guidelines." Assistive Devices - CFR(s): 483.60(g) §483.60(g) Assistive The facility must present and utensils for reseappropriate assistate can use the assistiment and snacks. This REQUIREME by: Based on observative review, the facility frequipment to promise drinking for 1 of 1 mutrition and who end drinking from a glate Findings include: R7's quarterly Minit 12/18/17, identified was independent wassistance.	age 200 ons are safe and follow their Eating Equipment/Utensils we devices rovide special eating equipment sidents who need them and ance to ensure that the resident we devices when consuming NT is not met as evidenced tion, interview and document failed to provide adaptive ote independence with residents (R7) reviewed for expressed difficulty with ss. mum Data Set (MDS) dated I R7 had intact cognition and with eating after setup	F 807	This Plan of Correction constitutes r written allegation of compliance for the deficiencies cited. However, submiss of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet requirements established by state ar federal law. 1.It is the policy of the facility to provious adaptive equipment to all residents in conjunction with OT to ensure reside remains as independent and high functioning as they can. R7 was note	any he sion that f and ide in ent ed to
	stated he was bein a regular glass, ho the mugs with hand was fearful of spillin hand and finger de going to spill one [k stated he had repe	on 3/6/18, at 2:03 p.m. R7 g served his juices at meals on wever, wished he could use dles he used to have as he ng it. R7 stated he had poor xterity and was "eventually beverages]." Further, R7 atedly asked for his mugs with ever, nobody had followed up		have a sippy cup on his diet card and appeared to have very difficult time drinking with regular cup due to shak However sippy cup was not available Staff stated resident preferred regula cup, OT to evaluation for more appropriate cup and one resident ag with. 2.Because all many residents need adaptive devices many are potentiall affected by the cited deficiency. This	king. e. ar rees

F 810 Continued From page 201 R7's Quarterly Nutrition Note dated 3/1/18, identified R7 required approximately 2010 milliliters (ml) of fluid a day to maintain good nutritional status. R7 uses " built-up silverware, plan dated 11/8/17, identified R7 was at risk for dehydration and impaired nutrition related to his mobility and age. The plan listed several interventions to help meet his identified nutrition goals including having occupational therapy (OT) screen and provide adaptive equipment as needed along with, "Use ordered adaptive equipment built-up silverware, blue inner-lip plate." The care plan lacked any identified need or intervention to use a cup with handles or "sippy cup." PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) I staff Udiscussed with dietary manager and dietician and it is agreed the diet slip will be updated when appropriate cup is determined and in meantime staff to encourage sippy cup if R7 does not agree offer cup and fill half way, refill as needed. All staff update at in-service 4/4/2018 about adaptive equipment and importance of offering it or alerting charge nurse if further follow up is needed to find another option. All residents with adaptive devices have been reviewed for use and appropriateness. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nursing, on 4/4/2018 all staff received in-service training for adaptive equipment. Reviewed respect and dignity with and importance of giving residents		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		E SURVEY PLETED
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MOORHEAD, MN 56560	NAME OF	PROVIDER OR SUPPLIE	≺			DDE	
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R7's Quarterly Nutrition Note dated 3/1/18, identified R7 required approximately 2010 milliliters (ml) of fluid a day to maintain good nutritional status. R7 uses " built-up silverware, a sippy cup and inner-lip plate to assist him in feeding himself." In addition, R7's nutritional care plan dated 11/8/17, identified R7 was at risk for dehydration and impaired nutrition related to his mobility and age. The plan listed several interventions to help meet his identified nutrition goals including having occupational therapy (OT) screen and provide adaptive equipment as needed along with, "Use ordered adaptive equipment: built-up silverware, blue inner-lip plate." The care plan lacked any identified need or intervention to use a cup with handles or "sippy cup." discussed with dietary manager and dietician and it is agreed the diet slip will be updated when appropriate cup is determined and in meantime staff to encourage sippy cup if R7 does not agree offer cup and fill half way, refill as needed. All staff update at in-service 4/4/2018 about adaptive equipment and importance of offering it or alerting charge nurse if further follow up is needed to find another option. All residents with adaptive devices have been reviewed for use and appropriateness. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the director of nursing, on 4/4/2018 all staff received in-service training for adaptive equipment. Reviewed respect and dignity with and importance of giving residents	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
a.m. dietary aide (DA)-A approached R7 and served him a regular 240 ml glass of apple juice and a cup of coffee filled with chocolate milk. R7 reached for the glass of apple juice and pulled it towards him on the table, then used both hands around the glass, picked it up and brought it to his lips. R7 was visibly shaky as he picked up the glass from the table despite using two hands around the regular glass. At 8:24 a.m. nursing assistant (NA)-K approached R7 with his breakfast meal and placed it on the table in front of him along with a white colored slip of paper. The slip of paper identified R7's name along with his current diet. Further, the slip identified a section labeled, "Adaptive Equipment," which included, "Sippy Cup." At 8:28 a.m. R7 again picked up the regular glass of apple juice and pulled it towards him on the dietary manager to monitor menus and ensure what is posted is served. The dietary manager or designated quality-assurance representative will perform the following systematic changes: the dietary manager or OT will complete residents with adaptive devices or needing devices 2 audits 3x per week x 4 weeks, then 2 audits 2x week x 4 weeks then weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance representative will be auditor.	F 810	R7's Quarterly Nuidentified R7 required milliliters (ml) of fl nutritional status. a sippy cup and in feeding himself." plan dated 11/8/1 dehydration and in mobility and age. interventions to himself and provide needed along with equipment: built-uplate." The care for intervention to cup." During observation on 3/9/18, at 8:11 in the main dining a.m. dietary aide served him a reguland a cup of coffereached for the glassylips. R7 was visitinglass from the takaround the regulants assistant (NA)-Kabreakfast meal ar of him along with The slip of paper his current diet. Esection labeled, "Aincluded, "Sippy Cipilor of the policy of the paper his current diet. Esection labeled, "Aincluded, "Sippy Cipilor of the paper his current diet. Esection labeled, "Aincluded, "Sippy Cipilor of the paper his current diet. Esection labeled, "Aincluded, "Sippy Cipilor of the paper his current diet. Esection labeled, "Aincluded, "Sippy Cipilor of the paper his current diet. Esection labeled, "Aincluded, "Sippy Cipilor of the paper his current diet. Esection labeled, "Sippy Cipilor of the paper his current diet. Esection labeled, "Sippy Cipilor of the paper his current diet. Esection labeled, "Sippy Cipilor of the paper his current diet. Esection labeled, "Sippy Cipilor of the paper his current diet. Esection labeled, "Sippy Cipilor of the paper his current diet. Esection labeled, "Sippy Cipilor of the paper his current diet. 