Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 15, 2022

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

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

Dear Administrator:

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

On December 1, 2022, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F0580 -- S/S: D -- 483.10(g)(14)(i)-(iv)(15) -- Notify Of Changes (injury/decline/room, Etc.)
F0609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations
F0610 -- S/S: D -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation
F0689 -- S/S: D -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices

As a result of the revisit findings:

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

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

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 14, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2023

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

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

Dear Administrator:

On October 31, 2022, we notified you a remedy was imposed. On December 1, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 10, 2023.

As authorized by CMS the remedy of:

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically Submitted
October 31, 2022

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

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

Dear Administrator:

On October 14, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On October 13, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 15, 2022, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 15, 2022, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 14, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Moorhead Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 14, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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" and/ or "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

Department of Health & 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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
October 31, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: MYG111

Dear Administrator:

The above facility was surveyed on October 11, 2022 through October 14, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING ______ B. WING ______	C 10/14/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 10/11/22 through 10/14/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The following complaints were found to be SUBSTANTIATED:

H50525059C (MN87498), with a deficiency cited at F689.

The immediate jeopardy began on 10/4/22, when R1 eloped from the facility without staff's knowledge and the WanderGuard system failed to alert staff. The immediate jeopardy was removed on 10/13/22.

The above findings constituted substandard quality of care, and an extended survey was conducted on 10/14/22.

As a result of the investigation, additional deficiencies were cited at F580, F609, and F610.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.

Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING ______ B. WING ______	C 10/14/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		11/10/22

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F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify family following an incident of elopement for 1 of 1 residents (R1) reviewed who was found outside the facility without staff knowledge. Findings include: R1's admission Minimal Data Set (MDS) dated 9/25/22, indicated R1 had diagnoses of orthostatic hypotension, depression and anxiety disorder and had moderate cognitive impairment. Further, MDS indicated R1 required extensive assistance from two staff for bed mobility, and transfers and utilized a wheelchair for mobility. Review of facility report submitted to the SA dated 10/7/22, at 1:29 p.m. indicated R1 had eloped from the building on 10/4/22, at approximately 12:00 a.m. R1's progress note dated 10/4/22, indicated R1 was last observed in facility at 12:00 a.m. and during rounds at 12:30 a.m. R1 was not in his room. R1 was found outside near the main entrance, sitting on the cement without his wheelchair, wearing sweatpants and no shirt. R1	F 580	Facility notified R1's family of elopement from facility. Chart review was completed on 11/4/22 for all residents at risk of elopement. All discrepancies addressed and followed-up on. Each nursing shift was educated on 11/7/212 on family notification. Staff will contact appropriate people during their shift including the POA, MD, Director of Nursing and the Administrator. Audit will be performed weekly x 4 weeks, and Monthly x 5 months. These audits will be regarding notice of fall or significant change and will include: time resident notified, time POA notified, time MD notified, time DON notified, and time Administrator notified. Results will be talked about at monthly QA meeting.	

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F 580	Continued From page 3	F 580		

was assessed for injuries and no injuries were noted. Further, the progress note indicated the nurse manager will notify family and provider during business hours. R1's record lacked evidence family was notified.

On 10/11/22, at 11:27 a.m. family member (FM)-A indicated R1 had displayed mild confusion, anxiety, and delusional episodes since being admitted to the facility. FM-A confirmed they were unaware R1 had a WanderGuard implemented and R1 was found outside of the facility on 10/4/22, without staff knowledge.

On 10/11/22, at 3:08 p.m. registered nurse (RN)-A indicated R1 was found outside of the facility sitting on the cement and leaning against a tree by the main entrance on 10/4/22, at approximately 12:00 a.m. and R1's WanderGuard did not alert staff. Further, RN-A indicated staff were expected to notify family immediately if an emergency other wise if an incident occurs in the middle of the night with no injury staff will report to the morning shift to update family. RN-A confirmed she did not update R1's family and was unsure if the family was updated.

On 10/11/22, at 5:00 p.m. RN-B indicated staff are expected to notify family immediately if there was an injury or nonemergent updates staff can do during business hours. Further, RN-B was unsure if R1's family was notified following the elopement incident.

On 10 /12/22, at 9:05 a.m. director of nursing (DON) indicated nursing staff were expected to update families immediately during an emergency or the following day during business hours if nonemergent.

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F 580	Continued From page 4 Review of facility policy titled Elopements dated 5/22, directed staff to notify the resident's legal representative once the resident returns to the facility.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		11/10/22

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F 609	Continued From page 5 Based on interview and document review, the facility failed to report an incident of elopement to the State Agency (SA), within 24 hours, as required for 1 of 1 residents (R1) reviewed for elopement. Findings include: R1's care plan dated 10/4/22, indicated R1 was at risk for elopement related to disoriented to place, impaired safety awareness, and aimless wandering. Review of facility report submitted to the SA dated 10/7/22, at 1:29 p.m. indicated R1 had eloped from the building on 10/4/22, at approximately 12:00 a.m. On 10/11/22, at 3:08 p.m. registered nurse (RN)-A indicated R1 required the use of a WanderGuard (WG) due to at risk for eloping from facility. Further, RN-A indicated R1 was found outside of the facility sitting on the cement and leaning against a tree by the main entrance on 10/4/22, at approximately 12:00 a.m. and R1's WG did not alarm staff. RN-A indicated R1's nurse manager RN-B was updated on the incident during the night but was unsure on time. On 10/11/22, at 5:00 p.m. RN-B indicated RN-A had called in the middle of the night on 10/4/22, and reported R1 was found outside and was last witnessed in the facility approximately 30 minutes earlier. Further, RN-B indicated she then notified director of nursing (DON) following the phone call with RN-A. In addition, RN-B indicated the incident was discussed at the manager meeting that morning and the administrator was notified then. RN-B was unsure on reporting requirement	F 609	R1's elopement was reported. Reports of this nature will be made within 24 hours. All residents at risk of elopement charts were reviewed. Nurse will contact Director of Nursing and the Administrator when there is an elopement and Administrator will report within allotted time. Any situations of elopement will be brought to the Administrator and will be reported within the 24 hour time frame. Any reportable incidents will be discussed daily in morning meeting and reported timely. An audit will be performed by DON weekly x 4 weeks and monthly x 5 months on timely reporting including: incident type, incident date, incident time, time Administrator notified, and time submitted for follow up. The audits will be addressed monthly at QA meeting.	

