

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 21, 2019

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

RE: Project Number H5052081C and H5052084C

Dear Administrator:

On April 25, 2019, we informed you that the following enforcement remedy was being imposed:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 24, 2019.

On April 30, 2019, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

• Civil money penalty. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated survey completed on April 9, 2019 that included an investigation of complaint number H5052084C. The most serious deficiency was found to be be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required and continued noncompliance was cited.

On April 30, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to abbreviated surveys, completed on March 5, 2019 and April 9, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 30, 2019. We have determined, based on our visit, that your facility has corrected as of April 30, 2019.

As a result of the revisit findings:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective May 24, 2019 be rescinded as of April 30, 2019. (42 CFR 488.417 (b))

In our letter of April 25, 2019, 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 was prohibited from conducting a Nursing

Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 24, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 30, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of April 30, 2019:

• Civil money penalty. (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.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 21, 2019

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

Re: Reinspection Results - Complaint Number H5052081C and H5052084C

Dear Administrator:

On April 30, 2019 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigations completed on March 5, 2019 and April 9, 2019. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health 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



Electronically delivered

March 22, 2019

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

RE: Project Number H5052071, H5052081C, H5052082C and H5052083C

Dear Administrator:

On March 5, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments 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. In addition, at the time of the March 5, 2019 abbreviated standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5052071, H5052081C, H5052082C and H5052083C.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required. In addition, at the time of the March 5, 2019 abbreviated standard survey the Minnesota Department of Health completed an investigation of complaint number H5052071, H5052082C and H5052083C were found to be unsubstantiated.

REMEDIES

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 24, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 24, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 24, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 24, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Moorhead Rehabilitation & Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 24, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" 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

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 and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 5, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process Minnesota Department of Health

> Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				APPROVED
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	2019, an abbreviat your facility to conc Your facility was fo	8, 2019, and March 1, 4, 5, ed survey was completed at duct complaint investigations. und not to be in compliance 83, Subpart B, requirements e Facilities.				
	substantiated:	plaint(s) was/were found to be rencies issued at F Tag 686				
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	as your allegation of Department's acce enrolled in ePOC, at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.				
F 684 SS=D	an on-site revisit of conducted to valida with the regulations accordance with yo Quality of Care	acceptable electronic POC, your facility may be ate that substantial compliance s has been attained in our verification.	F 68	14		4/5/19
		care fundamental principle that nent and care provided to				
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electror	nically Signed					04/01/2019

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.

PRINTED: 04/05/2019

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F 684	facility residents. Ba assessment of a re- that residents receir accordance with pro- practice, the compri- care plan, and their This REQUIREMEN by: Based on interview facility failed to ensi- hospice services for multiple pressure ut to hospice services hospitalization. Findings include: Review of R1's Rev Minimum Data Set identified R1 had m and had diagnoses vascular accident (0 (one sided paralysis disorder. The MDS extensive assistance activities of daily liv bed mobility, dressi MDS identified R1 h had not received ho Review of R1's disc dated 1/9/19, identii discharge to an accu identified R1 require ADL's and had no p	Ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered residents' choices. NT is not met as evidenced A and document review, the ure coordination of care with r 1 of 1 resident (R1) with lcers and had been admitted following an acute Ariew of R1's admission (MDS) dated 11/5/18, ioderate cognitive impairment which included; cerebral CVA), (stroke,) hemiplegia s) dementia and personality identified R1 required the form two facility staff for ing (ADL's), which included ng, bathing and toileting. The nad no terminal diagnosis and	F 6	This Plan of Correction con written allegation of complia deficiencies cited. However, of this Plan of Correction is a admission that a deficiency of one was cited correctly. This Correction is submitted to ma requirements established by federal law. 1. It is the policy of Moorhea Rehabilitation and Healthcat the facility ensures residents treatment and care in accord professional standards of pr residents' choices and the c person-centered care plan. the facility is to ensure coord care with hospice services for resident upon identification to during admission to hospice for proper care and treatment the individual needs and pre- identified by the comprehen- assessment. The facility fail coordination of care with hos- for resident R1 who was new to hospice services following hospitalization. Resident R	nce for the submission not an exists or that s Plan of eet o state and ad re Center that s receive dance with the actice, omprehensive In addition, dination of or each to hospice, and ongoing nt based on sferences as sive resident led to ensure spice services wly admitted g an acute		

Facility ID: 00938

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F 684	hospice services. Review of R1's care revealed R1 require ADL's, which incluc two hours. R1's car following his return and did not identify and was receiving Review of R1's hos dated 1/18/19, reve hospitalized from 12 following diagnoses (systemic blood infe summary revealed hospital with hospic cares. Review of R1's hos 1/18/19, revealed F with hospice end of diagnosis of aspirat The note revealed f collaborated with th R1's hospitalization decline and medica revealed R1 was to for all ADL's and id wounds and had sh while he was hospir identified R1 had a pressure ulcer on h with eschar on his l	gnoses and had not received e plan revised 11/9/18, ed extensive assistance with led routine repositioning every e plan lacked any revision from the hospital in January R1 had a terminal prognosis hospice services. pital discharge summary	F 684	 the potential to be affected by this deficient practice. Upon review, two resident recently resides at facility whospice services. The resident's plicare was reviewed and revised. The current agreement between hospice facility was reviewed. Policies entite Hospice Program, Palliative Care a Palliative Care End of Life Care – Cowere reviewed and updated by IDT A meeting was held with Red River hospice and facility IDT team on Ma 27th to review R1 and concerns regulations coordination of care for president and implemented processes ensure proper coordination of care. Monthly meetings were planned as up to assure ongoing compliance we coordinator was educated on the nea a significant change MDS with all n hospice admissions. On March 27, an in-service education was provided all nursing and HIM personnel which reviewed updated policies, proceduand ensuring proper coordination of neas session and ongoing education as identified. 4.Weekly audits completed by DON/Designee on all hospice resident and communication and communication of care. Findings 	with an of he e and led nd CP team. Valley arch garding esent es to follow vith eed for ew 2019 ed to h ures f care. by swer ents,	

Facility ID: 00938

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F 684	repositioning plan f admission note rev Prevalon boots (sp boots) which were f Review of R1's pro 1/20/19, revealed th - 1/19/19, revealed th - 1/19/19, revealed review R1's orders note revealed an as changes from his o lacked any indication return from the hos - 1/20/19, revealed p.m. A later note re notified of R1's dea R1's medical record his return to the face record lacked any of cognition, body sys other information of to the facility on 1/1 During an interview facility director of m hospice referral at to to the facility on 1/18/19, f admission orders a assessment. She in present in the facilit the hospital. The D record lacked any of	 For R1. However, the hospice ealed R1 had bilateral ecialized pressure relieving to be worn at all times. gress notes from 1/18/19, to he following; a hospice nurse was in to and to check on him. The ssessment showed no original admission. The note on of R1's skin condition upon of R1's skin condition upon origital. d R1 had passed away at 7:00 evealed hospice had been of the statement of the	F 68	4 deficient practice, immediate edu and appropriate interventions wil implemented and an ad hoc initia further dictate appropriate monitor Findings will be brought to monit for continued IDT review and recommendation for continued o monitoring to assure ongoing col DON is responsible to monitor.	l be ated to pring. hly QAPI ngoing	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/05/2019 APPROVED 0938-0391
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F 684	coordination of care and the facility staff the facility was not multiple pressure u unaware R1's hosp R1's pressure ulcer During a telephone p.m. the registered for hospice (RN-A) admitted to hospice 1/18/19, following I indicated the hospic paperwork sent fron R1 had four pressu was unaware of the communicated to th presence of the pre- if any coordination discussed with the stated hospice staff and/or verbal repor resident information to the facility's elect During a group inte facility administrato administrator stated on improving coord hospice providers s administrator stated coordination for R1 the facility had not admission note pric obtained his hospic death. The adminis	e between the hospice nurse Further, the DON confirmed aware of the presence of leers for R1 and she was ice nurse had been aware of s. interview on 2/28/19, at 2:43 nurse, primary case manager confirmed R1 had been for end of life cares on his hospitalization. The RN-A ce RN had reviewed the m the hospital and was aware re ulcers. She indicated she hospice RN had he facility staff regarding the essure ulcers and was unsure of R1's care had been facility nursing staff. She relied on hospital records ts from facility staff for n as they do not have access fron care with the DON and r on 2/28/19, at 3:52 p.m. the d the facility had been working ination of care with their ince November 2018. The d they were unaware of any 's care with hospice staff and received R1's hospice or to R1's death and had not e admission note following his trator stated the hospice the facility had full access to	F	584			