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Esection labeled, "Aincluded, "Sippy Cipilor of the paper his current d	utrition Note dated 3/1/18, irred approximately 2010 uid a day to maintain good R7 uses " built-up silverware, nner-lip plate to assist him in In addition, R7's nutritional care 7, identified R7 was at risk for mpaired nutrition related to his The plan listed several elp meet his identified nutrition aving occupational therapy (OT) de adaptive equipment as n, "Use ordered adaptive up silverware, blue inner-lip plan lacked any identified need use a cup with handles or "sippy on of the breakfast meal service a.m. R7 was seated at a table proom in his wheelchair. At 8:16 (DA)-A approached R7 and ular 240 ml glass of apple juice are filled with chocolate milk. R7 hass of apple juice and pulled it the table, then used both hands picked it up and brought it to his oly shaky as he picked up the ole despite using two hands are glass. At 8:24 a.m. nursing approached R7 with his and placed it on the table in front a white colored slip of paper. identified R7's name along with further, the slip identified a Adaptive Equipment," which Cup." At 8:28 a.m. R7 again	F 81	discussed with dietary mana dietician and it is agreed the be updated when appropriate determined and in meantime encourage sippy cup if R7 do offer cup and fill half way, reall staff update at in-service about adaptive equipment and of offering it or alerting charge further follow up is needed to option. All residents with ada have been reviewed for use appropriateness. No other reaffected. 3. To enhance currently compoperations and under the director of nursing, on 4/4/20 received in-service training frequipment. Reviewed respendith and importance of giving the tools they need to be such their ADL's. 4. Effective 4/4/2018, a quality program was implemented usupervision of the dietary manadesignated quality-assurance representative will perform the systematic changes: the diet or OT will complete residents adaptive devices or needing audits 3x per week x 4 weeks the months to ensure compliance. Any deficiencies will be correspot, and the findings of the	diet slip will e cup is e staff to oes not agree fill as needed. 4/4/2018 nd importance ge nurse if o find another aptive devices and esidents were cliant ection of the 018 all staff or adaptive ct and dignity g residents ccessful in cy-assurance anager to what is posted ager or e ne following tary manager s with devices 2 s, then 2 en weekly x2 e in this area. ected on the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245052	B. WING		03/	13/2018
	PROVIDER OR SUPPLIE	R ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, 2810 SECOND AVENUE NORT MOORHEAD, MN 56560	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 810	mouth, visibly sha R7 consumed 10 spilling it. When interviewed stated R7 used to beverages, howe stopped. NA-K si "updated" with infi they don't update observed R7's which verified it directed however, felt it was complained." When interviewed stated R7 used a not a sippy cup do do so. DA-A state cook to make sur stated staff should using a sippy cup	page 202 aky as he lifted it from the table. 0% of the provided juice without d on 3/9/18, at 8:45 a.m. NA-K be use a sippy cup for his ever, NA-K thought this was tated the kitchen struggled to be formation at times and stated " those tickets [white slip]." NA-K nite menu slip on the table and I to use a sippy cup at meals, asn't an issue because he "never d on 3/9/18, at 8:50 a.m. DA-A "regular glass" for his meals, espite his menu slip directing to ed she would check with the e. At 8:53 a.m. cook (CK)-B d be serving his juices to him as he struggled and was "not the regular cups" consistently.	F8	quality-assurance com further review or correct 5.All staff will be respon	ctive action.	
	During interview of practical nurse (LR7 have "some dadding R7 was not if he needed help sometimes. LPN-adaptive equipmes "meal card [white the items which a maybe required sadaptive equipment to use those things	had witnessed R7 to shake and king before. on 3/9/18, at 9:01 a.m. licensed PN)-I stated she had observed ifficulty" with drinking fluids of someone who would verbalize despite maybe needing it I stated a resident using ent would have it listed on the slip]" and staff should be using re listed. LPN-I stated the staff ome "education" on using ent, and added it was important as for residents who need them is independent as they can be "				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245052	B. WING		03/13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 SECOND AVENUE NORTH MOORHEAD, MN 56560	00/10/2010
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 810	director of nursing R7 had used sippy knowledge they ha DON added, "he not able to feed himsel A facility policy on a meal(s) was requered.	on 3/12/18, at 9:02 a.m. the (DON) stated she was aware cups in the past and to her d not been discontinued. eeds to be served them," to be f. use of adaptive equipment at sted, however, none was	F 810		4/22/40
	CFR(s): 483.60(i)(1) §483.60(i) Food sa The facility must - §483.60(i)(1) - Pro- approved or consistate or local author (i) This may include from local produce and local laws or re (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for §483.60(i)(2) - Stor serve food in accor standards for food This REQUIREME by: Based on observar review, the facility for	fety requirements. cure food from sources lered satisfactory by federal, orities. e food items obtained directly rs, subject to applicable State egulations. oes not prohibit or prevent g produce grown in facility o compliance with applicable bod-handling practices. does not preclude residents ods not procured by the facility. re, prepare, distribute and rdance with professional	F 812	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submi	the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/30/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X4) DATE SURVEY COMPLETED (X4) PROVIDER'S PLAN OF CORRECTION (X5)	CENTE	RS FUR MEDICARE	& MEDICAID SERVICES			UI UI	VIB NO.	0938-0391
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MOORHEAD REHABILITATION & HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			245052	B. WING			03/1	13/2018
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	MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER					
	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