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F 609	Continued From page 6 timeframe to the SA and stated, "reporting is above my head". On 10/11/22, at 5:34 p.m. DON indicated on 10/4/22, R1 wandering into the therapy department due to the doors being unlocked and left open and was found outside the facility by the front entrance at approximately 12:30 a.m. DON confirmed R1's WG did not alert staff. Further, DON indicated facility policy for reporting elopements to the SA was within 5 days per administrators' guidance. Review of facility policy titled Elopements dated 5/22, directed staff all elopements will be reported to the Office of Health Facility Complaints (OHFC) and a full report with follow up and summary of incident and outcome as specified by state and federal regulations. Facility lacked timeframe for reporting elopements to the SA.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610		11/7/22

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F 610	Continued From page 7 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an elopement was thoroughly investigated and appropriate interventions were implemented to prevent future elopements for 1 of 1 residents (R1), whose WanderGuard failed to alert staff, was placed incorrectly and was not being tested per manufacturer's guidelines. Findings include: R1's admission Minimal Data Set (MDS) dated 9/25/22, indicated R1 had diagnoses of orthostatic hypotension, depression and anxiety disorder and had moderate cognitive impairment. Further, MDS indicated R1 did not exhibit wandering behaviors but required the use of a WanderGuard (WG) daily. Review of facility reported incident submitted to the State Agency on 10/7/22, indicated R1 had eloped from the facility on 10/4/22, at approximately 12:00 a.m. R1 had self-propelled in his wheelchair to the therapy department exit door and was found outside the building near the main entrance. R1's WG was attached to metal frame of wheelchair at time of incident which was removed and a new WG placed on R1's leg as an immediate intervention. Review of 5-day investigation submitted to the State Agency dated 10/11/22, indicated the root cause of the incident to be therapy department door was left unlocked when all therapy staff left	F 610	A more complete investigation was completed, getting interviews from all staff and not just nursing staff. All patients at risk for elopement have been reviewed and interventions put into place as necessary. Nursing staff has been educated regarding investigations of incidents and interventions. All investigations will get a written statement from staff, resident and/or family. An audit will be performed on investigation process by DON weekly x 4 weeks and monthly x 5 months on timely reporting, and addressed monthly at QA meeting.	

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F 610	Continued From page 8 for the day. Further, R1 was noted to wander through facility with wheelchair and was not known to self-ambulate, so following the incident of R1 walking out of the therapy door and leaving his WG and wheelchair in the therapy department a new WG was placed on R1's left ankle along with implementing frequent checks. Interviews with R1's nursing assistants (NA-A and NA-B) on 10/11/22, who worked the night of the elopement, revealed confirmed the WG system alarm was sounding at the time of the incident when they found R1's wheelchair in the therapy department, however the alarm was "faint" and could not be heard from the residential care floor. NA-A and NA-B also confirmed they were not formally interviewed by the DON during the investigation. On 10/11/22, at 5:34 p.m. director of nursing (DON) indicated she completed the investigation which included interviewing the over night nurse on duty the night of 10/4/22, when the elopement occurred. DON stated the root cause of the elopement was due to therapy department failing to lock the door before leaving and due to R1 self ambulating out of the door leaving his wheelchair and WG behind the WG system did not alert staff of exit from the facility. DON confirmed she did not interview R1's nursing assistants that responded to the elopement and found R1 outside. On 10/11/22, at 9:05 a.m. DON confirmed the facility had completed their 5-day investigation and submitted the investigation to the State Agency. DON confirmed the WG manufacturer was not called to inquire about WG system malfunction, was not aware the alarm sounded or	F 610		

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F 610	Continued From page 9 that the volume was low (though all doors were checked following the elopement), or R1's WG's was not placed according to manufacturer's guidelines.	F 610		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure to ensure safety checks were completed following an elopement and the appropriate use of a WanderGuard device to ensure staff are alerted when a resident elopes from the facility 1 of 3 residents (R1). This resulted in an immediate jeopardy for R1. In addition, the facility failed to follow manufacturer's guidelines for WanderGuard system use and testing for 4 of 4 residents (R1, R2, R3, R4) reviewed for elopement. The immediate jeopardy began on 10/4/22, when R1 eloped from the facility without staff's knowledge and the WanderGuard system failed to alert staff. The immediate jeopardy was identified on 10/12/22 and the administrator, director of nursing (DON), quality assurance director, and nurse manager were notified of immediate jeopardy at 2:05 p.m. on 10/12/22.	F 689	R1's wander guard checks to ensure appropriate placement were put on TAR to be checked daily. 15-minute checks are no longer on paper and are done electronically in POC by CNA regarding resident well being and location in the facility. All residents with wander guards had their wander guards replaced and moved to the recommended area. All TARS were updated with wander guard visual checks and testing. POC for residents has been updated on safety checks. Staff has been educated regarding elopement checks and wander guard placement. An audit will be performed by DON weekly x 4 weeks and monthly x 5 months on	11/10/22

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F 689	Continued From page 10	F 689		

The immediate jeopardy was removed on 10/13/22, but noncompliance remained at the lower scope and severity of a D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R1's admission Minimal Data Set (MDS) dated 9/25/22, indicated R1 had diagnoses of orthostatic hypotension, depression and anxiety disorder and had moderate cognitive impairment. Further, MDS indicated R1 required extensive assistance from two staff for bed mobility, and transfers and utilized a wheelchair for mobility.

R1's care plan dated 10/4/22, indicated R1 was at risk for elopement related to disoriented to place, impaired safety awareness, and aimless wandering. The care plan directs staff to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, identify patten of wandering, wander alert bracelet (WanderGuard), and monitor location. R1's care plan lacked direction for staff on how often monitoring or visual checks on R1.

R1's medical record lacked evidence R1's WanderGuard (WG) function was being monitored since placement on 9/23/22.

R1's incident report dated 10/4/22, indicated nursing staff noted R1 was not in room at 12:30 a.m. during rounds. R1 was last seen in the facility at 12:00 a.m. by nursing staff. R1 had self-propelled in wheelchair and exited the door in the therapy room. R1 was found outside sitting on the cement without his wheelchair by the front

elopement charting and wander guard placement. The audits will cover accident hazards/supervision/devices including: date, wander guard in correct place, wander guard working properly, tester in med room, and CNA safety checks complete. The audits will be addressed monthly at QA meeting.

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F 689	Continued From page 11	F 689		

entrance (this door is approximate 15-20 ft from therapy door). R1 was assessed for injuries and no injuries were noted.

Review of facility reported incident submitted to the State Agency on 10/7/22, indicated R1 had eloped from the facility on 10/4/22, at approximately 12:00 a.m. R1 was found outside the building near the front entrance. R1 had a new WG placed on R1's leg as an immediate intervention.

On 10/11/22, at 11:27 a.m. R1 was observed sitting in his recliner in his room. R1 had a circle shaped WG on left ankle. During continuous observation until 12:04 p.m. an unidentified nursing assistant visually checked on R1. (37 minutes).