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F 684	Continued From pa	age 5	F 684				
	A facility policy and procedure for coordination of hospice services was not obtained.						
F 686 SS=G		Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 686	5		4/5/19	
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that if (ii) A resident with p necessary treatment with professional st promote healing, p new ulcers from de This REQUIREMENT by: Based on interview facility failed to con assessment for the development for 1 history of a recently who developed mu facility. This deficie harm when he devel slough or eschar: w visualized due to th eschar (eschar tiss that is hard or soft	ves care, consistent with ards of practice, to prevent d does not develop pressure ndividual's clinical condition they were unavoidable; and pressure ulcers receives nt and services, consistent tandards of practice, to revent infection and prevent		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 Moorhead Rehabilitation and Healthcare Cer the Director of Nursing or designer ensures, based on the compreher	r the iission or that of and hter that e		

Facility ID: 00938

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT			<u>/IB NO.</u> (X3) DATE	SURVEY
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	•	wound), and one deep tissue			plan. Furthermore, this includes rea	sidents	
	injury. The facilty fa	ailed to identify and implement			who enter the nursing home without		
	appropriate interve	ntions for R1 during his initial			pressure sores, that they do not de	velop	
		nd when R1 returned to the			pressure sores unless the individua		
		lization with 2 unstageable			clinical condition demonstrates, and		
	deep tissue injury.	tage 2 pressure ulcer and 1			physician authenticates, that they w unavoidable; and that a resident wh		
	deep lissue injuly.				pressure sores receives necessary	10 1185	
	Findings include:				treatment and services to promote		
	<u> </u>				healing, prevent infection and preve	ent	
		nission Minimum Data Set			new sores from development. R1 h		
		dated 11/5/18, identified R1			sustained actual harm when facility		
		nitive impairment and			to identify and implement appropria		
		cluded; cerebral vascular erwise referred to as a stroke,)			interventions during his initial stay a facility. In addition; R1 returned to t		
		ded paralysis), dementia and			facility post hospitalization with mult		
		r. The MDS identified R1			pressure ulcers. R1 expired on Jar		
		assistance from two facility			20th, 2019.	,	
		f daily living (ADL's), which			2. Residents who are admitted or		
		ity, dressing, bathing and			readmitted to the facility have the		
		identified R1 was dependent			potential to be affected in this area.		
		for transfers and had limited motion on one side of his			facility has implemented a new adm check list that has a list of tasks rela		
		tremities. The MDS identified			the identification and management		
	• •	rs, or rejection of care since			skin/wound issues. This check list	-	
		MDS identified R1 was at risk			includes entering into PCC under th		
		levelopment and did not have			User Defined Assessments (UDA) f		
		s at the time of the MDS.			inspections, Braden's, orders are at		
		dentified R1 had pressure in place which included;			for wound management, updating or CNA care sheets, bath sheets. Wh		
		devices for his bed and chair.			new skin alterations are identified, t		
	p. sees. e renoring (are entered into the UDA Assessme	-	
		nission Care Area Assessment			reassessed weekly by a licensed st	aff	
		/18, identified R1 had			until resolved. In addition, UDA will	notify	
	5	llar dementia with behavioral			licensed staff of ongoing routine		
		y disorder, major depressive			assessments, per significant chang		
		ty disorder and had moderate			quarterly and annual assessments.		
	cognitive impairme	nt. The CAA identified R1 was			IDT team monitors the UDA comple	tion	

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDIN	IG		C	
		245052	B. WING			03/05/2019	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		/00/2013	
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORT MOORHEAD, MN 56560	Н		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE	
F 686	Continued From pa	ige 7	F 68	36			
	able to use his call however, was at ris cognitive loss and i remembering care The CAA's identifie assistance of two s left sided flaccid he mobility, leading to Further, the CAA re pressure ulcers, wa pressure ulcers and mattress and cushi Review of R1's disc dated 1/9/19, identid discharge to an act no pressure ulcers discharge to the act identified R1 had n no behaviors. Review of R1's care revealed R1 had lin extensive assistant revealed R1's skin and required routin hours, follow facility prevention/treatme the resident/family/ of skin breakdown, needed any change color, wound healir infection, wound siz relieving/reducing of	light, make his needs known, sk for potential harm due to his ndicated R1 was at risk of not that was provided or needed. d R1 required extensive taff with bed mobility and had emiplegia which decreased his pressure ulcer formation. evealed R1 had no current as at low risk for developing d had a pressure reducing on in his wheelchair. charge return anticipated MDS fied R1 had an unplanned ute hospital and identified had at the time of his unplanned ute hospital. Further, the MDS o rejection of cares and had e plan, revised 11/9/18, nited mobility and required ce with ADL's. R1' care plan should be checked weekly e repositioning every two y policies/procedures for the nt of skin breakdown, inform caregivers of any new areas monitor/document/report as es in skin status: appearance, ng, signs and symptoms of ze, stage, and use of pressure		and scheduled assess morning during clinical compliance. The facil implemented a new nu communication tool for report. 3. System change; imp Admission Checklist, N hospital discharge repo- licensed staff have bee process and it has bee facility's competency of licensed staff during in In-service education for personnel was provide Nursing and Regional Services on March 27, included re-education for updated policies and p including wound Care, Risk Assessment, Pres Treatment, Prevention Pressure Ulcer Skin B Repositioning. In-serv provided by lecture, ha and answer session an education as identified 4. Weekly audits comp DON/Designee on all r and readmissions, and per week in the followi compressive skin asses admission or readmiss initiated on admit or re skin inspections, User	review to assure ity has also urse to nurse r hospital discharge olementation of new New nurse to nurse ort tool. All en educated on this en included on the thecklist for itial orientation. or all nursing ed by the Director or Director of Clinical 2019. This to staff on the procedures Pressure Ulcer of Pressure Ulcers reakdown CP and vice education was andouts, question nd ongoing l. oleted by new admissions a 2 at risk residents ng areas; essment on sion, care plan admission, weekly Defined	v f	

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		AND HUMAN SERVICES			FORM	04/05/2019 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	`́сом	E SURVEY PLETED
		245052	B. WING			C 05/2019
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
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		D BE	(X5) COMPLETION DATE
F 686	 686 Continued From page 8 skin,was chairfast, had slightly limited mobility, probable inadequate nutrition, and had a potential problem with friction and shear and identified R1 was at low risk for developing pressure ulcers. No further Braden's Scale forms or comprehensive skin assessments were found in R1's medical record. Review of R1's hospital history and physical dated 1/9/19, identified R1 presented to the emergency department with shortness of breath, had severe sepsis, right lower lobe pneumonia likely aspiration and was admitted to the hospital for antibiotic treatment. Review of R1's hospital certified wound and ostomy registered nurse (CWON) progress notes from 1/10/19, to 1/18/19, revealed the following: -deep tissue injury on R1's left midline, right sacrum, coccyx, which had been present upon admission to the hospital on 1/9/19. R1's deep tissue pressure injury measured 4 centimeters (cm) with an open area on the gluteal cleft which 		F	the PCP and responsible party will updated. Ongoing monitoring of f reviewed; upon identification of a practice, immediate education and appropriate interventions will be implemented and an ad hoc initiat further dictate appropriate monitor Findings brought to monthly QAPI PIP for continued IDT review and recommendations for continued monitoring to assure ongoing com	ndings deficient d ed to ing. as a	
	(cm) with an open a measured 0.5 cm T indicated R1's sacr progressing deep ti had serosanguinou ulcer. Further, the a dressing had been tissue injury. The n deep tissue pressu skin loss pressure sacrum/coccyx and serosanguinous dra					

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		AND HUMAN SERVICES				FORM	04/05/2019 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245052	B. WING _				C 05/2019
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER			310 SECOND AVENUE NORTH		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	injury of his sacrum had partial thickness - unstageable press which was present hospital on 1/9/19. ulcers measured 1. covered with black, revealed R1's left h ulcer was left open unstageable left he 1.8 cm by 2.4 cm a eschar. On 1/17/19 pressure ulcer was tissue. -an unstageable pro- lateral ankle, which to the hospital on 1 pressure ulcer mea was covered with b revealed R1's right pressure ulcer was unstageable right la measured 0.5 cm b with black eschar. O lateral ankle pressu- eschar tissue. -an unstageable pro- posterior ear, which to the hospital on 1 pressure ulcer mea was covered with b assessment revealed ulcer was likely fror tubing. The assess	n/coccyx was pink, red and	F 6	86			

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		AND HUMAN SERVICES			FORM	: 04/05/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY IPLETED
		245052	B. WING			05/2019
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER		2810 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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	cannula and indicativersus nasal cannulus unstageable left pomeasured 0.4 cm bwith black, dry eschleft posterior ear habed. -On 1/10/19, the notation of the skin indicated boots (specialized pressions) heels were floated boots (specialized pressions) heels were floated boots (specialized pressions) heels were floated boots (specialized pressions) in place. -On 1/17/19, the notation of the skin indication breakdown to his sate and continued to exhibit of the skin indicatin breakdown to his sate and 1/18/19, at 1:14 p.m admitted to the hos	ted to use oxygen mask ula tubing. On 1/14/19, osterior ear pressure ulcer by 0.3 cm and was covered har. On 1/17/19, unstageable ad dark red, dry pink wound otes indicated R1 had been on side to side repositioning, had sure relieving mattress and his with pillows under his calves. R1 would have Prevalon pressure relieving boots used essure ulcers,) and to limit nd limit his head of bed han 30 degrees. Detes indicated R1 remained on g mattress, every two hour continued to have his heels indicated R1 was difficult to turn himself in bed and Prevalon ecialized pressure relieving otes indicated R1 continued to eving air mattress, bilateral ating with heel protectors and t erythema (purplish red hue ng injury or breakdown) and	F 686			