manner to prevent foodborne illness with potential Salmonella poisoning (a bacterial infection which can cause diarrhea, fever and abdominal cramps and can lead to hospitalization or death). This resulted in an immediate jeopardy (IJ) situation for 2 of 2 residents (R25, R35) identified to consume unpasteurized, fried eggs on a routine basis; and for 27 of 27 additional residents (R22, R7, R26, R108, R38, R37, R37, R9, R45, R5, R44, R28, R42, R27, R55, R114, R56, R10, R29, R4, R208, R14, R209, R12, R20, R25, R52, R30) identified by the facility to consume the unpasteurized, fried or undercooked eggs and who were at increased risk of contracting a potentially life-threatening Salmonella infection as a result. The IJ began on 10/10/17, when the facility began to receive, prepare and serve unpasteurized shell eggs on a made-to-order basis which included having a runny yolk which was not fully cooked resulting in an increased potential for foodborne illness. On 3/8/18, at 12:38 p.m., however, non-compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E). In addition, the facility failed to ensure meal items and re-heated food was prepared and served hot enough to reduce or prevent foodborne illness for 7 of 7 residents identified to consume a reheated meal. Further, the facility failed to ensure cleaned dishes were allowed to air dry and not stacked away for re-use while wet; and ensure 1 of the proposition of the proposition of the proposition of the proposition of the stacked away for re-use while wet; and ensure 1 of the state of the sum and re-heated food the sum of the	F 812	manner to prevent Salmonella poisoni can cause diarrhea and can lead to hos resulted in an imme for 2 of 2 residents consume unpasteu basis; and for 27 of R7, R26, R108, R3 R28, R42, R27, R5 R208, R14, R209, I identified by the fact unpasteurized, fried who were at increas potentially life-threa a result. The IJ began on 10 to receive, prepare eggs on a made-to-having a runny yolk resulting in an increasillness. On 3/8/18, registered dietician Clinical Reimburse. The IJ was remove however, non-compacope and severity potential for more timmediate jeopardy. In addition, the faciliand re-heated food enough to reduce of 7 of 7 residents ide meal. Further, the cleaned dishes were	foodborne illness with potential ng (a bacterial infection which, fever and abdominal cramps spitalization or death). This ediate jeopardy (IJ) situation (R25, R35) identified to rized, fried eggs on a routine 727 additional residents (R22, 8, R37, R9, R45, R5, R44, 85, R114, R56, R10, R29, R4, R12, R20, R25, R52, R30) sility to consume the dor undercooked eggs and sed risk of contracting a stening Salmonella infection as a stening Salmonella i	F8	312	admission that a deficiency exists of one was cited correctly. This Plan of Correction is submitted to meet requirements established by state at federal law. 1. It is the policy of this facility to ensiminate healthy and safe meal service. Sore the many ways that this has been densuring fresh food, properly cooked and making sure there are no signs symptoms of gastroenteritis or salmonella. After the surveyor report finding non-pasteurized eggs in kitch and learning 2-3 residents at eggs cooked the were non-pasteurized a eggs were immediately removed, at pasteurized ones ordered; residents reviewed for any signs or symptom illness. It also ensures food temps a safe, kitchen equipment is clean and dishes are dried appropriately to redinfection. 2. Because all residents receive the meals here in facility all are potential affected by the cited deficiency, 3/8 the director of dietary reviewed which eggs were ordered, and which residence or orders now only contain pasteurized eggs. Vendor was notified, and order changed within their system to only shell eggs that are pasteurized. Die and nursing staff aware of current profor eggs, food temps, kitchen equip dish drying protocols. 3. To enhance currently compliant	of and sure me of one is ed food, or rted chen lightly nd and s were of duce ir ally /2018, ch dents sy. All d shell er supply tary policy ment,	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		E SURVEY PLETED
		245052	B. WING _		03/	13/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		10/2010
				2810 SECOND AVENUE NORTH		
MOORHE	EAD REHABILITATIO	N & HEALTHCARE CENTER		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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 812	These practices have residents identified prepared and servickitchen. Findings include: UNPASTEURIZED A United States (United States) (Unit	reduce the risk of associated foodborne illness. ad potential to affect 57 of 57 l to receive food and/or meals ed by the main production DEGGS: S) Food and Drug A) Egg Safety: What You Need ated January 2016, identified ntain bacteria called, an estimated 79,000 case(s) in associated foodborne illness th year from eating these is. The feature explained people were at higher risk of ess," as a result of contracting ted these people to be, " lts, pregnant women, and ned immune systems (such as and individuals with HIV/AIDS, es)." There were several steps to and/or eliminate the risk of eng, "Cook eggs until both the are firm. Scrambled eggs	F 81	staff that cook will receive in training regarding state and requirements for safe egg hat cooking. The training will er cooking eggs safely and using pasteurized eggs for serving 4. Effective 3/8/2018, a quality program was implemented usupervision of the director of monitor cooking of eggs. The dietary or designated quality representative will perform the systematic changes: randon or weekly checking residents eggs not fully cooked. Any of will be corrected on the spot findings of the quality-assuration will be documented and submonthly QAPI meeting for furor corrective action. 4/4/201 meeting reviewed food temposteurized eggs and made changes, drying dishes to ail cleanliness of kitchen equipped 5. Audits of kitchen eggs, equitemps and kitchen cleanline done 3x per week for 4 week week for 2 months to ensure via dietary manager or desig 6. Dietary Manager and Dieti responsible for this POC.	federal andling and inphasize ing j. ty-assurance under the f dietary to ne director of r-assurance the following inly checking, is who prefer deficiencies in, and the inther review ance checks mitted at the urther review all staff is, to order ir and iment. uipment, food iss are being iks then 1x per is compliance ignee.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION			E SURVEY PLETED
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIEI	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZI 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 812	eggs and egg pro available," and, "Cand white are firm Salmonella infection more dangerous included older addimmune systems " may get a mobe life-threatening. On 3/6/18, at 12:3 production kitcher (CK)-A. The kitch refrigerator in use inspected. This reboxes with addition of them. There we flats, along with sereplaced empty elboxes were labeled and neither of the or visible eggs plamarkings or any elboxes were labeled and neither of the or visible eggs plamarkings or any elboxes were labeled and been pasteur the risk of food-bocooked or are onlowith shell eggs ar stamping on the elevere used on a "remade-to-order "fristaff prepare and week for the bread buring observation on 3/8/18, at 7:25 making scrambled using a pasteurize can next to the gr	ducts, which are widely Cook eggs until both the yolk a." Further, the article identified ons, "can be serious and is for certain people," which alts and people with weakened dictating these affected people, re serious illness that can even	F8	112			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03	/13/2018	