On 10/11/22, at 3:08 p.m. registered nurse (RN)-A indicated all residents who are at risk for eloping have a WG and interventions in their care plans directing staff what to do when they are exhibiting exit seeking or wandering behaviors. RN-A indicated R1 appeared to be confused and exhibited wandering behaviors but was unaware if R1 required visual safety checks. Further, RN-A indicated on 10/4/22, at approximately 1:00 a.m. RN-A observed two nursing assistants (NA) outside with R1. R1 was sitting on the cement by the main entrance leaning against a tree without his wheelchair. R1's wheelchair was found at the therapy department exit door and his WG had not alerted staff. Following the incident R1 was placed on 15-minute visual safety checks, but RN-A was unsure if R1 continued to be on the safety checks at that time.

On 10/11/22, at 3:35 p.m. nursing assistant

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F 689	Continued From page 12 (NA)-A indicated residents who are at risk for elopement were identified in each resident's care plan and frequent visual safety checks are in place to ensure the resident was still in the facility. NA-A indicated R1 had confusion and exhibited exit seeking and wandering behaviors more in the evenings. NA-A stated interventions used when R1 was exhibiting these behaviors included redirection and frequent visual checks but was unsure how often stated at least hourly. NA-A stated NA-B was R1's care staff on the night of 10/4/22, and R1 was last observed attempting to exit the front entrance in his wheelchair at approximately 12:30 a.m. when staff redirected R1 back to his room and into bed. At approximately 1:00 a.m. during rounds NA-A stated R1 was not in his room and they began to search for R1 in the facility. NA-A and NA-B heard a faint alarm in the therapy department where R1's wheelchair with the WG attached was found next to the exit door, so staff exited outside and found R1 sitting on the cement by the main entrance. Further, NA-A indicated following the incident R1 was placed on 15-minute visual safety checks but was unsure if those safety checks were still in place. (time noted in interview was different than time indicated in facility incident reported to State Agency) On 10/11/22, at 3:54 p.m. interview with regional services manager (RSM) at RF Technologies (WG manufacturer) indicated if there was a malfunction with the facility's WG system, the facility would be expected to contact RF Technologies to work through the problem. On 10/11/22, at 4:01 p.m. NA-C indicated R1's cognition varied each day and R1 exhibited wandering and exit seeking behaviors. NA-C	F 689		

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indicated interventions for R1's behaviors included a WG placement and checking on R1 "regularly" but was unsure if R1 required scheduled visual safety checks.

On 10/11/22, at 4:16 p.m. NA-B indicated needs assistance with all activities of daily living due to R1's low blood pressure and fall risk. NA-B stated R1 was disorientated and exhibits wandering and exit seeking behaviors and NA-B was unsure what interventions were in place for R1's behaviors. Further, NA-B indicated on 10/4/22, at approximately 11:00 p.m. R1 began exhibiting wandering and exit seeking behaviors and while beginning rounds at approximately 12:00 a.m. R1 was not in his room. NA-B indicated NA-B checked in the therapy department and heard the WG system alarm but it was very faint. NA-B observed R1's wheelchair at the door with the WG attached and R1 was outside by the main entrance. In addition, NA-B indicated following the incident 15- minute visual checks were implemented for R1, but was unsure if they were still in place.

On 10/11/22, at 5:00 p.m. nurse manager (NM) indicated residents are assessed for elopement risk on admission and interventions were determined by the providers and nursing staff. NM was not aware of interventions for R1's wandering and exit seeking behaviors other than a WG placed and reorientation or redirection. NM indicated R1 had an elopement from facility on 10/4/22, due to the WG system alarm did not sound because R1 left his wheelchair inside the facility. Further, NM confirmed R1 had a WG placed on his ankle following the incident rather than on his wheelchair and NM was unsure if R1 was on visual safety checks following R1's

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elopement incident. NM indicated placement of a WG is determined by the least restrictive placement which is typically the wheelchair unless the resident is ambulatory then it would be placed on their ankle. NM confirmed R1 did not have WG daily function monitoring and placement check in his record and indicated the nurse practitioner typically puts in an order for staff to complete this.

On 10/11/22, at 5:34 p.m. director of nursing (DON) indicated since R1's elopement on 10/4/22, R1's WG was placed on his ankle and 15-minute safety checks were implemented to prevent future elopements. DON confirmed R1's care plan was not revised with new interventions and the interventions were only communicated verbally to nursing care staff. In addition, DON indicated the 15-minute checks were being completed by paper form by R1's nursing care staff. At 6:02 p.m. DON confirmed the 15-minute checks were not being implemented due to not being able to find the documentation at either nursing stations.

Review of facility policy titled Elopements dated 5/22, indicated all residents shall be screened during admission and annually reviewed or with significant change for potential for elopement on the elopement assessment. Further, policy directed staff to implement the following safety measures for residents who are identified to be at risk for elopement: WanderGuard bracelets for each resident will be tested weekly, WanderGuard doors will be tested monthly, a log of residents with WanderGuard bracelets will be kept by nursing with expiration dates of the WanderGuard, and if the WanderGuard system is down visual checks of the residents with

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WanderGuard bracelets would be done every 30 minutes.

The immediate jeopardy that began on 10/4/22, was removed on 10/13/22, when R1's wander guard was tested for function and placement daily and an order was placed in his chart, R1 was assessed for appropriate interventions related to elopement risk and his care plan was revised, all residents at risk of elopement were assessed, WGs were placed correctly according to manufacturer's instructions, elopement policy was reviewed and revised, education provided to all staff regarding elopement before staff started their shift.

In addition:

R2's quarterly MDS dated 8/22/22, indicated R2's diagnoses included depression, psychotic disorder and had moderate cognitive impairment. Further, R2 did not exhibit behaviors but required the use of a WG alarm daily.

R3's quarterly MDS dated 9/21/22, indicated R3 had a diagnosis of delirium and moderately impaired cognition. R3 did not exhibit wandering behavior but required the use of a WG alarm daily.

R4's quarterly MDS dated 8/18/22, indicated R4's diagnoses included stroke, anxiety and had severely impaired cognition. R4 did not exhibit wandering behavior but required the use of a WG alarm daily.

On 10/11/22, at 2:53 p.m. LPN-B stated there are currently four residents in the facility who are considered high risk for elopement, and they all

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have a WG in place. Further, LPN-B indicated WGs are monitored daily for placement and functioning by bringing each resident to the door that is alarmed.

On 10/11/22, at 3:08 p.m. RN-A indicated placement of a WG was determined by assessing each resident and place the WG in a least restrictive area, typically on their ankle or wheelchair.

On 10/11/22, at 5:00 p.m. NM indicated nursing staff are expected to monitor each resident's WG functioning and placement daily by bringing each resident to the door to ensure the alarm will sound.

On 10/12/22, at 9:15 a.m. R2 was observed laying in bed in room with a circle WG on left ankle, confirmed by DON.

On 10/12/22, at 9:17 a.m. R3 was observed in his room in bed with a circle WG on left ankle and a second WG placed on the back of his wheelchair on the metal frame, confirmed by DON

On 10/12/22, at 9:19 a.m. R4 was observed self-propelling in hallway in his wheelchair with a circle WG on his ankle, confirmed by DON.