		AND HUMAN SERVICES				FORM	04/05/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245052	B. WING _				C 0 5/2019
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HEALTHCARE CENTER			10 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	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	organism, severe s respiratory failure w pneumonia. The inti indicated R1 had ac admission to the ho sacrum/coccyx, wo ankle and left poster the aforementioned the time of R1's faci 10/24/18, R1's faci 10/24/18, R1 was a another long term of was alert, oriented needs known. The use of a full body m had left sided weak cm scab on his righ on his groin. -10/25/18, R1's legs to float his heels an -10/26/18, had an of heel for comfort and available. -11/5/18, R1 had be and refused to get times. The note lac repositioning. -11/7/18, R1 had dia facility night shift nu later refused to get	epsis, acute on chronic vith hypoxemia and aspiration eragency referral form ctive skin wounds upon ospital, identified on right und left heel, right lateral erior ear. The form identified I wounds remained active at	F 68	86			

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		AND HUMAN SERVICES			FORM	04/05/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245052	B. WING		C 03/05/2019	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	00,	
мооры		N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH		
WOORN		N& HEALINCARE CENTER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa education provided offloading. -11/11/18, visual ha floating in his room refusal of cares, rep condition. -11/18/18, R1 had r been verbally aggre However, the note f skin condition. -11/24/18, refused t The note did not ad education provided offloading. -11/26/18, refused a times however, did	ge 12 for the risks and benefits of Illucinations of a baby bath No further documentation of positioning or R1's skin received a shower and had essive towards an NA. lacked any information of R1's to get dressed and out of bed. ldress R1's repositioning or as to the risks and benefits of a weekly skin check three not address education ks and benefits of offloading or	F 68	DEFICIENCY)		
	and appeared paint to the facility to ass -12/31/18, revealed redness had minim -1/9/19, not feeling 100.4 degrees Fahi abnormal lung sour ambulance to the h -1/20/19, R1 passe	I R1's ear swelling and ized greatly. well, had a temperature of renheit, elevated heart rate, nds and was sent by				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/05/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245052	B. WING				
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	however, his medic documentation of d the facility. R1's medical record development of R1' lacked a comprehe throughout his entir and upon return, fro During an interview NA-E indicated she and able to make h R1 had required exery indicated R1 would was oftentimes con offered. NA-E state any pressure ulcer upon his return to th During an interview NA-A stated R1 had cares, though would basis. NA-A stated what he wanted and decisions. NA-A stated what he wanted and decisions. NA-A stated what he felt R1 w approximately once repositioning appro stated R1 required repositioning, about she was unaware o or after R1's hospita indicated he had a	al record lacked ate or details of his return to d did not identify the 's multiple pressure ulcers and nsive skin assessment, 'e stay in the facility, prior to om the hospital. on 2/28/19, at 9:10 a.m. felt R1 was alert, oriented is own decisions. NA-E stated tensive assistance with ADL's two hour repositioning. NA-E frequently refuse cares and nbative whenever cares were d she was unaware if R1 had before his hospitalization or	F	586			

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		AND HUMAN SERVICES				FORM	04/05/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245052	B. WING				05/2019
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOORHE	EAD REHABILITATION	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	mattress or any oth interventions used. During an interview licensed practical n R1 was verbally ab would routinely refu- want to stay in his r LPN-D stated she of completing a skin of would routinely refu- she was not aware before he left and w hospital. Further, LI R1 having had a pr any other specialize such as Prevalon b hospitalization. During an interview NA-E stated R1 wo yell, swear at staff a and attempt to bloc cares. However, NA was approached a more apt to comply could not recall R1 ulcers before or afte January. During an interview trained medication compliant with care the "right way." TMA make his wishes kr times when R1 was was on a routine re	A on 2/28/19, at 10:10 a.m. burse (LPN)-D stated she felt busive towards facility staff and use cares, meals and would room throughout her shift. could not recall ever check on R1 and indicated he use his baths. LPN-D indicated if R1 had any pressure ulcers when he returned from the PN-D stated she did not recall ressure relieving mattress or ed pressure relieving devices, boots prior to or after his and would put up his hands ock her from assisting him with A-E indicated she felt if R1 certain way, he would be a with cares. NA-E stated she ever having any pressure er his hospitalization in and (TMA)-A indicated R1 was as when he was approached A-A stated she felt was able to nown and indicated there were a confused. She indicated R1 positioning plan of every two	F 6	586	DEFICIENCY)		
		positioning plan of every two ed. TMA-A stated R1's skin					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG			С
		245052	B. WING			03/	05/2019
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	was intact the last t skin. TMA-A indicat specialized pressur Prevalon boots. Fu standard mattress a place prior to his ho Review of R1's wee 11/4/18, to 1/6/19, r -11/4/18, skin intact -12/2/18, skin intact -12/2/18, skin intact -12/30/18, open are secondary to celluli small bruise on the -1/6/19, skin intact. R1's medical record documentation of o condition. During an interview LPN-E stated R1 of which included repo could not recall if st check on R1 or hac ulcers for R1. LPN- had a history of pre any pressure ulcers During an interview LPN-B stated she h on 1/6/19, and had ulcers. LPN indicate ever having had pre	ime she had observed his ed she did not think R1 had re relieving devices, such as inther, she stated R1 utilized a and wheelchair cushion in ospitalization in January. ekly skin checks forms from revealed the following; ct. t. ct. t. ct. ta above his left ear, tis, small scab on left shin and top of his left foot. d lacked further ngoing monitoring of R1's skin f on 2/28/19, at 1:00 p.m. ften refused any assistance, ositioning. LPN-E stated she he had ever completed a skin I been aware of any pressure E stated she was unaware R1 ssure ulcer or had developed	F 6	86			

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		AND HUMAN SERVICES				FORM	04/05/2019 APPROVED 0938-0391	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED C	
		245052	B. WING				05/2019	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 686	she could not recal been present when hospital with hospit had not completed During an interview LPN-C stated he co completed a body s assessment before LPN-C indicated R heel upon his initial admitted with an or applied for comfort. applied for comfort. applied a heel cup cup was not availat stated he was unav resolved. LPN-C in above R1's left ear January and indica see R1 and had ord LPN-C stated he th education to R1 on allowing staff to pro- could not recall whe to R1 had ever bee indicated he was un pressure ulcers upo and indicated he di pressure ulcers bef During an interview NA-H stated he cou concerns with R1 b hospitalized in Janu routinely resistant to hour repositioning s	age 16 I when. LPN-B stated she had R1 had returned from the ce services, and indicated she a skin check upon his return. A on 2/28/19, at 3:00 p.m. buld not recall ever having skin check on R1, or any skin or after R1's hospitalization. 1 had a small scab on his I admission and had been der for a heel cup to be . LPN-C stated he had never to his heel, because the heel ble in the facility. LPN-C ware when R1's heel scab had dicated he had noticed a sore before he was hospitalized in ated R1's practitioner came to dered antibiotics for cellulitis. hough the had provided the risks and benefits of not ovide cares, repositioning, but ether the education provided and ocumented. LPN-C naware whether R1 had any on his return from the hospital d not think R1 had any fore his hospitalization. A on 2/28/19, at 3:10 p.m. uld not recall any skin before or after he had been uary. NA-H stated R1 was o cares, was on an every two schedule and indicated R1 ance with cares, including pximately once a shift, at best.	F 6	886				

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	-	AND HUMAN SERVICES			FORM	APPROVED 0938-0391	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		245052	B. WING				05/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
MOORHE	EAD REHABILITATION	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 686	NA-H stated there we let him enter his room nurse. NA-H indicated any special pressure R1. During an interview stated R1 refused of and physically block and physically block any cares, which should be four or so hould be found and the refusals. Review of R1's phy revealed an order of pad to R1's left hee wheelchair, monitor Another order dated staff to monitor R1's left heel in bed and discontinue when refusal and discontinue when refusal for the staff to monitor R1's left heel in bed and discontinue when refuse or the staff to monitor R1's more record (TAR) from January 2019, lister orders consistently each shift: -Heel Pad: apply to or in wheelchair, even 10/24/18 -Monitor left heel, ke bed and in wheelchair, even the staff to make the staff to heel heel heel heel heel heel heel hee	were times R1 would refuse to om and he would notify the ted he could not remember re relieving devices used for on 2/28/19, at 3:24 p.m. NA-I cares daily, would yell, swear k her from assisting him with he would then notify the facility I she felt R1 could have went urs without repositioning due visician orders, signed 1/14/19, dated 10/24/18, to apply a heel el while supine in bed or in r for improvement of heel pain. d 10/24/18, directed facility s left heel, keep pressure off wheelchair with pillows,	F 68	36			