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 812	had visible marking been pasteurized, the egg shells in the grown and e-to-order egg. CK-B explained showed the surve unpasteurized showed the surve unpasteurized showed the surve unpasteurized showed the steam service during the At 7:48 a.m. CK-E serving pans contisted she was ready and able to gathered in the did requested her too the fried eggs. Che the stacked fried edgrees (F) now, been 145 degrees before placing the 7:25 a.m The egout of the egg wheremoved. RD-A, table when the egs stated the eggs showed the eggs	gs to demonstrate they had CK-B was questioned about the trash and stated she made with them describing the gs as, "like over easy fried." The made these eggs using the in the walk-in refrigerator, and yor the same boxes and flats of ell eggs observed on 3/6/18, red and then placed these fried in table out in the dining room for	F8	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03	/13/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 812	routinely unless to the meal service the cooks serve undercooked eggmenu. When que unpasteurized eg CK-B was unawawere unpasteuriz responsible to or vendors. RD-A observed to from the steam to in the kitchen and undercooked with explained madeside up" and "over prepared for reside up" and "over prepared eggestable were disposed to the facility was or pasteurized eggestable were disposed unpasteurized eggestable unp	hey were listed on the menu for (every Tuesday). CK-B stated l'about sixty" fried and/or gs when they were listed on the estioned about using gs for made-to-order cooking, are the shell eggs being used red, further adding CK-A was der all food items from the leggs, which were removed able just prior, with the surveyor diverified the eggs were in a visibly runny yolk. RD-A to-order eggs, including "sunny re easy", were frequently dents to consume, however, she yonly used pasteurized eggs im. RD-A proceeded to visualize ll eggs in the facility's walk-in rerified the eggs being used to der eggs were unpasteurized. It is greated to by the RD-A at that time, he was unaware how long the gs had even been obtained as anly supposed to using when preparing fried or	F8	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		03	/13/2018	
	PROVIDER OR SUPPLIE	R ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 812	On 3/8/18, at 8:16 interview with RI residents of the fawhen it was listed in addition other rathey request it," of there were no pass which could have undercooked or nexpressed using undercooked, magood," because prompromised heasick" with Salmon call had been place and informed their unpasteurized egishe "would assun just been delivered cases of eggs har Further, RD-A stamanaging the kitt with the facility so employed in their FoodSafe certified. The past four (4) were requested for provided the followhich contained to food items served dated and identified. On 3/6/18, fried served for breakford 168 degrees.	S a.m. during a follow up on the stated nearly all the acility were served fried eggs on the menu (every Tuesday), esidents were served them "if on other days. RD-A verified steurized eggs in the facility been used to make nade-to-order fried eggs. RD-A unpasteurized eggs for de-to-order service was "not eople who are elderly or have alth were "more at risk of getting sella poisoning. She stated a coed to the food service vendor on they could no longer send ge to the facility. RD-A stated ne" the unpasteurized eggs had alto within the past week as two digust come in "last Thursday." Ited CK-A had been in charge or then, however, was no longer there was nobody else dietary department who was do. Weeks of temperature records or the meal services, and RD-A wing HACCP Recording Charts the recorded temperatures of the for each meal. These were	F 81:	2			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		2810	EET ADDRESS, CITY, STATE, ZIP CODE D SECOND AVENUE NORTH ORHEAD, 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) COMPLETION DATE
F 812	these were scrambanother cooked eg temperature was 1 - On 2/20/18, fried breakfast with a redegrees. - On 2/13/18, fried breakfast with a redegrees. No other days in the provided to demonprepared, cooked at the resident popular by CK-A and RD-A fried, undercooked and "by request" by was provided to defried eggs had been checked for proper A listing of resident fried, made-to-ordefacility provided and High Risk for Salm of 27 current reside R38, R37, R9, R45, R209, R12, R20, R14, R56, R14, R56, R14, R56, R14, R56, R15, R114, R156, R15, R15, R15, R15, R15, R15, R15, R15	st, however, did not specify if led eggs, fried eggs, or g dish. The recorded	F8	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03	/13/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		N SHOULD BE	(X5) COMPLETION DATE	
F 812	interferes with the and/or to be rece treatment drugs vimune system), section labeled, "Eggs 2 - 3 x [time being identified u R25's quarterly M1/10/18, identified mellitus and had interview on 3/8/1 was provided and times a week." T "sunny side up [fr flipped with the yolk was liqui R25 explained he eating these, too, kitchen. R35's annual MD had moderate co interview on 3/8/1 had been served from the kitchen described these of [fried on both side while the yolk ren R7's quarterly ME had intact cognitinat 1:51 p.m. R7 v with his meals at he saw another reggs the week prup eggs. R7 sta	e body's ability to fight infections) iving chemotherapy (cancer which can weaken the body's Further, the listing identified a Resident that will request Fried es] per week," with R25 and R35 inder this heading. Inimum Data Set (MDS) dated a R25 had diagnosis of diabetes intact cognition. During 18, at 11:13 a.m. R25 stated he disconsumed fried eggs a "couple these eggs were typically served ried on just one side and never olk being completely liquid and surface being barely set]" and diand runny when consumed. It is seen they were served by the sees "a lot," of other residents when they were served by the seed at 1/31/18, identified R35 gnitive impairment. During 18, at 11:19 a.m. R35 stated he fried eggs with a "runny" yolk in the past couple weeks. R35 eggs as being served "over easy es so the egg whites are firm	F8	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE B10 SECOND AVENUE NORTH IOORHEAD, MN 56560	,	
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F 812	When interviewed or registered nurse reservices (DCS)-A soff-campus and not questioned about unade-to-order serving with the old schexample of people farm and having lest DCS-A explained sany higher risk popillness when consulanywhere else add potential risk," from eggs as if someone would likely not be stated RD-A was the incharge of the "own there." A facility provided Sinvoice dated 8/29/received pasteurized different food vendused and delivered kitchen. These involuments in the continued to proceed the continued to proceed with 15 dozed delivered over 21 sweeks.	on 3/8/18, at 8:41 a.m. gional director of clinical tated the administrator was a available for interview. When sing unpasteurized eggs for vice, DCS-A stated she would nool theory" and provided an eating "fresh" eggs from the ess infections and illness. The did not feel the facility had ulation for potential foodborne ming undercooked eggs than ing there was "very little a consuming the undercooked e was "used to that," they come ill. Further, DCS-A are acting kitchen manager and versight of what's happening in Sysco (food supply vendor) 17, identified the facility ed egg shells. On 10/10/17, a for company, Reinhart, was the ordered items for the oices, dated 10/10/17 to 3/2/18 ry), identified the facility began rized egg shells on 10/10/17, resent day. A total of 23 cases in) of unpasteurized eggs were eparate deliveries during these	F	312			