On 10/12/22, at approximately 9:19 a.m. DON indicated staff were expected to monitor each resident's WG daily by bringing each resident to the door to ensure it is functioning and in place daily.

On 10/12/22, at 9:42 a.m. RSM at RF Technologies (WG manufacturer) indicated the circle WG should be placed on the resident's

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F 689	Continued From page 17 wrist only due to less transmission and placing the circle WG on an ankle it is further from the receiver which places the resident at greater risk of getting out of the facility. Further, RSM indicated testing the WGs should be completed using a tester provided by RF technologies and not bringing the resident to the door due to inconvenience to the resident as well as safety concerns with showing the resident the exits and functioning. Review of WG manual titled, Wander Management Transmitters User Guide dated on page 10 directs a CodeWatch (circle WGs) was smaller than a transmitter and is placed on the wrist of a resident. Further, WG User Guide directed to test operation of transmitters using the transmitter tester and never take a resident to a door to test their transmitter.	F 689		

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{F 000}	INITIAL COMMENTS Moorhead Restorative Care Center is a Special Focus Facility (SFF).On 11/28/22, to 12/1/22, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited 10/14/22. The facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints SUBSTANTIATED: H50525059C (MN00087498), with a deficiency cited at F689 were reviewed for compliance, and were found NOT be corrected and remain OUT OF COMPLIANCE. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 580} SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	{F 580}		12/20/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2022

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

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{F 580}	Continued From page 1 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	{F 580}		

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{F 580}	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician and power of attorney were notified of newly developed pressure ulcers for 1 of 1 resident (R33) reviewed for facility acquired pressure ulcers. R33's admission Minimum Data Set (MDS) dated 11/6/22, identified R33 had diagnoses which included debility (physical weakness), atrial fibrillation, and hypertension. Identified R33 had moderately impaired cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and bathing. Identified R33 was always incontinent of bowel and bladder and was not on a toileting plan. Identified R33 was at risk for pressure ulcers and had a pressure relieving device for his bed and chair and was not on a turning and repositioning program. R33's admission Care Area Assessment (CAA) dated 11/6/22, revealed R33 had moderate cognitive impairment which limited his abilities to recognize his needs. Identified R33 required extensive assistance with ADL's, and was not able to remember the need to change position. Revealed R33 preferred to be lying in his bed or seated in a wheelchair and was to have a pressure relieving device on his bed and his wheelchair. Identified R33 was at risk for developing pressure ulcers and had no pressure ulcers at the time of the assessment. R33's admission skin assessment dated 10/31/22, revealed R33's skin was intact.	{F 580}	Facility notified R33's POA and Physician of pressure ulcer An audit has been done to ensure notification to responsible party and physician has been completed for patients as necessary Staff has been educated on notifying of responsible party and physician as needed for all patients. An audit on notification of responsible party and physician will be done weekly x 4 weeks and monthly x 3 months. All audits will be brought to and monitored through the QAPI further follow up and recommendations.	

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R33's weekly skin review form dated 11/25/22, identified R33 had a small open area on his sacrum in which barrier cream was applied.

During an interview on 11/30/22, at 9:05 a.m. with nurse manager (NM)-A, stated R33 had no pressure ulcers when he was admitted to the facility approximately one month prior. NM-A confirmed R33 currently had facility acquired pressure ulcers, one stage two on his sacrum and pressure ulcers to both heels which were unstagable due to deep tissue injury. NM-A stated she was not aware if R33's family had been notified of the pressure ulcers.

During an interview on 11/30/22, at 9:16 a.m. Certified Nurse Practioner (NP)-A, stated she had met with R33 several times since his admission and was familiar with him. NP-A indicated she had been notified approximately a week ago R33 had redness on his buttocks, and felt it was due to R33's bowel and bladder incontinence. NP-A confirmed she had not been notified R33's sacrum was noted to have an open area on 11/25/22, and had not been notified of R33's bilateral heel deep tissue injury.

R33's medical record lacked any documentation R33's practioner or family member/power of attorney had been notified of his pressure ulcers.

During an interview on 12/1/22, at 10:29 a.m. the director of nursing (DON) indicated she would have expected R33's practioner and family member to be notified of any changes in R33's condition, which included newly developed pressure ulcers.

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{F 580}	Continued From page 4 During a telephone interview on 12/1/22, at 10:44 a.m. R33's family member (FM)-A indicated she was not been notified R33 had any pressure ulcers. FM-A stated she would have wanted to have been notified of any changes in R33's condition. Review of a facility policy titled, Change in a Resident's Condition or Status reviewed 11/30/21, identified it was the purpose of the policy the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the residents's medical/mental condition and/or status.	{F 580}		
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	{F 609}		12/20/22

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{F 609}	Continued From page 5 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than 2 hours, an allegation of abuse to the State Agency (SA) for 3 of 3 residents (R4, R13, R26) reviewed for abuse. Findings include: R4 R4's quarterly Minimum Data Set (MDS) dated 11/2/22, identified R4 had diagnosis which included cerebral vascular accident (CVA), hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms. legs, and facial muscles) and seizure disorder. Indicated R4 had severe cognitive impairment and required limited assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R4's care plan revised 9/3/22, revealed R4 had a mood problem related to feeling unsafe with another resident at the facility. The care plan directed staff to limit exposure to the resident R4 felt unsafe around. The facility SA report dated 9/2/22, at 7:08 p.m. indicated R4 stated there was unwanted kissing between R4 and R14. The report identified R4	{F 609}	These 3 residents' reports have been filed, investigated, and closed. An audit done to ensure that no other allegations exist that require reporting at this time. Any allegations affecting patients will be reported immediately. Staff have been educated on required timeliness of reporting and reporting requirements. Audit will be performed to ensure any allegations requiring reporting are reported timely, weekly x 4 weeks and Monthly x 3 months. These results will be presented at QAPI	

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and R14 were placed on frequent checks to ensure well-being.

During an interview on 12/1/22, at 9:24 a.m. registered nurse (RN-D) stated on 9/2/22, while R4 was eating breakfast around 8:00 a.m. RN-D noticed three red marks on R4's neck. RN-D stated she asked R4 what happened to her neck and R4 stated "R14 had placed hickeys on her neck" and she did not like it. RN-D was unsure of what time the allegation of abuse was reported to the administartor.

During an interview on 12/1/22, at 9:41 a.m. trained medication aide (TMA-B) indicated she noticed three red marks on R4's neck around 8:30 a.m. on 9/2/22. TMA-B indicated she had informed RN-D R4 identified the red marks were from R14 and R4 did not like having the red marks present on her neck.

During an interview on 12/1/22, at 9:55 a.m. administrator stated he had been made aware of the allegation of abuse before 10 a.m. on 9/2/22. Administrator confirmed the allegation of abuse had not been reported to the SA within two hours. Administrator stated his expectation would have been the allegation of abuse would have been reported to the SA within two hours.