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		AND HUMAN SERVICES			FORM	: 04/05/2019 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245052	B. WING			C 105/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH		N & HEALTHCARE CENTER		810 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 686	Continued From partouch bed, every shouch bed, every shouring a group interincluding the DON, consultant, R1's means the DON, administ confirmed R1's means throughout the durat from 10/24/18, to 1/20/19. At that time certified wound and identified R1 had for admission to the horized for a comprehensive asset throughout the durat from 10/24/18, to 1/20/19. At that time certified wound and identified R1 had for admission to the horized for a comprehensive asset throughout the durat from 10/24/18, to 1/20/19. At that time certified wound and identified R1 had for admission to the horized for the facility had been pressure ulcers, or The DON, administ confirmed R1's means indicated R1's skin stated he expected the facility were to hassessment to deterpert to the hospital phad presented to the department (ED) ar to the hospital with and hypoxemia. ME terrible condition with hospital as he had a state of the department (ED) ar to the hospital as he had a state of the hospital as he had as he had a state of the hospital as he had as he had a state of the hospital as he had as he		F 686	DEFICIENCY)		

If continuation sheet Page 19 of 23

		AND HUMAN SERVICES			FORM	: 04/05/2019 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		245052	B. WING			05/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	admission on 1/9/19 though R1's bruisin being careful when bruising was on his legs. She stated R1 dependent on staff hemiplegia which h stated R1's pressur managed by the ho had certified wound stated she had disc terminal prognosis and stated they had placement for R1, t R1 back to the facil services. MD-A stat ulcers were avoidal appropriate pressur as off loading his he applying a foam pro and routine monitor R1 continued to hat discharge. During a telephone p.m. the hospital's of nurse (CWON)-A co admitted to the hos pressure ulcers. CV completed an asses ulcers on the morni confirmed R1 had t	nge 19 9. MD-A stated she felt as ing was likely from staff not working with him as his a arms, back, buttocks and 1 would be completely for all of his cares due to his ad affected his left side. MD-A re ulcers were assessed and ospital's wound team which d and ostomy nurses. MD-A cussed R1's current condition, with R1's family members, d been unable to find other herefore she had discharged lity with hospice end of life ted she felt R1's pressure ble, had he received re relieving interventions such eels, routine repositioning, bector on R1's oxygen tubing ring of his skin. MD-A stated ve pressure ulcers upon	F 686			

If continuation sheet Page 20 of 23

		AND HUMAN SERVICES				FORM	04/05/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245052	B. WING			C 03/05/2019	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	She stated she was developed the deep tissue pressure inju- the last 48-72 hour hospitalization R1 v side and had been pressure relieving r sacral deep tissue improve prior to his though would have relieving intervention -an unstageable pr upon admission to by 3.0 cm on 1/10/7 thick eschar. CWO heel ulcer had been extensive eschar w She stated R1's lef 1/14/19, and mease continued to be cov CWON stated she completely avoidab interventions. The of Prevalon boots on his heel ulcer rema She stated she woo relieving intervention he returned to the f stated R1's unstage on his affected side significantly increase pressure ulcer. -an unstageable pr malleolus (ankle bo hospital, measured	s not certain when R1 b tissue injury, but felt deep iry could have occurred within s. CWON-A stated during his was routinely turned side to placed on an air alternating mattress. She stated R1's pressure injury had began to discharge from the hospital, expected continued pressure ons to be implemented. essure ulcer of his left heel the hospital, measured 1.8 cm 19, and was covered with a N-A stated she felt R1's left in there "long term" due to the thich covered the wound bed. t heel was measured again on ured 1.8 cm by 2.8 cm and vered with thick, black eschar. felt heel ulcers were ble with offloading CWON-A stated R1 had while he was hospitalized and ined stable upon discharge. uld have expected pressure ons to be implemented when facility. Further, CWON-A eable heel pressure ulcer was	F 6	\$86			

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		AND HUMAN SERVICES			FORM	: 04/05/2019 APPROVED : 0938-0391	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED C	
		245052	B. WING			05/2019	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MOORH	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 686	indicated she also f avoidable as it was offloaded. The CWU unstageable pressu for "a while" and in unstageable pressu -an unstageable pressu -an unstageable pressu -an unstageable pressu -an unstageable pressu -an unstageable pressu a pressure ulcer rel cannula that had be CWON-A stated, w he had used a face She stated R1's un present upon admis had improved and w (partial loss of skin CWON-A stated sh pressure relieving i upon R1's hospital stated she had not treatments upon R1's receiving any dress interventions of off- sufficient. Review of R1's phy 12/26/18 revealed t -10/23/18, R1 had t nursing home, with stroke with left side subacute cerebral i (difficulty swallowin a history of left hee wound that had rec	felt this pressure ulcer was an area which was easily ON-A stated she felt R1's ure ulcer had also been there ndicated he had the ure ulcer upon discharge. essure ulcer of his posterior felt was a "classic example" of lated to the tubing of a nasal een used at the facility. The hile R1 had been hospitalized e mask for oxygen delivery. Istageable posterior had been ssion and at discharge, though was able to be staged at a two thickness.) we would have expected interventions to be in place discharge on 1/18/19. She ordered any specific 1's discharge as he was not sing changes, and felt nursing -loading would have been ysician notes from 10/23/18 to	F 68				

Facility ID: 00938

If continuation sheet Page 22 of 23

		AND HUMAN SERVICES				FORM	: 04/05/2019 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245052	B. WING				05/2019
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	with an offloading b twice daily on the le positioning. -12/26/18, R1 had red, swollen left ear diagnosed with per outer ear tissue sur had been prescribe moist compresses An undated facility Treatment, reveale was to provide guid pressure ulcers and pressure ulcers. Th guidelines for asse ulcers, pressure ulc treatment and infect definitions and dese pressure ulcers, int strategies, docume supervisor any wor refusals of interven The policy directed ongoing assessme interventions and a to aid in the healing	been seen at the facility for a r. The note revealed R1 was ichondritis (infection of the rounding the cartilage) and ed an antibiotic and warm both for seven days. policy titled Pressure Ulcer d the purpose of the policy lelines for the care of existing d the prevention of additional re policy identified general ssment of current pressure cer care, interventions, tion control. The policy listed criptions of all stages of erventions and care ntation and reporting to sening a pressure ulcer or	F6	886			

Facility ID: 00938

If continuation sheet Page 23 of 23



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 22, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Number H5052071, H5052081C, H5052082C and H5052083C

Dear Administrator:

A complaint investigation was completed on March 5, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all licensing orders are corrected, the form should be signed and returned electronically 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

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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: 04/05/2019 FORM APPROVED

Minneso	ota Department of He	ealth				ATTROVED
-	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00938	B. WING		03/0)5/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MOORH	EAD REHABILITATIO	N & HEALTHCARL	COND AVENU AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN Rev When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fror orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	2019, an abbreviate determine compliant following correction indicate in your ele you have reviewed date when they will	8, 2019, and March 1, 4, 5, ed survey was conducted to note for state licensure. The orders are issued. Please ctronic plan of correction that these orders, and identify the				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE iically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 04/01/19

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00938	B. WING		03/	03/05/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IOORHI	EAD REHABILITATIO	N & HEALTHCAR	COND AVENUE EAD, MN 5656				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLE DATE	
2 000	Continued From page 1		2 000				
	The following complaint was found to be substantiated: H5052081C Correction orders issued at MN Rule 4658.0520 subp.1 and MN Rule 4685.0525 subp.3						
	substantiated: H5052071 was four time of the survey. H5052082C was for time of the survey.	plaints were not found to be nd to be in compliance at the bund to be in compliance at the bund to be in compliance at the					
	signature is not req page of state form. is required, it is req	led in ePOC and therefore a juired at the bottom of the first Although no plan of correctior uired that the facility pt of the electronic documents	ו				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			4/5/19	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des and 4658.0405. A be out of bed as mu is a written order fro	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 nursing home resident must uch as possible unless there om the attending physician ust remain in bed or the remain in bed.	1				

KL8211

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Minnesota Department of Health										
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		00938	B. WING		03/0	5/2019				
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE						
MOORHEAD REHABILITATION & HEALTHCARI 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 SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE				
2 830	Continued From page 2		2 830							
Minnesota D	by: Based on interview facility failed to ens hospice services for multiple pressure u to hospice services hospitalization. Findings include: Review of R1's Rev Minimum Data Set identified R1 had m and had diagnoses vascular accident (((one sided paralysi disorder. The MDS extensive assistand activities of daily liv bed mobility, dress MDS identified R1 h had not received ho Review of R1's diso dated 1/9/19, identified Review of R1's diso dated 1/9/19, identified and had no behavio had no terminal dia hospice services.	view of R1's admission (MDS) dated 11/5/18, noderate cognitive impairment which included; cerebral CVA), (stroke,) hemiplegia s) dementia and personality identified R1 required ce from two facility staff for ring (ADL's), which included ing, bathing and toileting. The had no terminal diagnosis and		corrected						
minesola D	epartment of rieditin									