	a.m. RD-A stated the Reinhart as their material from Sysco in Octo	interview on 3/12/18, at 9:12 ne facility was currently using ain food vendor; switching ber 2017. The invoices from					

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		245052	B. WING _		03	/13/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		, 10,2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	the unpasteurized delivered in Octol switched vendors charge of ordering ordered items sho (previous) RD to correct and within unpasteurized eg should be "155 [d served as this war code. Further, RI unpasteurized eg undercooked or vacceptable as the with compromised processes were "bacterial infection." A facility Safe Egg 12/23/17, identified follow safe handling the FDA and Ames spread of salmon foodborne illnessed esignee was resproperly received being served. Further pasteurized shell concerns of Salm residents at risk," egg shells "mus with whites solid at Although, the risk relatively small stream or diseas and are more like	d shell eggs started being per 2017, when the facility at RD-A explained a cook was in g the food items, however, all build have been reviewed by the make sure the items were a budget. RD-A expressed any gs being prepared undercooked legrees] at least," when being is "per regulation" and food D-A reiterated serving gs which were prepared with runny yolk(s) was not elderly population and people d immune systems or disease so vulnerable" to a potential and associated illness. G Handling policy dated and associated illness. G Handling policy dated and the dietary service "must ing of eggs, as recommended by erican Egg Board to avoid the ella and other potential es." The director of dietary or sponsible to ensure eggs were, stored and cooked prior to inther, it was "preferred to use eggs per stated by FDA due to innella Enteritidis [SE] for and dictated, if used, all raw st be cooked to 155 [degrees F] -	F 81				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		245052	B. WING		03	/13/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		10.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	This unnecessary immediate correct serious harm, injude acquired from eggs which were consumed. The IJ which begon 3/9/18, at 1:38 implemented a result of the pasteurized eggs undercooked, friesult of the pasteurized eggs undercooked, friesult of the pasteurized egg hand of the pasteurized they had the safe preparate undercooked egg	y risk resulted in a need for ction as it had a high potential for ction as it had a high potential for ction as it had a high potential for cury or death should any infection eating the unpasteurized, fried prepared undercooked and an on 10/10/17, was removed a p.m. when the facility emoval plan which included: Inpasteurized eggs from ervice and ordering new, to use when preparing ed eggs; Intion to the dietary and nursing that and Federal requirements dling and preparation and; It is a preparation and; It is a preparation in the correct eggs d, delivered and prepared. It is 1:06 p.m. direct and staff were interviewed and received education regarding ion of made-to-order, gs; and the kitchen was toured to the teurized eggs were available to	F8	12			
	On 3/6/18, at 12: was completed w was in use outsid this was a mobile	32 p.m. an initial kitchen tour with cook (CK)-A. A steam table the kitchen, and adjacent to e cart with several metallic ced on top. These pan(s)					

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	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
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F 812	contained various from the lunch m brown gravy, rice During observation 3/6/18, at 5:19 main production mashed potatoes toast. A single Sinto the wall in the kitchen. CK-A lowerious sized, corprepared items. any visible holes items inside the steam covering(s) and bresidents. There temperatures obtomeal. When questioned temperature of the checked them at from the oven an foil adding she would write them down'the temperatures baked fish was 1 the squash was 1 further, inside the containing hamble with gravy, and rithe end of the lur When questioned	page 215 si items, identified by CK-A as eal including mashed potatoes, and hamburger patties. on of the evening meal service of p.m. CK-C prepared food in the kitchen including baked fish, with gravy, baked squash and seco steam table was plugged e dining room, just outside the added the steam table with vered, metallic containers of the The foil covering(s) did not have or marks to identify the food containers had been checked for imperature prior to placing them table. CK-A removed the foil began to plate food for the was no observed food rained prior to the service of the did about checking the ine food items, CK-C stated she "4 pm" when she removed them did covered them with aluminum as "a little busy" and just "didn't on the flowsheet. CK-C recited of each item aloud stating the 80 degrees (F) when removed, 175 F and the toast was 120 F. The steam table were containers arger patties, mashed potatoes ce just as was observed during inch meal service at 12:32 p.m did about using these items for the vice, CK-C stated these were	F8	12			

I ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	R ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 812	earlier, she just h CK-C was unawa reached in the ov the steam table for the temperature of served about sev the service and vicehecked for temp An HACCP Reco provided and revi spacing to record along with a cook However, under t blank with no foor recorded for eithe service temperatu When interviewed stated the served checked for propoplacing it on the service thecked for propoplacing it on the service temperature the items are too low "four times" to ch temperatures tha service began. During interview of corporate register kitchen staff shou "right before they steam table," so t re-heat the items cool. She stated to serving temperature	and reheated them. However, are how hot these items had been before she placed them in or service as she did not check of them. CK-C stated she en (7) people these items during erified they should have been becature prior to serving. Trying Chart dated 3/6/18, was ewed. The flowsheet provided each meals' dishes served ing and service temperature. The heading of "Supper:" was left ditems or temperatures being er a cooking temperature or	F8	12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		2810	EET ADDRESS, CITY, STATE, ZIP CODE 0 SECOND AVENUE NORTH ORHEAD, 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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From pa	age 217	F 8	12			
	should not be re-us	sing food items from the d should be "making new					
		ood temperature(s) and ing was not provided.					
	WET DISHES:						
	was completed with metallic, free stand contained several s A stack of four (4) ' droplets inside and attempted to be se stacked "six inch" p water droplets inside	P. p.m. an initial kitchen tour in cook (CK)-A. A single ing cabinet was opened which stacks of metallic serving pans. 12/8ths" pans had visible water stuck together when parated. In addition, two pans also contained visible de. These pans dripped water then they were removed from ysically separated.					
	stated the pans should h to air dry before being pu	mmediately following, CK-A buld have been left on the rack ing put away in the shelving staff were "in a hurry" and just tead.					