R13

R13's quarterly MDS dated 8/27/22, identified R13 was cognitively intact and had diagnoses which included: diabetes mellitus type two, hypertension and chronic kidney disease. Indicated R13 was independent with activities of daily living (ADLs). identified R13 had received insulin injections seven of past seven days and

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{F 609}	Continued From page 7	{F 609}		

antidepressant medication seven of seven days.

R13's Care Area Assessment (CAA) dated 5/27/22, identified R13 was cognitively intact and was able to make his needs known. Indicated R13 had some behavioral symptoms which included social inappropriateness.

R13's care plan revised 6/13/22, identified R13 was independent with bed mobility, transfers, dressing and toilet use. R13's care plan indicated R13 had behavioral problem which included fixation on specific staff followed by repeated allegations of perceived retaliation of unknown origin that could not be substantiated.

During an interview on 11/28/22, at 2:30 p.m. R13 stated he had made a report to a nurse, unidentified, who had filed a report with the facility regarding concerns with registered nurse Infection preventionist (RNIP)-A who had mistreated him and placed something in his water.

During a follow up interview on 11/28/22, at 2:40 p.m. with an interpreter present, R13 identified he was afraid of RNIP-A. R13 stated he believed RNIP-A was trying to poison him as he had witnessed her place eye drops in his water the last Sunday morning of September. R13 indicated he had been refusing medications from RNIP-A. R13 stated he just wanted to stay in his room because he was afraid and felt the facility had not done anything to resolve the issue.

Review of the SA reports and grievance log provided by the facility lacked documentation of a report filed related to R13's allegation.

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{F 609}	Continued From page 8 On 11/28/22, at 7:28 p.m. surveyor reported to administrator R13 indicated he had been mistreated by a staff member and was afraid of her. Administrator confirmed no SA report had been filed regarding R13's allegation and stated he would interview R13. During an interview on 11/29/22, at 8:27 a.m. administrator indicated the director of social services (DSS)-A and himself interviewed R13 with an interpreter present on the evening of 11/28/22. A grievance form was completed after the interview and both the administrator and DSS-A interviewed RNIP-A. Administrator stated the plan going forward was to have another nurse administer R13's eye drops. Administrator confirmed R13 alleged during their interview RNIP-A placed eye drops in his water and was afraid of her. Administrator confirmed the facility had not completed a SA report of alleged abuse. During an interview on 11/29/22, at 8:41 a.m. DSS-A confirmed when interviewed, R13 had reported he believed RNIP-A had placed eye drops in his water and stated he was afraid of taking medications from her. DSS-A stated the facility was unsure if the allegation was accurate and indicated R13 was not always truthful. DSS-A stated RNIP-A stated she had not placed eye drops in R13's water and indicated R13 and RNIP-A did not like one other. DSS-A confirmed she had been aware R13 had been refusing medications from RNIP-A prior to the surveyor reporting the allegation. DSS-A confirmed R13 requested a grievance form be filed. DSS-A confirmed the facility had not filed an abuse allegation report to the SA.	{F 609}		

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{F 609}	Continued From page 9	{F 609}		

Continued From page 9

Review of R13's Concern Or Problem Resolution Form dated 11/28/22, identified R13 had a concern RNIP-A placed eye drops in his water to poison him. R13 identified the date of occurrence on 9/27/22. R13 was now afraid to take medications from RNIP-A. The form identified a different staff member would now provide medications to R13.

During an interview on 11/30/22, at 11:41 a.m. director of nursing (DON) indicated she was aware of R13's allegation of abuse and the facility had interviewed RNIP-A and R13. DON stated as a result of the allegation, the facility now had another nurse administering R13's medications. DON-A stated she had been aware R13 refused medication from RNIP-A and had been aware of his accusation regarding eye drops placed in his water for about a month. DON confirmed if R13 said he had been mistreated and felt afraid of RNIP-A, it would have been considered an allegation of abuse and it should have been reported to the SA.

During a follow-up interview on 12/1/22, at 1:05 p.m. administrator confirmed the facility had not submitted a vulnerable adult report to the SA within the required time frames and stated they had submitted a vulnerable adult report today to the SA. Administrator indicated after further review of R13's grievance form, he felt it was more of an allegation of abuse than they thought in the beginning since R13 had expressed he did not feel safe.

R26

R26's significant change in status assessment (SCSA) Minimum Data Set (MDS) dated

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{F 609}	Continued From page 10	{F 609}		

10/25/22, identified R26 had diagnoses which included knee replacement, arthritis, anemia and hypertension. Indicated R26 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and dressing. R26 had other behaviors directed towards others four (4) to six (6) days but not daily, which interfered with her care and/or disrupted her living environment (these could include hitting, scratching self, rummaging, or verbal symptoms like screaming).

R26's care plan revised 10/25/22, revealed R26's safety was at risk, was a potential for abuse due to current medical conditions, need for assistance with cares, mobility and her husband had had "escalated behaviors towards resident." The care plan revealed when R26's husband visited, frequent checks were to be completed.

Review of facility state agency (SA) report dated 11/29/22, at 9:43 a.m. identified on 11/27/22, at 12:00 in R26's room, she had "received verbal abuse from her husband." The report identified a witness as nursing assistant (NA)-A. The report identified when staff heard verbal altercations in the residents room, they would intervene, and if necessary ask the husband to leave.

During an interview on 12/1/22, at 8:28 a.m. NA-A indicated R26's husband visited daily and she had heard R26's husband yell at her in the past once, when she did not remember something he had said. NA-A indicated on 11/27/22, she had passed by R26's room and noticed she had looked upset. NA-A indicated she had asked R26 if anything was wrong, and R26 told her to forget about it. NA-A indicated she felt R26 was upset by her

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{F 609}	Continued From page 11 husband at times and was concerned he was verbally abusing her. She indicated she had not observed R26 crying or any changes in her mood, however she indicated R26 appeared upset when her husband visited. NA-A indicated she had not reported her concern to anyone until morning report on 11/29/22, as R26 had declined to say anything. NA-A indicated she completed frequent checks on R26 when her husband was at the facility and encouraged her to keep her door open. During an interview on 12/1/22, at 9:49 a.m. the director of social services stated she was made aware of an allegation R26's husband had verbally abused R26 on 11/27/22. She indicated she had met with R26 regarding the allegation and R26 denied any abuse or concerns. She indicated R26 has had no observed changes in her mood or behavior within the last few weeks. The director indicated she had met with R26's husband on several occasions when he had become verbally aggressive towards her, and had hit a wall out of frustration during a conversation with her. She stated she had never seen R26's husband act aggressive towards her or yell at R26 in the past and had not observed R26 appear fearful when her husband was visiting. . The director of social services indicated she had met with R26 to assess her psychosocial needs, the facility had implemented frequent checks for R26 while her husband was visiting, and immediately after he left. She indicated she was reaching out to see if R26 would talk with a mental health practioner in addition to working with the county regarding concerns with R26's husbands cognitive status and safety in the community.	{F 609}		