KL8211

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00938	B. WING		03/	05/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MOORH	EAD REHABILITATION	N & HEALTHCAR	COND AVENUE			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
2 830	revealed R1 require ADL's, which incluc two hours. R1's car following his return and did not identify and was receiving Review of R1's hos dated 1/18/19, reve hospitalized from 1, following diagnoses (systemic blood infe summary revealed hospital with hospic cares. Review of R1's hos 1/18/19, revealed R with hospice end of diagnosis of aspirat The note revealed f collaborated with th R1's hospitalization decline and medica revealed R1 was to for all ADL's and id wounds and had sh while he was hospir identified R1 had a pressure ulcer on h with eschar on his right ulcer with posterior wound bed. The no repositioning plan f admission note reve	ed extensive assistance with led routine repositioning every re plan lacked any revision from the hospital in January R1 had a terminal prognosis hospice services.	f			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00938	B. WING		03/0	5/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORHI	EAD REHABILITATIO	Ν & ΗΕΔΙ ΤΗCΔΡΙ	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page 4		2 830			
	Review of R1's pro 1/20/19, revealed th	gress notes from 1/18/19, to he following;				
	 - 1/19/19, revealed a hospice nurse was in to review R1's orders and to check on him. The note revealed an assessment showed no changes from his original admission. The note lacked any indication of R1's skin condition upon return from the hospital. - 1/20/19, revealed R1 had passed away at 7:00 					
	p.m. A later note re notified of R1's dea	vealed hospice had been th.				
	his return to the fac record lacked any o cognition, body sys	d lacked any documentation of sility on 1/18/19. R1's medical documentation of his stems, skin condition or any f his prognosis upon his return 8/19.				
	facility director of m hospice referral at t to the facility on 1/1 believed R1's hosp facility on 1/18/19, t admission orders a assessment. She ir present in the facilit the hospital. The D record lacked any of nurses initial visit a coordination of care and the facility staff the facility was not multiple pressure u	on 2/28/19, at 2:04 p.m. the ursing (DON) stated R1 had a the hospital prior to his return 18/19. The DON stated she ice nurse had come to the family had signed hospice nd would complete an initial ndicated she had not been ty when R1 had returned from ON confirmed R1's medical documentation of R1's hospice nd was unaware of any e between the hospice nurse f. Further, the DON confirmed aware of the presence of lcers for R1 and she was sice nurse had been aware of rs.				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		03/05/2019	
AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
IOORH	EAD REHABILITATION	N & HFAI THCARI	COND AVENUE			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULI		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 5	2 830			
	p.m. the registered for hospice (RN-A) admitted to hospice 1/18/19, following f indicated the hospic paperwork sent from R1 had four pressu was unaware of the communicated to the presence of the pre- if any coordination discussed with the stated hospice staff and/or verbal repor resident information to the facility's elect During a group inte facility administrator administrator stated on improving coord hospice providers a administrator stated coordination for R1 the facility had not admission note price obtained his hospic death. The adminis company used by t residents electronic A facility policy and hospice services w SUGGESTED MET The director of nurs	he facility staff regarding the essure ulcers and was unsure of R1's care had been facility nursing staff. She f relied on hospital records ts from facility staff for h as they do not have access tronic medical record system. erview with the DON and hr on 2/28/19, at 3:52 p.m. the d the facility had been working lination of care with their since November 2018. The d they were unaware of any 's care with hospice staff and received R1's hospice or to R1's death and had not ce admission note following his strator stated the hospice he facility had full access to c medical records.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/05/2019	
		00938	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MOORHE	EAD REHABILITATION	N & HEALTHCAR	COND AVEN			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
2 830	Continued From pa	ige 6	2 830			
	these polices, and	re, educate staff regarding audit resident records for e policies and procedures.				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			4/5/19
	comprehensive res of nursing services	sores. Based on the ident assessment, the directo must coordinate the nursing care plan which	r			
	without pressure s pressure sores unle condition demonstr	to enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on interview facility failed to con assessment for the development for 1 of history of a recently who developed mu	ent is not met as evidenced and document review, the duct a comprehensive skin prevention of pressure ulcer of 1 resident (R1) who had a y healed pressure ulcer and ltiple pressure ulcers in the nt practice caused R1 actual		corrected		
	harm when he deve	eloped four pressure ulcers; (Unstageable ulcer related to				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00938	B. WING		03/	05/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
MOORH	EAD REHABILITATION	N & HEALTHCARL	COND AVENUE EAD, MN 56560				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	S PLAN OF CORRECTION () ECTIVE ACTION SHOULD BE COM ENCED TO THE APPROPRIATE D DEFICIENCY)		
2 900	slough or eschar: w visualized due to th eschar (eschar tiss that is hard or soft i brown, or tan in col Necrotic tissue and adherent to the bas sides/edges of the injury. The facility fa appropriate interver stay in the facility a facility post hospita pressure ulcers,1 s deep tissue injury. Findings include: Review of R1's adm (MDS) assessment had moderate cogn diagnoses which in accident (CVA, othe hemiplegia (one sic personality disorde required extensive staff for activities of included bed mobilit toileting. The MDS on two facility staff functional range of upper and lower ex R1 had no behavio his admission. The for pressure ulcers Further, the MDS ic ulcer interventions	ge 7 yound bed cannot be the presence of slough or ue; dead or devitalized tissue n texture; usually black, or, and may appear scab like. eschar are usually firmly se of the wound and often the wound), and one deep tissue illed to identify and implement ntions for R1 during his initial nd when R1 returned to the lization with 2 unstageable tage 2 pressure ulcer and 1 hission Minimum Data Set dated 11/5/18, identified R1 itive impairment and cluded; cerebral vascular erwise referred to as a stroke, led paralysis), dementia and r. The MDS identified R1 assistance from two facility daily living (ADL's), which ity, dressing, bathing and identified R1 was dependent for transfers and had limited motion on one side of his tremities. The MDS identified rs, or rejection of care since MDS identified R1 was at risk levelopment and did not have s at the time of the MDS. dentified R1 had pressure in place which included; devices for his bed and chair.					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING	B. WING		05/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
IOORH	EAD REHABILITATIO	N & HEALTHCARL	OND AVENUE AD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Review of R1's adm (CAA's) dated 11/5, diagnoses of vascu disturbance, anxiet disorder, personalit cognitive impairment able to use his call however, was at ris cognitive loss and if remembering care The CAA's identifie assistance of two s left sided flaccid her mobility, leading to Further, the CAA rep pressure ulcers, was pressure ulcers and mattress and cushi Review of R1's disc dated 1/9/19, identit discharge to an act no pressure ulcers discharge to the act identified R1 had no no behaviors. Review of R1's care revealed R1 had lin extensive assistance revealed R1's skin and required routin hours, follow facility prevention/treatment the resident/family/ of skin breakdown, needed any change color, wound healin	nge 8 nission Care Area Assessment /18, identified R1 had lar dementia with behavioral y disorder, major depressive ty disorder and had moderate nt. The CAA identified R1 was light, make his needs known, k for potential harm due to his ndicated R1 was at risk of not that was provided or needed. d R1 required extensive taff with bed mobility and had emiplegia which decreased his pressure ulcer formation. evealed R1 had no current as at low risk for developing d had a pressure reducing on in his wheelchair. charge return anticipated MDS fied R1 had an unplanned ute hospital and identified had at the time of his unplanned ute hospital. Further, the MDS o rejection of cares and had e plan, revised 11/9/18, nited mobility and required ce with ADL's. R1' care plan should be checked weekly e repositioning every two y policies/procedures for the nt of skin breakdown, inform caregivers of any new areas monitor/document/report as es in skin status: appearance, ng, signs and symptoms of ze, stage, and use of pressure				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00938	B. WING		03/	03/05/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
NOORHI	EAD REHABILITATIO	N & HEALTHCARL	COND AVENUE EAD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ige 9	2 900				
	relieving/reducing of	relieving/reducing device in bed/chair.					
	Review of R1's Braden Scale for Predicting Pressure Sore Risk form, dated 10/31/18, identified R1 had a problem with very moist skin,was chairfast, had slightly limited mobility, probable inadequate nutrition, and had a potential problem with friction and shear and identified R1 was at low risk for developing pressure ulcers.						
	No further Braden's comprehensive ski R1's medical recore	n assessments were found in					
	dated 1/9/19, identi emergency departr had severe sepsis,	pital history and physical fied R1 presented to the nent with shortness of breath, right lower lobe pneumonia d was admitted to the hospital pent.					
	ostomy registered i	pital certified wound and nurse (CWON) progress notes 18/19, revealed the following:	5				
	sacrum, coccyx, wh admission to the ho tissue pressure inju (cm) with an open a measured 0.5 cm T indicated R1's sacr progressing deep th had serosanguinou ulcer. Further, the a dressing had been	on R1's left midline, right hich had been present upon ospital on 1/9/19. R1's deep ury measured 4 centimeters area on the gluteal cleft which the wound assessment al ulcer was consistent with a issue injury and indicated R1 is drainage from the pressure assessment indicated a borde applied to R1's sacral deep otes indicated on 1/14/19,	r				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING	B. WING		05/2019
NAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	ATE, ZIP CODE		
MOORH	EAD REHABILITATIO	N & HEALTHCARL	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CO(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX(EACH CORRECTIVE ACTIOTAGCROSS-REFERENCED TO THE DEFICIENCY)				TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ige 10	2 900			
	skin loss pressure ulcer on his left midline, right sacrum/coccyx and had a small amount of serosanguinous drainage (watery pink) and was left open to air. On 1/17/19, deep tissue pressure injury of his sacrum/coccyx was pink, red and had partial thickness loss.					
which hospita ulcers covere reveal ulcer v unstag 1.8 cm eschar pressu tissue. -an un lateral to the pressu was co reveal pressu unstag measu with bl lateral	which was present hospital on 1/9/19. ulcers measured 1. covered with black, revealed R1's left h ulcer was left open unstageable left he 1.8 cm by 2.4 cm a eschar. On 1/17/19	sure ulcer on R1's left heel, upon admission to the R1's unstageable pressure 8 cm by 3 cm and was eschar. The assessment theel unstageable pressure to air. On 1/14/19, the el pressure ulcer measured and was covered with black o, unstageable left heel covered with dry eschar				