	corporate registere were some concern kitchen amongst the should have been a stacked and put aw this should be done bacterial growth in A facility Kitchen Saidentified staff "will	a 3/8/18, at 8:28 a.m. the d dietician (RD)-A stated there has with "good follow up" in the e staff at times, and the dishes allowed to air dry before being yay for use. RD-A explained to reduce the chance of the wet, stacked dishes. Anitation policy dated 12/23/17, ensure all pots, pans utensils s are air dried prior to use."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING_		03	/13/2018
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 812	SOILED MIXER: An undated Universection labeled, "directed to wash the support and the best bowel, as a large wired detached at the best bowel, a large wired detached from the positioned along the attached at the best bowel, a large wired detached from the point where the whad several chunical colored speckling face of the mixing mixing bowl contact colored substance this and stated not the mixer that day colored chunks we potatoes. CK-A stored the wight of the use. When interviewed corporate register had observed and thought the white, possible cake bat stated the mixer stated the mixer stated the mixer stated the winter stated the	ex Operators Manual identified a Cleaning Your Mixer," and he body of the mixer, the bowl eater shaft with warm water and er, "Wash the bowl and beater	F8	12		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		245052	B. WING _			03/13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP O 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	12/23/17, identified and clean the device guidance or dictatic completed.	Citchen Mixer Protocol dated a procedure to disassemble e, however, lacked any on on how often this should be	F 8 ⁻			
	of the Act, the facilit which is located in a reservation) must he agreement with one for participation under programs that reas (i) Residents will be the hospital, and enthe hospital when the appropriate as deter physician or, in an enther practitioner policy and consiste (ii) Medical and other and treatment of retransferring facility determining whether appropriate service restrictive setting the hospital, or reintegribe exchanged betwood to the sexual service and the sexual service restriction or reintegribe exchanged betwood to the sexual service and the sexual service restriction of the sexual sexual service restriction of the sexual servi	agreement. cordance with section 1861(I) by (other than a nursing facility a State on an Indian ave in effect a written transfer or more hospitals approved der the Medicare and Medicaid onably assures that- transferred from the facility to assured of timely admission to ransfer is medically rmined by the attending emergency situation, by in accordance with facility int with state law; and er information needed for care sidents and, when the deems it appropriate, for er such residents can receive s or receive services in a less an either the facility or the ated into the community will reen the providers, including e information required under	F 84	13		4/23/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION NG	` ′	SURVEY PLETED
		245052	B. WING_		03/1	13/2018
NAME OF F	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	.0.2010
MOORHE	EAD REHABILITATION	N & HEALTHCARE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 843	facility to make trar This REQUIREMEI by: Based on interview facility failed to dev an in-effect transfer Medicare participat potential to affect a who could require hasis. Findings include: During the extende 3/13/18, evidence with facility had a tra a local Medicare participated. When interviewed administrator stated transfer agreement were going to call Shad a copy of one. emergency transfer just call 911 and has	nsfer feasible. NT is not met as evidenced v and document review, the elop and/or have evidence of r agreement with a local ing hospital entity. This had Il 58 residents in the facility nospitalization on an emergent d survey from 3/5/18 to was requested to demonstrate ansfer agreement in place with articipating hospital entity. nation or evidence was on 3/12/18, at 1:28 p.m. the d they were unable to locate a t with a local hospital, however, Sanford Health and see if they Further, if someone required r to a hospital, the staff would have the ambulance bring them ford hospital for care.	F 84	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. Transfer agreement has been developed and signed by ED and sessentia Health and Sanford Health 4-3-18. 2. The agreement is to ensure that residents will be transferred from the facility to the hospital when transfermedically appropriate as determine the attending physician, or in an emergency situation. 3. Both hospitals indicated they wouth agreement but needed to send legal their legal team first to review indicated that it typically takes two weeks to get back from their legal 4. The ED will discuss this deficience the QAPI meeting on 4-30-18 and make sure the agreement always grenewed prior to expiration.	the ssion or that of and ent to h on he r is ed by uld sign it to r. They to four team. by at will gets	
F 844 SS=C		ership Requirements 1)-(3)	F 84	5.The ED is responsible for this PC		4/23/18
		ure of ownership. facility must comply with the nents of §420.206 and 455.104				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
		245052	B. WING		03/	13/2018
	PROVIDER OR SUPPLIE	R ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 844	of this chapter. §483.70(k)(2) The notice to the State licensing the facil change occurs in (i) Persons with a as defined in §§4 chapter; (ii) The officers, demployees; (iii) The corporation company responsifacility; or (iv) The facility's a nursing. §483.70(k)(3) The facility's a nursing. §483.70(k)(3) The facility's a nursing. Based on intervie facility failed to ernotified as require nursing (DON) was This had potential facility. Findings include: During the extend 3/13/18, evidence the SA had been hired to her position.	e facility must provide written e agency responsible for ity at the time of change, if a nownership or control interest, 20.201 and 455.101 of this irectors, agents, or managing on, association, or other sible for the management of the administrator or director of e notice specified in paragraph on must include the identity of ital or company. ENT is not met as evidenced ew and document review, the issure the State agency (SA) was ed when the current director of as appointed to their position. It to affect all 58 residents in the ded survey from 3/5/18 to e was requested to demonstrate notified when the DON was	F 844	The preparation of the followin correction for this deficiency do constitute and should not be in as an admission nor an agreen facility of the truth of the facts a conclusions set forth in the stat deficiencies. The plan of correct prepared for this deficiency was solely because the provisions of federal law require it. Without with respect to: 1. On 3-12-18 a letter was typed letterhead and sent to the SA venotifying them of a change in key 2. The letter stated that there has change in the Director of Nursing them of province to the same than the change in the province the same transfer to the same transfer	tes not terpreted nent by the alleged or tement of ction is executed of state and vaiving the vistates d on facility ia email ey staff. ad been a	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245052	B. WING			03/	13/2018
	PROVIDER OR SUPPLIER EAD REHABILITATIO	N & HEALTHCARE CENTER		28	REET ADDRESS, CITY, STATE, ZIP CODE 10 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 844	The DON was char 1/23/18. When interviewed administrator state on 1/23/18, and veuntil today with the the administrator s	on 3/12/18, at 1:28 p.m. the d the current DON was hired rified the SA was not notified provided letterhead. Further, tated he was "unaware" the SA when the DON position was	F 8	44	and was signed and dated by the E 3.The ED is now fully aware of this requirement and will discuss this deficiency at the QAPI meeting on 4-30-18. 4.The ED is responsible for this PC		

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PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 245052 03/07/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH **MOORHEAD REHABILITATION & HEALTHCARE CENTER** MOORHEAD, MN 56560 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Moorhead Rehab & HCC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99. The Health Care Facilities Code. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

04/09/2018

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A: BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245052	B. WING			03/	07/2018	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		281	EET ADDRESS, CITY, STATE, ZIP CODE 0 SECOND AVENUE NORTH ORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC 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	
K 000	Continued From 445 Minnesota S St. Paul, MN 551	treet, Suite 145	K	000				
	Or by e-mail to: Marian.Whitney@ and Angela.kappenm							
		ORRECTION FOR EACH JST INCLUDE ALL OF THE FORMATION:						