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{F 609}	Continued From page 12 During an interview on 12/1/22, at 10:22 a.m. the director of nursing (DON) stated she was notified of the allegation of verbal abuse of R26 by her husband on 11/29/22, during morning report. The DON stated she would have expected to be notified immediately when facility staff observed the concern. The DON indicated R26's husband visited daily, and had not observed R26's husband acting abusive towards her. During an interview on 12/1/22, at 12:58 p.m. the facility administrator stated he had been made aware of the allegation during morning report on 11/29/22, and had submitted a report to the SA immediately. The administrator stated he expected to be notified of all allegations of abuse immediately and indicated a SA report should have been completed within two hours of the allegation. However, he indicated he had not been aware of the allegation until two days afterwards. A facility policy titled Abuse Prevention Program revised 6/22/22, indicated all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were to be reported immediately, but no later than 2 hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or no later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the state agency.	{F 609}		
{F 610} SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	{F 610}		12/20/22

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{F 610}	Continued From page 13 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a thorough investigation to assure residents were safe, following an allegation of abuse, for 1 of 3 residents (R13) investigated for abuse. In addition, the facility failed to prevent further potential abuse by allowing the alleged perpetrator (AP) to continue to have access to R13 and other vulnerable adults following the allegation of abuse. Findings Include: R13's quarterly Minimum Data Set, dated 8/27/22, identified R13 was cognitively intact, with diagnoses which included: diabetes mellitus type two, hypertension and chronic kidney disease. R13 was independent with activities of daily living (ADLs). R13 had received insulin injections seven of past seven days and antidepressant	{F 610}	R13 was interviewed regarding the incident, an investigation of the identified Nurse was conducted and completed. Identified Nurse was suspended until investigation was complete. Nurse won't be assigned to patient, and if needed will have another staff member present when with patient. Other resident's were interviewed to ensure no other allegations were present. Staff were educated on the need for thorough investigations and preventing further potential abuse to residents. Audit will be performed weekly x 4 weeks and monthly x 3 months. Results from audit will be presented at QAPI.	

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{F 610}	Continued From page 14	{F 610}		

medication seven of seven days.

R13's Care Area Assessment (CAA) dated 5/27/22, identified R13 was cognitively intact and and was able to make his needs known. R13 had some behavioral symptoms which included social inappropriateness.

R13's care plan revised 6/13/22, identified R13 was independent with bed mobility, transfers, dressing and toilet use. R13's care plan identified R13 had a behavioral problem which included fixation on specific staff followed by repeated allegations of perceived retaliation of unknown origin that could not be substantiated.

On 11/29/22, at 8:27 a.m. RNIP-A was observed passing medications on R13's hallway, and was standing in front of the medication cart, two doors down from R13's room.

During an interview on 11/28/22, at 2:30 p.m. R13 stated he had made a report to a nurse, unidentified, who had filed a report with the facility regarding concerns with registered nurse Infection preventionist (RNIP)-A who had mistreated him and placed something in his water.

During a follow up interview on 11/28/22, at 2:40 p.m. with an interpreter present, R13 identified he was afraid of RNIP-A. R13 stated he believed RNIP-A was trying to poison him as he had witnessed her place eye drops in his water the last Sunday morning of September. R13 indicated he had been refusing medications from RNIP-A. R13 stated he just wanted to stay in his room because he was afraid and felt the facility had not done anything to resolve the issue.

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{F 610}	Continued From page 15	{F 610}		

Review of the SA reports and grievance log provided by the facility lacked documentation of a report filed related to R13's allegation.

On 11/28/22, at 7:28 p.m. surveyor reported to administrator R13 indicated he had been mistreated by a staff member and was afraid of her. Administrator confirmed no SA report had been filed regarding R13's allegation and stated he would interview R13.

During an interview on 11/29/22, at 8:27 a.m. administrator indicated the director of social services (DSS)-A and himself interviewed R13 with an interpreter present on the evening of 11/28/22. A grievance form was completed after the interview and both the administrator and DSS-A interviewed RNIP-A. Administrator stated the plan going forward was to have another nurse administer R13's eye drops. Administrator confirmed R13 alleged during their interview RNIP-A placed eye drops in his water and was afraid of her.

During an interview on 11/29/22, at 8:41 a.m. DSS-A confirmed when interviewed, R13 had reported he believed RNIP-A had placed eye drops in his water and stated he was afraid of taking medications from her. DSS-A stated the facility was unsure if the allegation was accurate and indicated R13 was not always truthful. DSS-A stated RNIP-A stated she had not placed eye drops in R13's water and indicated R13 and RNIP-A did not like one other. DSS-A confirmed she had been aware R13 had been refusing medications from RNIP-A prior to the surveyor reporting the allegation. DSS-A confirmed R13 requested a grievance form be filed. DSS-A

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indicated no other staff or residents had been interviewed.

Review of R13's Concern Or Problem Resolution Form dated 11/28/22, identified R13 had a concern RNIP-A placed eye drops in his water to poison him. R13 identified the date of occurrence on 9/27/22. R13 was now afraid to take medications from RNIP-A. The form identified a different staff member would now provide medications to R13.

During an interview on 11/30/22, at 11:00 a.m. RNIP-A confirmed she had remained working in the facility after R13's allegation of abuse however she had been instructed to not administer R13's medications. RNIP-A confirmed she continued to have contact with R13 and other residents in the facility and was never removed from the facility's schedule while the investigation ensued.

During an interview on 11/30/22, at 11:41 a.m. DON stated R13 and RNIP-A were interviewed after the allegation of abuse was received and confirmed no other residents or staff had been interviewed. DON indicated RNIP-A continued to work in the facility and was never removed from the facility's schedule. DON indicated her usual practice was to suspend a staff member during an investigation. DON stated she would normally choose three other residents at random to interview to determine if they felt safe or had concerns.