	lateral ankle, which to the hospital on 1 pressure ulcer mea was covered with b revealed R1's right pressure ulcer was unstageable right la measured 0.5 cm b with black eschar.	essure ulcer on R1's right was present upon admission /9/19. R1's unstageable usured 0.6 cm by 0.4 cm and lack, eschar. The assessment lateral ankle unstageable left open to air. On 1/14/19, ateral ankle pressure ulcer by 0.5 cm and was covered On 1/17/19, unstageable right ure ulcer was covered with dry	t			
	posterior ear, which to the hospital on 1 pressure ulcer mea was covered with b	essure ulcer on R1's left n was present upon admission /9/19. R1's unstageable isured 0.4 cm by 0.3 cm and ilack eschar tissue. The ed R1's unstageable pressure				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IDENTITION THOM NOW DELY.	A. BUILDING:			
		00938	B. WING		03/05/2019	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORHI	EAD REHABILITATIO	N & HEALTHCARL	COND AVENUE EAD, MN 5656			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 11	2 900			
	ulcer was likely from oxygen nasal cannula tubing. The assessment revealed R1 would have foam tubing protectors when he used a nasal cannula and indicated to use oxygen mask versus nasal cannula tubing. On 1/14/19, unstageable left posterior ear pressure ulcer measured 0.4 cm by 0.3 cm and was covered with black, dry eschar. On 1/17/19, unstageable left posterior ear had dark red, dry pink wound bed.					
	an every two hour s a specialized press heels were floated The note indicated boots (specialized to aid in healing pre- time on his back ar elevation greater th -On 1/14/19, the no a pressure relieving repositioning and c floated. The note in and did not move h heel protectors (specialized)	otes indicated R1 had been on side to side repositioning, had sure relieving mattress and his with pillows under his calves. R1 would have Prevalon pressure relieving boots used essure ulcers,) and to limit nd limit his head of bed han 30 degrees. Detes indicated R1 remained on g mattress, every two hour ontinued to have his heels indicated R1 was difficult to turr imself in bed and Prevalon ecialized pressure relieving				
	use a pressure relia lower extremity floa continued to exhibi	otes indicated R1 continued to eving air mattress, bilateral ating with heel protectors and t erythema (purplish red hue ig injury or breakdown) and acrum.				
	dated 1/18/19, and	al Interagency Referral Form faxed to the facility on n., identified R1 had been				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:		- (X3) DATE SURVEY COMPLETED	
		00938	B. WING		03/05/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
IOORH	EAD REHABILITATIO	Ν & ΗΕΔΙ ΤΗCΔΡΙ	COND AVENUE AD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	problems of pneum organism, severe s respiratory failure w pneumonia. The inti indicated R1 had a admission to the ho sacrum/coccyx, wo ankle and left poste the aforementioned the time of R1's dis Review of R1's faci 10/24/18, R1 was another long term of was alert, oriented needs known. The use of a full body m had left sided weak cm scab on his righ on his groin. -10/25/18, R1's leg to float his heels an -10/26/18, had an of heel for comfort and available. -11/5/18, R1 had be and refused to get times. The note lac repositioning. -11/7/18, R1 had di facility night shift nu	spital on 1/9/19, and had active ionia due to infectious epsis, acute on chronic with hypoxemia and aspiration teragency referral form ctive skin wounds upon ospital, identified on right und left heel, right lateral erior ear. The form identified a wounds remained active at				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00938	B. WING		03/	05/2019
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IOORHI	EAD REHABILITATION	N & HEALTHCARL	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ige 13	2 900			
	documentation of F	R1's repositioning and any for the risks and benefits of				
	floating in his room	Illucinations of a baby bath . No further documentation of positioning or R1's skin				
	been verbally aggre	received a shower and had essive towards an NA. lacked any information of R1's	3			
	The note did not ac	to get dressed and out of bed. Idress R1's repositioning or as to the risks and benefits of				
	times however, did	a weekly skin check three not address education ks and benefits of offloading o repositioning.	r			
		nis left ear was red, swollen ful and provider would come ess R1's ear.				
	-12/31/18, revealed redness had minim	l R1's ear swelling and ized greatly.				
	100.4 degrees Fah	well, had a temperature of renheit, elevated heart rate, nds and was sent by lospital.				
	-1/20/19, R1 passe	d away at 7:00 p.m.				
	R1 returned from th	ne hospital on 1/18/19,				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00938	B. WING		03/05/201	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
EAD REHABILITATION	N & HEALTHCARL				
(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
however, his medic documentation of d the facility. R1's medical record development of R1' lacked a comprehe throughout his entir and upon return, fro During an interview NA-E indicated she and able to make h R1 had required exery indicated R1 would was oftentimes con offered. NA-E state any pressure ulcer upon his return to th During an interview NA-A stated R1 had cares, though woul basis. NA-A stated what he wanted an decisions. NA-A stated what he wanted an decisions. NA-A stated what he felt R1 w approximately once repositioning appro stated R1 required repositioning, about	ate or details of his return to d did not identify the 's multiple pressure ulcers and nsive skin assessment, re stay in the facility, prior to om the hospital. on 2/28/19, at 9:10 a.m. e felt R1 was alert, oriented is own decisions. NA-E stated tensive assistance with ADL's two hour repositioning. NA-E frequently refuse cares and nbative whenever cares were d she was unaware if R1 had before his hospitalization or he facility. on 2/28/19, at 9:20 a.m. d required assistance with his d refuse cares on a daily she felt R1 was alert, knew d was able to make his own ated she felt R1 would refuse did not like and felt he needed nent to allow cares, bathing e every few weeks and ximately once a shift. NA-A routine assistance with t every two hours and stated		DEFICIEN		
	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER EAD REHABILITATION SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pathowever, his medic documentation of d the facility. R1's medical record development of R1 lacked a comprehe throughout his entir and upon return, from During an interview NA-E indicated she and able to make h R1 had required exery indicated R1 would was oftentimes com offered. NA-E state any pressure ulcer upon his return to the During an interview NA-A stated R1 had cares, though would basis. NA-A stated what he wanted an decisions. NA-A stated what he wanted an decisions	OF CORRECTION IDENTIFICATION NUMBER: 00938 00938 PROVIDER OR SUPPLIER STREET ALL EAD REHABILITATION & HEALTHCARI 2810 SEC MOORHE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 however, his medical record lacked documentation of date or details of his return to the facility. R1's medical record did not identify the development of R1's multiple pressure ulcers and lacked a comprehensive skin assessment, throughout his entire stay in the facility, prior to and upon return, from the hospital. During an interview on 2/28/19, at 9:10 a.m. NA-E indicated she felt R1 was alert, oriented and able to make his own decisions. NA-E stated R1 had required extensive assistance with ADL's and required every two hour repositioning. NA-E indicated R1 would frequently refuse cares and was oftentimes combative whenever cares were offered. NA-E stated she was unaware if R1 had any pressure ulcer before his hospitalization or upon his return to the facility. During an interview on 2/28/19, at 9:20 a.m. NA-A stated R1 had required assistance with his cares, though would refuse cares on a daily basis. NA-A stated she felt R1 was alert, knew what he wanted and was able to make his own decisions. NA-A stated she felt R1 would refuse cares from staff he did not like and felt he needed a lot of encouragement to allow cares. NA-A stated R1 required routine assistance with repositioning approximately once a shift. NA-A stated R1 required routine assistance with repositioning approximately once a shift. NA-A stated R1 required routine assistance with	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE (A. BUILDING: 00938 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA 2810 SECOND AVENUE MOORHEAD, MN 565500 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 14 2 900 however, his medical record lacked documentation of date or details of his return to the facility. 2 900 R1's medical record lacked documentation of R1's multiple pressure ulcers and lacked a comprehensive skin assessment, throughout his entire stay in the facility, prior to and upon return, from the hospital. 2 900 During an interview on 2/28/19, at 9:10 a.m. NA-E indicated she felt R1 was alert, oriented and able to make his own decisions. NA-E stated R1 had required extensive assistance with ADL's and required every two hour repositioning. NA-E indicated R1 would frequently refuse cares and was oftentimes combative whenever cares were offered. NA-E stated she was unaware if R1 had any pressure ulcer before his hospitalization or upon his return to the facility. During an interview on 2/28/19, at 9:20 a.m. NA-A stated She felt R1 was alert, knew what he wanted and was able to make his own decisions. NA-A stated she felt R1 would refuse cares from staff he did not like and felt he needed a lot of encouragement to allow cares. NA-A stated She felt R1 would allow cares. NA-A stated R1 required routine assistance with repositioning approximately once every few weeks and repositioning approximately once a shifin, NA-	TO F DEFICIENCIES OF CORRECTION (M1) PROVIDER/SUPPLIER(LIA IDENTIFICATION NUMBER: 00938 (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCE TO DEFICIENC Continued From page 14 2 900 Nowever, his medical record lacked documentation of date or details of his return to the facility. PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCE) TO DEFICIEN R1's medical record did not identify the development of R1's multiple pressure ulcers and lacked a comprehensive skin assessment, throughout his entire stay in the facility, prior to and upon return, from the hospital. ID DURING an interview on 2/28/19, at 9:10 a.m. NA-E indicated she felt R1 was alert, oriented and able to make his own decisions. NA-E stated R1 had required every two hour repositioning. NA-E indicated R1 would frequently refuse cares and was oftentimes combative whenever cares were offered. NA-E stated she was unaware if R1 had any pressure ulcer before his hospitalization or upon his return to the facility. During an interview on 2/28/19, at 9:20 a.m. NA-A stated R1 had required assistance with his cares, fhough would refuse cares on a daily basis. NA-A stated she felt R1 would allow cares, bathing approximately once every few weeks and repositioning approximately once a shift. NA-A stated R1 required routine assistance with repositioning, about every two hour sand stated	TO F DEFICIENCIES OF CORRECTION (Y1) PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: (X3) DATE A BUILDING: O0938 B. WING 03// PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SAN DATE ADDREMABILITATION & HEALTHCARI Z810 SECOND AVENUE NORTH MOORHEAD, MN 56500 SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX CONTINUED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED B DY PLL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 14 2 900 PREFIX TAG PREFIX TAG PREFIX TAG R1's medical record lacked documentation of date or details of his return to the facility. 2 900 PREFIX TAG PREFIX TAG PREFIX TAG During an interview on 2/28/19, at 9:10 a.m. NA-E indicated she feit R1 was allert, oriented and able to make his own decisions. NA-E stated R1 had required every two hour repositioning, NA-E indicated R1 would frequently refuse cares and was oftentimes combative whenever cares were offered. NA- stated She feit R1 was allert, new what he wanted and was able to make his own decisions. NA-A stated She feit R1 would refuse cares from staff he did not like and feit he needed a lot of encouragement to allow cares. NA-A stated She feit R1 would allow cares. Shoring approximately once every few weeks and repositioning, about every two hours and stated she was unware of any pressure ulcers before what he wanted and was able to make his own decisions. NA-A stated She fit R1 would