	1. A description of to correct the def	of what has been, or will be, done iciency.						
	2. The actual, or	proposed, completion date.						
	responsible for co	l/or title of the person orrection and monitoring to rrence of the deficiency						
	stages. In 1963 the constructed without determined to be 1998 a 1-story account east of the and was determined to the construction. In 2 constructed to the building and a direct of the original east of the original constructed.	b & HCC was built in three the original 1-story building was but a basement and was Type II (111) construction. In ddition was constructed to the east wing of the original building ned to be Type V (111) 2009 a dayroom addition was e north east corner of the original hing room addition to the south all dining room was constructed. are Type II (000), 1-story without						
	accordance with	ng is sprinkler protected in NFPA 13 Standard for the rinkler Systems 1999 edition.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245052	B. WING _		03/07/2018
	ROVIDER OR SUPPLIER AD REHABILITATION	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	one building, existing as the least fire resident of the NFPA 101 section of the facility has a carcensus of 58 at the section of the requirement at NOT MET as evided fire Alarm System CFR(s): NFPA 101 fire Alarm System accordance with an with the requirement electric Code, and and Signaling Code acceptance, mainted available. 9.6.1.3, 9.6.1.5, NFT his REQUIREMENT of the National Fire Alarm as required 2012 edition, section of the National Fire Alarm and affect allive and affect allive resident of the National Fire Alarm as required 2010 edition, section of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and affect allive resident of the National Fire Alarm and the North A	2016 this was surveyed as and, with the construction type istive construction type per 3.2.1.3 (3) apacity of 78 beds and had a time of the survey. 42 CFR, Subpart 483.70(a) is need by: - Testing and Maintenance - Testing and Maintenance is tested and maintained in approved program complying and of NFPA 70, National NFPA 72, National Fire Alarm as Records of system enance and testing are readily	K 00		ed the or of uted and the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	.` ′	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245052	B. WING		03/0	07/2018
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, Z 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 345	on 03/07/2018 resemble detector n	page 3 or between 12:00 pm to 3:30 pm view of the records revealed a next to room 410 failed and was	К3	1.Protection Systems was a new smoke detector had in hallway next to room 4	1.Protection Systems was contacted, and a new smoke detector has been installed in hallway next to room 410 in accordance with NFPA 72. 2.Fire Alarm System will continue to be inspected on an annual basis and will have a sensitivity test completed. 3.The DOM is responsible for this POC.	
			К 3	 Fire Alarm System will inspected on an annual I have a sensitivity test co The DOM is responsib 		
	services for more period, the author notified, and the lapproved fire wat parties left unprofire alarm system 9.6.1.6	of Service ire alarm system is out of than 4 hours in a 24-hour rity having jurisdiction shall be building shall be evacuated or an ich shall be provided for all tected by the shutdown until the has been returned to service. ENT is not met as evidenced				
	facility has failed acceptable writte be followed in the system has to be more hours in a 2 2012 edition sect practice could aff response and not affect the safety oundetermined nut. Findings include: On the facility tou	rd review and staff interview, the to provide a complete and n policy containing procedures to e event that the Fire Alarm placed out-of-service for four or 24 hour period as per NFPA 101 ion 9.6.1.6. This deficient fect the facility's ability for early tification of a fire and would of all 78 residents as well as an mber of staff, and visitors.		The preparation of the f correction for this deficie constitute and should not as an admission nor an facility of the truth of the conclusions set forth in the deficiencies. The plan of prepared for this deficient solely because the provifederal law require it. With foregoing statement, the with respect to: -Fire Watch Policy was a includes the following properties. The moment of the provincient of the province of the provinc	ency does not a to be interpreted agreement by the facts alleged or the statement of a correction and a correction are was executed sions of state and atthout waiving the e facility states are attention and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		SURVEY PLETED
		245052	B. WING _		03/0	7/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	-	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 346	not contain the ver more than 4 hours not contain curren This deficient cond	tem out of service policy did biage when out of service for in a 24 hour period and it did toontact information. Sition was confirmed by the and the Maintenance Director	K 34	the fire alarm system is identified. 2.If the Fire alarm is off line for mo 4 hours in a 24-hour period, the Maintenance Director or Administra notify the State Fire Marshal (Robe Baumann 612-215-0525) and a Fir Watch will be in effect. 3.If the Sprinkler system is offline f than 10 hours in a 24-hour period, State Fire Marshal will be notified, Fire Watch will be implemented. 4.Maintenance Director will immed notify local fire department and fire service vendor. 5.The Maintenance Director or Administrator will notify all staff and announce over the PA system that facility will operate on fire watch. 6.Administrator and/or Maintenance Director will designate one staff me to be the Watch Inspector. This pe will have no other duties and main facility Fire Watch Log. 7.Facility will maintain Fire Watch I until repairs are complete. 8.Policy was posted on communicat board and put in both communicat books. 9.The DOM and ED are responsib	ator will enter the or more the and a iately alarm the ember roon tain the orotocol ation ion	
	Sprinkler System - CFR(s): NFPA 101		K 35	this POC.		4/4/18
	extent and duration	er system is impaired, the n of the impairment has been or buildings involved are				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245052	B. WING _		03/0	07/2018
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 354	or designated rep department and o jurisdiction have be sprinkler system is hours in a 24-hou of the building affe approved fire wate system has been 18.3.5.1, 19.3.5.1 This REQUIREMED by: Based on a recorfacility has failed the acceptable writter be followed in the sprinkler system in for ten or more how NFPA 25. This defacility is ability for of a fire and would residents as well astaff, and visitors Findings include: On the facility tour pm on 03/07/2018 the Fire Sprinkler not contain the vermore than 10 hou not contain currer.	are submitted to management resentative, and the fire ther authorities having leen notified. Where the sout of service for more than 10 repriod, the building or portion ected are evacuated or an chis provided until the sprinkler returned to service. 9.7.5, 15.5.2 (NFPA 25) ENT is not met as evidenced device and staff interview, the oprovide a complete and a policy containing procedures to event that the automatic fire has to be placed out-of-service ours in a 24 hour period as perficient practice could affect the early response and notification diffect the safety of all 78 as an undetermined number of	K 38	The preparation of the follow correction for this deficiency constitute and should not be as an admission nor an agree facility of the truth of the facts conclusions set forth in the st deficiencies. The plan of corr prepared for this deficiency we solely because the provisions federal law require it. Without foregoing statement, the facility with respect to: -Fire Watch Policy was creat includes the following proced 1. Staff will notify Administration Maintenance the moment at the fire alarm system is ident 2. If the Fire alarm is off line for 4 hours in a 24-hour period, for Maintenance Director or Administration of the State Fire Marshal Baumann 612-215-0525) and Watch will be in effect. 3. If the Sprinkler system is of than 10 hours in a 24-hour per State Fire Marshal will be not Fire Watch will be implement	does not interpreted ement by the salleged or tatement of rection was executed so of state and t waiving the lity states ed and dures: on and disruption in tified. For more than the ininistrator will (Robert d a Fire eriod, the tified, and a	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245052	B. WING		03/0	7/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 354	Continued From pa	age 6	K 354	A.Maintenance Director will immed notify local fire department and fire service vendor.		