During an interview on 12/1/22, at 1:03 p.m. administrator confirmed the facility had not originally completed a thorough investigation however now the facility were beginning to further

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{F 610}	Continued From page 17 investigate the allegation. The facility policy titled Grievances/Complaints, Filing reviewed 6/22, identified the social service director of designee was the grievance officer. The policy identified the grievance officer would coordinate actions with appropriate state and federal agencies, dependent upon the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property would have been reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. The policy indicated the grievance officer, administrator and staff would have taken immediate action to prevent further potential violations of resident rights while the alleged violation was being investigated.	{F 610}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 3 (R8) residents identified at risk for falls to prevent further falls. Findings include:	{F 689}	Interventions have been placed on this patient to prevent further falls. Staff educated to ensure following of interventions Patients were reviewed to ensure all fall risks are in place and being followed as to	12/20/22

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{F 689}	Continued From page 18 R8's quarterly Minimum Data Set (MDS) dated 11/3/22, identified R1 had moderate impaired cognition and had diagnoses which included diabetes mellitus, borderline personality disorder (a mental illness characterized by a distorted self-image, impulsiveness, unstable and intense relationships, and extreme emotions) and depression. Indicated R1 required limited assistance for transfers and extensive assistance for toileting. R8's fall assessment dated 10/28/22, identified R1 was at high risk for falls due to impaired cognition, medications, and previous falls. R8's fall assessment indicated R8 was incontinent of bladder and required staff assistance with transfers. Review of R8's care plan revised 10/20/22, revealed R8 was at high risk for falls related to immobility and weakness. The care plan revealed fall interventions which included call light in reach, bed in low position at night and a fall mat next to the bed. Review of 8's adverse event reports from 10/13/22, to 11/29/22, revealed the following: -10/13/22, R8 had an unwitnessed fall at 10:30 p.m. The event report identified staff found R8 on the floor The report revealed another resident informed staff R8 had self transferred from her bed and fell onto the floor. The report identified R8 had been sent to the emergency room (ER) to be evaluated related to R8 having an unwitnessed fall. The report further reveled R8 had not received any injuries from the fall. The report lacked immediate interventions to prevent	{F 689}	prevent falls. Staff educated on the need for fall interventions on patients to prevent falls and following them as indicated. An Audit to ensure fall interventions are being followed as indicated will be completed weekly x 4 weeks and monthly x 3 months. Audit results will be presented at QAPI	

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future falls.

-10/17/22, R8 had a witnessed fall at 9:30 p.m. event report revealed R8 had call light on and when staff entered the room R8 was standing by her bed and was starting to sit down so staff lowered R8 to the floor. The report lacked immediate interventions to prevent future falls.

-10/18/22, R8 had an unwitnessed fall at 4:20 a.m. The report revealed R8 was found on the floor next to her bed. The report revealed R8 stated "I don't like this bed it is possessed I'm not going back. The report revealed an immediate intervention to place a fall mat on the floor next to the bed.

During an observation on 11/28/22, at 7:00 p.m. R8 was lying in bed. No fall mat next to the bed.

During an observation on 11/29/22, at 3:12 p.m. R8 was lying on her stomach in bed and slid to the floor to her knees next to the bed. No fall mat next to R8's bed. Surveyor alerted licensed practical nurse (LPN-A) that R8 was on the floor. When LPN-A arrived R8 had gotten to a standing position and was attempting to get back into bed so LPN-A assisted R8 into bed. R8 was assessed by nurse practioner (NP) and was sent to the ER for bilateral knee pain. X-ray report dated 11/29/22, revealed R8 had a contusion to her right knee.

During an interview on 11/29/22, at 3:22 p.m. LPN-A indicated R8 was suppose to have a fall mat on the floor next to her bed due to R8 frequently puts herself on the floor and has had falls out of bed. LPN-A confirmed R8 did not have a fall mat next to the bed prior to her fall.

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

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

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{F 689}	Continued From page 20 During an interview on 11/30/22, at 1:01 p.m. nursing assistant (NA-D) indicated R8 has placed herself on the floor and has had some falls. NA-D further indicated she had not been aware R8 was supposed to have a fall mat on the floor next to the bed and stated she had never seen a mat on the floor next to R8's bed. During an interview on 11/30/22, at 1:13 p.m. clinical manager (CM) stated R8 has placed herself on the floor and has had falls out of bed. CM confirmed R8 was to have a fall mat on the floor next to her bed. CM confirmed there was no fall mat next to R8's bed at the time of the fall. During an interview on 11/30/22, at 1:29 p.m. director of nursing (DON) stated R8 had placed herself on the floor and has had falls. DON verified R8 was to have a fall mat next to her bed. DON confirmed R8 had not had a fall mat next to her bed during her fall on 11/29/22. DON stated her expectation was R8's fall interventions including the fall mat would have been implemented. A facility policy titled Falls and Fall Risk, Managing reviewed 10/22, indicated according to the MDS, a fall was defined as: unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. The policy indicated in conjunction with the attending physician , staff would identify and implement relevant interventions, to try to minimize serious consequences of falling.	{F 689}		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/11/22 through 10/14/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H50525059C (MN87498) with a licensing order issued at 0830. As a result of the investigation, additiional licensing orders were issued at 0265. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form	2 265		11/7/22

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2 265	Continued From page 3 of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify family following an incident of elopement for 1 of 1 residents (R1) reviewed who was found outside the facility without staff knowledge. Findings include: R1's admission Minimal Data Set (MDS) dated 9/25/22, indicated R1 had diagnoses of orthostatic hypotension, depression and anxiety disorder and had moderate cognitive impairment. Further, MDS indicated R1 required extensive assistance from two staff for bed mobility, and transfers and utilized a wheelchair for mobility. Review of facility report submitted to the SA dated 10/7/22, at 1:29 p.m. indicated R1 had eloped from the building on 10/4/22, at approximately 12:00 a.m. R1's progress note dated 10/4/22, indicated R1 was last observed in facility at 12:00 a.m. and during rounds at 12:30 a.m. R1 was not in his room. R1 was found outside near the main entrance, sitting on the cement without his wheelchair, wearing sweatpants and no shirt. R1 was assessed for injuries and no injuries were noted. Further, the progress note indicated the	2 265	2265 All residents had potential of being affected. QA notification of family/representative and md weekly for a month, monthly for three months, quarterly until resolved. What we did to be compliant- daughter was notified of fall 10/11/22, education was given to nursing staff on 11/7/2022 that nursing staff must notify family/representative and MD of all sig changes during their shift and not to pass this task onto the next oncoming nurse. QA was put into effect on 11/7/22. Quality nurse or designee doing QA.	