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		03/	05/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
NOORH	EAD REHABILITATION	Ν & ΗΕΔΙ ΤΗCΔΡΙ	COND AVENUE EAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	licensed practical n R1 was verbally ab would routinely refu- want to stay in his r LPN-D stated she c completing a skin c would routinely refu- she was not aware before he left and v hospital. Further, LI R1 having had a pr any other specialize such as Prevalon b hospitalization. During an interview NA-E stated R1 wo yell, swear at staff a and attempt to bloc cares. However, NA was approached a more apt to comply could not recall R1 ulcers before or affu- January. During an interview trained medication compliant with care the "right way." TMA make his wishes kr times when R1 was was on a routine re hours and as need	ge 15 on 2/28/19, at 10:10 a.m. urse (LPN)-D stated she felt usive towards facility staff and use cares, meals and would oom throughout her shift. could not recall ever heck on R1 and indicated he use his baths. LPN-D indicated if R1 had any pressure ulcers when he returned from the PN-D stated she did not recall essure relieving mattress or ed pressure relieving devices, oots prior to or after his on 2/28/19, at 10:53 a.m. uld routinely refuse cares, and would put up his hands k her from assisting him with A-E indicated she felt if R1 certain way, he would be with cares. NA-E stated she ever having any pressure er his hospitalization in on 2/28/19, at 11:42 a.m. aid (TMA)-A indicated R1 was us when he was approached A-A stated she felt was able to nown and indicated there were confused. She indicated R1 positioning plan of every two ed. TMA-A stated R1's skin ime she had observed his				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		03/	05/2019
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORHI		N & HEALTHCARL	COND AVENUE EAD, MN 5656			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Prevalon boots. Fu standard mattress a place prior to his ho Review of R1's wee 11/4/18, to 1/6/19, r -11/25/18, skin intact -12/2/18, skin intact -12/16/18, skin intact -12/30/18, open are secondary to celluli small bruise on the -1/6/19, skin intact. R1's medical record documentation of o condition. During an interview LPN-E stated R1 of which included repo could not recall if st check on R1 or hac ulcers for R1. LPN- had a history of pre any pressure ulcers During an interview LPN-B stated she h on 1/6/19, and had ulcers. LPN indicate ever having had pre	re relieving devices, such as inther, she stated R1 utilized a and wheelchair cushion in ospitalization in January. ekly skin checks forms from revealed the following; t. ct. ct. ea above his left ear, tis, small scab on left shin and top of his left foot. d lacked further ngoing monitoring of R1's skir on 2/28/19, at 1:00 p.m. ften refused any assistance, ositioning. LPN-E stated she he had ever completed a skin d been aware of any pressure E stated she was unaware R1 issure ulcer or had developed	4	DEFICIENC	ΥΥ)	

LITATION & HEALTHCAR	PREFIX TAG 2 900 ar return. 0.m. wing any skin ization. his been be d never he heel I-C scab had d a sore	UE NORTH	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	5/2019 (X5) COMPLET DATE
LITATION & HEALTHCARI MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FU ORY OR LSC IDENTIFYING INFORMATI From page 17 mpleted a skin check upon his nterview on 2/28/19, at 3:00 p. ed he could not recall ever hav a body skin check on R1, or an it before or after R1's hospitaliz cated R1 had a small scab on his initial admission and had be ith an order for a heel cup to b comfort. LPN-C stated he had eel cup to his heel, because th a vailable in the facility. LPN /as unaware when R1's heel s PN-C indicated he had noticed	2810 SECOND AVEN MOORHEAD, MN 56 ULL TON) ID PREFIX TAG 2 900 ar return. 0.m. tving any skin ization. bis been be d never he heel I-C scab had d a sore	UE NORTH 560 PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO	ACTION SHOULD BE	COMPLET
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ed he thought he had provided o R1 on the risks and benefits aff to provide cares, repositioni ecall whether the education pro- ever been documented. LPN-C e was unaware whether R1 ha cers upon his return from the l ed he did not think R1 had any cers before his hospitalization nterview on 2/28/19, at 3:10 p. d he could not recall any skin rith R1 before or after he had b d in January. NA-H stated R1 v sistant to cares, was on an even tioning schedule and indicated v assistance with cares, includ	came to ellulitis. d s of not ing, but rovided C ad any hospital y n. b.m. been was very two d R1 ting			
	had ordered antibiotics for or ed he thought he had provide o R1 on the risks and benefits iff to provide cares, reposition call whether the education prover been documented. LPN- e was unaware whether R1 h cers upon his return from the ed he did not think R1 had an cers before his hospitalization herview on 2/28/19, at 3:10 p d he could not recall any skin ith R1 before or after he had in January. NA-H stated R1 sistant to cares, was on an ex- tioning schedule and indicate assistance with cares, includ g approximately once a shift, d there were times R1 would r his room and he would not it indicated he could not reme	had ordered antibiotics for cellulitis. ed he thought he had provided o R1 on the risks and benefits of not iff to provide cares, repositioning, but ecall whether the education provided over been documented. LPN-C e was unaware whether R1 had any cers upon his return from the hospital ed he did not think R1 had any cers before his hospitalization.	had ordered antibiotics for cellulitis. ed he thought he had provided o R1 on the risks and benefits of not iff to provide cares, repositioning, but call whether the education provided wer been documented. LPN-C e was unaware whether R1 had any cers upon his return from the hospital ed he did not think R1 had any cers before his hospitalization. Atterview on 2/28/19, at 3:10 p.m. d he could not recall any skin ith R1 before or after he had been d in January. NA-H stated R1 was sistant to cares, was on an every two tioning schedule and indicated R1 assistance with cares, including g approximately once a shift, at best. d there were times R1 would refuse to r his room and he would notify the d indicated he could not remember	had ordered antibiotics for cellulitis. ed he thought he had provided o R1 on the risks and benefits of not off to provide cares, repositioning, but ecall whether the education provided ver been documented. LPN-C e was unaware whether R1 had any cers upon his return from the hospital ed he did not think R1 had any cers before his hospitalization. Interview on 2/28/19, at 3:10 p.m. d he could not recall any skin ith R1 before or after he had been t in January. NA-H stated R1 was sistant to cares, was on an every two tioning schedule and indicated R1 assistance with cares, including g approximately once a shift, at best. d there were times R1 would refuse to r his room and he would notify the 4 indicated he could not remember pressure relieving devices used for