	not exceed 32 gallo density of container shall not exceed 0 container capacity exceeded within ar soiled linen or trast capacities greater located in a room pwhen not attended Containers used so to be excluded from where each contain gallons unless atternances.	rash Containers h collection receptacles shall ons in capacity. The average r capacity in a room or space 5 gallons/square feet. A total of 32 gallons shall not be ny 64 square feet area. Mobile n collection receptacles with than 32 gallons shall be protected as a hazardous area	K 754	5.The Maintenance Director or Administrator will notify all staff and announce over the PA system that facility will operate on fire watch. 6.Administrator and/or Maintenanc Director will designate one staff me to be the Watch Inspector. This pe will have no other duties and maintfacility Fire Watch Log. 7.Facility will maintain Fire Watch until repairs are complete. 8.Policy was posted on communicate board and put in both communicate books. 9.The DOM and ED are responsibe this POC.	the se ember erson tain the protocol ation ion	4/4/18

,	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - Main Building 01	(X3) DATE : COMPI	
		245052	B. WING		03/07	7/2018
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	O BE	(X5) COMPLETION DATE
K 754	18.7.5.7, 19.7.5.7 This REQUIREME by: Based on observate facility failed to protrash containers in as stated in the Lift edition section 19. could affect the saundetermined amount smoke or fire from the corridors non-uniteral findings include: On the facility tour pm on 03/07/2018 and linen containe corridor at all 4 corrooms that surrour	dard 6921 or equivalent. NT is not met as evidenced ation and staff interview the perly store soiled linen and a protected hazardous room e Safety Code NFPA 101 2012 7.5.7. This deficient practice fety of all 78 residents and an ount of staff and visitors if one of these containers made	K 754	The preparation of the following p correction for this deficiency does constitute and should not be interp as an admission nor an agreemen facility of the truth of the facts alleg conclusions set forth in the statem deficiencies. The plan of correctio prepared for this deficiency was essolely because the provisions of sfederal law require it. Without wait foregoing statement, the facility stwith respect to: 1. Staff were educated on 4-4-18 as staff meeting about the importance storing the trash and linen bins in corridor. 2. They were informed that both bic cannot be stored in one hallway as store one 32-gallon bin in each ald 3. By having one 32-gallon bin per this has reduced the capacity to 3 gallons in a 64 square foot area we not reduce the required width of left. 4. The DOM and ED will complete Trash/Linen audit x3 a week for 4 and then monthly for 3 months. 5. DOM and ED are responsible for	not preted at by the ged or nent of nent of nent of the ates at an all e of the ates alcove. alcove.	
	CFR(s): NFPA 101		K 90	POC.		3/15/18
		uilding System Categories are designed to meet Category				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY PLETED
		245052	B, WING		03/0	7/2018
	ROVIDER OR SUPPLIER AD REHABILITATIO	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 901	Categories are det	ements as detailed in NFPA 99. ermined by a formal and ssessment procedure fied personnel.	K 90°			
	by: Based on observation facility has failed to current facility Risk with the NFPA 99 "2012 edition section could affect all pations."	NT is not met as evidenced tion and staff interview, the provide a complete and Assessment in accordance Health Care Facilities Code" in 4.1. This deficient practice ents, as well as an iber of staff, and visitors.		The preparation of the following ple correction for this deficiency does constitute and should not be interpleas an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statem deficiencies. The plan of correction prepared for this deficiency was expected to the preparations of the province of the preparations of the prep	not reted t by the ged or ent of n kecuted	
-	pm on 03/07/2018 facility was not able document based of This deficient cond	between 12:00 pm and 3:30 during record review the e to provide a risk assessment n NFPA 99. lition was confirmed by the and the Maintenance Director		solely because the provisions of st federal law require it. Without waiv foregoing statement, the facility stawith respect to: 1.NFPA 99-2012 Utility Risk Asses was developed on an Excel Sprea 2.The risk assessment categories based on harm to the residents du loss of utility - Medical Gas, Electric Systems, and HVAC 3.On the assessment there are for categories: Death or serious injury injury, Discomfort, & No harm. 4.The risk assessment will be reviannually and as needed by the DC 5.The DOM is responsible for this	sment dsheet are e to cal ur, Minor sed DM.	
	Electrical Equipme CFR(s): NFPA 101	nt - Power Cords and Extens	K 92	·		4/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245052	B. WING			03/07/2018		
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 920	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG		DEFICIENCY)			
		8 observations revealed power or resident rooms were being			with respect to: 1.ED and DOM went around the	facility		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG 01 - MAIN BUILDING 01		COMPLETED	
		245052	B. WING		03/0	07/2018	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG			ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
K 920	and 405. In addition, an oxyginto a power strip a receptacle. This deficient cond	age 10 oms. 104, 204, 212, 306, 403 gen concentrator was plugged and not directly into a wall ition was confirmed by the and the Maintenance Director	К 9	and took away all the poweresident rooms and made concentrators were plugged the wall. They also inform these are considered a filter not allowed in rooms 2. Old power strips were oput out of commission and UL 1363 power strips. 3. The two-way outlets in will slowly be changed in outlets to eliminate the ustrips. 4. DOM will label all UL 13 so staff are aware they consume the strips. 4. DOM will label all UL 13 so staff are aware they consume the put in the communication book and board notifying staff that not labeled are prohibited 6. ED and DOM will discunsate resident council med (4-16-18). 7. Power strip audit will be for 4 weeks and then more months. 8. DOM & ED are respon POC.	e sure all led directly into hed residents that re hazard and confiscated and desident rooms to four-way se of power strips, an be used. He communication all power strips d. It is so this issue at leting on the done x2 a week onthly for 3		