	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	– B. WING		03/	05/2019
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE. ZIP CODE	00,	00/2013
MOORHI	EAD REHABILITATIO		COND AVENUE EAD, MN 5656	NORTH		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 18	2 900			
	R1.					
	stated R1 refused of and physically bloc any cares, which sl nurses. NA-I stated up to four or so how to his refusals. Review of R1's phy revealed an order of pad to R1's left hee wheelchair, monito Another order date staff to monitor R1'	v on 2/28/19, at 3:24 p.m. NA-I cares daily, would yell, swear k her from assisting him with he would then notify the facility d she felt R1 could have went urs without repositioning due visician orders, signed 1/14/19, dated 10/24/18, to apply a hee el while supine in bed or in r for improvement of heel pain d 10/24/18, directed facility s left heel, keep pressure off wheelchair with pillows, esolved.				
	Record (TAR) from January 2019, liste	nthly Treatment Administration October 2018, through d the following treatment documented as completed				
		eleft heel while supine in bed very shift. Start date of				
	bed and in wheelch	eep pressure off left heel in hair with pillows, discontinue ery shift. Start date of 10/24/18				
		eel when in bed so it does not hift. Start date of 10/24/18				
	including the DON,	rview on 2/28/19 at 3:52 p.m., facility administrator and edical record was reviewed.				

	NT OF DEFICIENCIES	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		03/	05/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MOORH		N & HFAI THCARI	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	The DON, administ confirmed R1's med comprehensive ass throughout the dura from 10/24/18, to 1/ 1/20/19. At that time certified wound and identified R1 had for admission to the hot 1/9/19. The administ had indicated R1 hat relieving intervention stated he felt the fa just to document." The facility had been pressure ulcers, or The DON, administ confirmed R1's med routine skin checks indicated R1's skin stated he expected the facility were to hassessment to deter During a telephone p.m. R1's hospital p had presented to the department (ED) ar to the hospital with and hypoxemia. MI terrible condition with hospital as he had shis body and four p admission on 1/9/19 though R1's bruisin being careful when bruising was on his legs. She stated R1	inge 19 rator and consultant dical record lacked a sessment of R1's skin ation of his stay at the facility, /9/19 and from 1/18/19, to e, they confirmed the hospital d ostomy documentation had our pressure ulcers upon ospital from the facility on strator confirmed R1's TAR ad been received pressure ons consistently, however, he cility staff were "documenting The administrator indicated in unaware R1 had any history of pressure ulcers. rator and consultant dical record had several e during his stay, which had was intact. The administrator all residents which resided in nave a complete head to toe ermine skin condition. interview on 3/1/19, at 1:47 obysician (MD)-A, stated R1 he hospital's emergency ind was subsequently admitted aspiration pneumonia, sepsis D-A stated she felt R1 was in hen he was brought to the significant bruising throughout ressure ulcers upon 9. MD-A stated she felt as ig was likely from staff not working with him as his a arms, back, buttocks and 1 would be completely for all of his cares due to his				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		03/	05/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
NOORH	EAD REHABILITATION	N & HFAI THCARI	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	stated R1's pressur managed by the ho had certified wound stated she had disc terminal prognosis and stated they had placement for R1, t R1 back to the facil services. MD-A stat ulcers were avoidal appropriate pressur as off loading his ha applying a foam pro and routine monitor R1 continued to ha discharge. During a telephone p.m. the hospital's of nurse (CWON)-A co admitted to the hos pressure ulcers. CV completed an asse ulcers on the morni confirmed R1 had t -deep tissue pressur area, was deep pur present as a typical ulcer often presents butterfly on the butt She stated she was developed the deep tissue pressure inju- the last 48-72 hours hospitalization R1 w	age 20 ad affected his left side. MD-A re ulcers were assessed and aspital's wound team which d and ostomy nurses. MD-A cussed R1's current condition, with R1's family members, d been unable to find other herefore she had discharged ity with hospice end of life ted she felt R1's pressure ble, had he received re relieving interventions such eels, routine repositioning, otector on R1's oxygen tubing ring of his skin. MD-A stated ve pressure ulcers upon interview on 3/4/19, at 3:49 certified wound and ostomy onfirmed R1 had been pital on 1/9/19 with four VON-A stated she had ssment of R1's pressure ing of 1/10/19. CWON-A he following pressure ulcers: ure injury of his sacrum/coccys rple in color and did not I "Kennedy ulcer" (type of s in the shape of a pear or tocks of those close to death.) s not certain when R1 o tissue injury, but felt deep iry could have occurred within s. CWON-A stated during his was routinely turned side to placed on an air alternating nattress. She stated R1's	5			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		03/	05/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORHI	EAD REHABILITATIO	Ν & ΗΕΔΙ ΤΗCΔΡΙ	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 21	2 900			
	improve prior to his though would have relieving intervention -an unstageable pri upon admission to by 3.0 cm on 1/10// thick eschar. CWO heel ulcer had been extensive eschar wi She stated R1's left 1/14/19, and meass continued to be con CWON stated she completely avoidate interventions. The Prevalon boots on his heel ulcer rema She stated she woo relieving intervention he returned to the fist stated R1's unstage on his affected side significantly increase	pressure injury had began to a discharge from the hospital, e expected continued pressure ons to be implemented. ressure ulcer of his left heel the hospital, measured 1.8 cm 19, and was covered with a N-A stated she felt R1's left n there "long term" due to the which covered the wound bed. It heel was measured again on ured 1.8 cm by 2.8 cm and vered with thick, black eschar. felt heel ulcers were ble with offloading CWON-A stated R1 had while he was hospitalized and ained stable upon discharge. uld have expected pressure ons to be implemented when facility. Further, CWON-A eable heel pressure ulcer was e (paralyzed) which sed his risk for developing a				
	malleolus (ankle bo hospital, measured covered with hard, indicated she also avoidable as it was offloaded. The CW unstageable press for "a while" and in	ressure ulcer of his right media one) upon admission to the d 0.6 cm by 0.4 cm and was black eschar tissue. She felt this pressure ulcer was an area which was easily ON-A stated she felt R1's ure ulcer had also been there ndicated he had the ure ulcer upon discharge.	1			
	-an unstageable pr					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		03/	05/2019
AME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
OORH	EAD REHABILITATION	N & HEALTHCAR	COND AVENUE EAD, 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	left ear, which she i a pressure ulcer rel cannula that had be CWON-A stated, whe had used a face She stated R1's un present upon admiss had improved and we (partial loss of skin) CWON-A stated sh pressure relieving in upon R1's hospital stated she had not treatments upon R4' receiving any dress interventions of off- sufficient. Review of R1's phy 12/26/18 revealed in -10/23/18, R1 had the nursing home, with stroke with left side subacute cerebral in (difficulty swallowin a history of left hee wound that had rece month. Further, the with an offloading b twice daily on the left positioning. -12/26/18, R1 had red, swollen left ear diagnosed with per outer ear tissue sur	felt was a "classic example" of lated to the tubing of a nasal een used at the facility. The hile R1 had been hospitalized mask for oxygen delivery. stageable posterior had been ssion and at discharge, though was able to be staged at a two thickness.) e would have expected nterventions to be in place discharge on 1/18/19. She ordered any specific 1's discharge as he was not sing changes, and felt nursing loading would have been				

ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		03/	05/2019
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE. ZIP CODE		
OORH	EAD REHABILITATIO		COND AVENUE EAD, MN 5656	NORTH		
X4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLE DATE
2 900	Continued From pa	age 23	2 900			
	moist compresses	both for seven days.				
	Treatment, revealed was to provide guid pressure ulcers an pressure ulcers. The guidelines for asser- ulcers, pressure ul- treatment and infer- definitions and des pressure ulcers, in strategies, docume supervisor any wor- refusals of interver The policy directed ongoing assessme interventions and a	I facility staff to provide ent, monitoring and implement analyze interventions in order				
		g of active pressure ulcers to ning and/or new development				