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2 265	Continued From page 4 nurse manager will notify family and provider during business hours. R1's record lacked evidence family was notified. On 10/11/22, at 11:27 a.m. family member (FM)-A indicated R1 had displayed mild confusion, anxiety, and delusional episodes since being admitted to the facility. FM-A confirmed they were unaware R1 had a WanderGuard implemented and R1 was found outside of the facility on 10/4/22, without staff knowledge. On 10/11/22, at 3:08 p.m. registered nurse (RN)-A indicated R1 was found outside of the facility sitting on the cement and leaning against a tree by the main entrance on 10/4/22, at approximately 12:00 a.m. and R1's WanderGuard did not alert staff. Further, RN-A indicated staff were expected to notify family immediately if an emergency other wise if an incident occurs in the middle of the night with no injury staff will report to the morning shift to update family. RN-A confirmed she did not update R1's family and was unsure if the family was updated. On 10/11/22, at 5:00 p.m. RN-B indicated staff are expected to notify family immediately if there was an injury or nonemergent updates staff can do during business hours. Further, RN-B was unsure if R1's family was notified following the elopement incident. On 10 /12/22, at 9:05 a.m. director of nursing (DON) indicated nursing staff were expected to update families immediately during an emergency or the following day during business hours if nonemergent. Review of facility policy titled Elopements dated 5/22, directed staff to notify the resident's legal	2 265		

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2 265	Continued From page 5 representative once the resident returns to the facility. SUGGESTED METHOD OF CORRECTION: The Adminstrator and/or designee could review the facility polices in regards to notifying family following an elopement, and educate staff on when family should be notified in a timely manner. They could monitor incidents, accidents, hospitalizations on a routine basis to ensure timely notification to families. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure to ensure safety checks were completed following an elopement and the appropriate use of a	2 830	2830 All residents had potential of being affected. QA weekly for a month, monthly for three	11/7/22

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2 830	Continued From page 6 WanderGuard device to ensure staff are alerted when a resident elopes from the facility 1 of 3 residents (R1). This resulted in an immediate jeopardy for R1. In addition, the facility failed to follow manufacturer's guidelines for WanderGuard system use and testing for 4 of 4 residents (R1, R2, R3, R4) reviewed for elopement. The immediate jeopardy began on 10/4/22, when R1 eloped from the facility without staff's knowledge and the WanderGuard system failed to alert staff. The immediate jeopardy was identified on 10/12/22 and the administrator, director of nursing (DON), quality assurance director, and nurse manager were notified of immediate jeopardy at 2:05 p.m. on 10/12/22. The immediate jeopardy was removed on 10/13/22, but noncompliance remained at the lower scope and severity level 2, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's admission Minimal Data Set (MDS) dated 9/25/22, indicated R1 had diagnoses of orthostatic hypotension, depression and anxiety disorder and had moderate cognitive impairment. Further, MDS indicated R1 required extensive assistance from two staff for bed mobility, and transfers and utilized a wheelchair for mobility. R1's care plan dated 10/4/22, indicated R1 was at risk for elopement related to disoriented to place, impaired safety awareness, and aimless wandering. The care plan directs staff to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, identify patten of	2 830	months, and quarterly until resolved. What we did for compliance found wander guard tester and secured with nurse at cart for testing wander guards, all wander guard testing tasks are done per manufacturers guidelines and put in PCC to test daily. Nurses were trained on how to use the wander guard tester. Wander guard placement on all residents wearing a wander guard were placed on appropriate limb per manufacturers guidelines. Safety checks were put into place electronically for C.N.A to chart. Therapy is locking entrance door to therapy when leaving for the day. During the weekend, the therapy door is locked. Educated staff on 11/7/22 on accidents wander guard procedure and new documentation. Quality nurse or designee doing QA.	

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2 830	Continued From page 7	2 830		

wandering, wander alert bracelet (WanderGuard), and monitor location. R1's care plan lacked direction for staff on how often monitoring or visual checks on R1.

R1's medical record lacked evidence R1's WanderGuard (WG) function was being monitored since placement on 9/23/22.

R1's incident report dated 10/4/22, indicated nursing staff noted R1 was not in room at 12:30 a.m. during rounds. R1 was last seen in the facility at 12:00 a.m. by nursing staff. R1 had self-propelled in wheelchair and exited the door in the therapy room. R1 was found outside sitting on the cement without his wheelchair by the front entrance (this door is approximate 15-20 ft from therapy door). R1 was assessed for injuries and no injuries were noted.

Review of facility reported incident submitted to the State Agency on 10/7/22, indicated R1 had eloped from the facility on 10/4/22, at approximately 12:00 a.m. R1 was found outside the building near the front entrance. R1 had a new WG placed on R1's leg as an immediate intervention.

On 10/11/22, at 11:27 a.m. R1 was observed sitting in his recliner in his room. R1 had a circle shaped WG on left ankle. During continuous observation until 12:04 p.m. an unidentified nursing assistant visually checked on R1. (37 minutes).

On 10/11/22, at 3:08 p.m. registered nurse (RN)-A indicated all residents who are at risk for eloping have a WG and interventions in their care plans directing staff what to do when they are exhibiting exit seeking or wandering behaviors.

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2 830	Continued From page 8 RN-A indicated R1 appeared to be confused and exhibited wandering behaviors but was unaware if R1 required visual safety checks. Further, RN-A indicated on 10/4/22, at approximately 1:00 a.m. RN-A observed two nursing assistants (NA) outside with R1. R1 was sitting on the cement by the main entrance leaning against a tree without his wheelchair. R1's wheelchair was found at the therapy department exit door and his WG had not alerted staff. Following the incident R1 was placed on 15-minute visual safety checks, but RN-A was unsure if R1 continued to be on the safety checks at that time. On 10/11/22, at 3:35 p.m. nursing assistant (NA)-A indicated residents who are at risk for elopement were identified in each resident's care plan and frequent visual safety checks are in place to ensure the resident was still in the facility. NA-A indicated R1 had confusion and exhibited exit seeking and wandering behaviors more in the evenings. NA-A stated interventions used when R1 was exhibiting these behaviors included redirection and frequent visual checks but was unsure how often stated at least hourly. NA-A stated NA-B was R1's care staff on the night of 10/4/22, and R1 was last observed attempting to exit the front entrance in his wheelchair at approximately 12:30 a.m. when staff redirected R1 back to his room and into bed. At approximately 1:00 a.m. during rounds NA-A stated R1 was not in his room and they began to search for R1 in the facility. NA-A and NA-B heard a faint alarm in the therapy department where R1's wheelchair with the WG attached was found next to the exit door, so staff exited outside and found R1 sitting on the cement by the main entrance. Further, NA-A indicated following the incident R1 was placed on 15-minute visual safety checks but was unsure if those safety	2 830		

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2 830	Continued From page 9	2 830		

checks were still in place. (time noted in interview was different than time indicated in facility incident reported to State Agency)

On 10/11/22, at 3:54 p.m. interview with regional services manager (RSM) at RF Technologies (WG manufacturer) indicated if there was a malfunction with the facility's WG system, the facility would be expected to contact RF Technologies to work through the problem.

On 10/11/22, at 4:01 p.m. NA-C indicated R1's cognition varied each day and R1 exhibited wandering and exit seeking behaviors. NA-C indicated interventions for R1's behaviors included a WG placement and checking on R1 "regularly" but was unsure if R1 required scheduled visual safety checks.

On 10/11/22, at 4:16 p.m. NA-B indicated needs assistance with all activities of daily living due to R1's low blood pressure and fall risk. NA-B stated R1 was disorientated and exhibits wandering and exit seeking behaviors and NA-B was unsure what interventions were in place for R1's behaviors. Further, NA-B indicated on 10/4/22, at approximately 11:00 p.m. R1 began exhibiting wandering and exit seeking behaviors and while beginning rounds at approximately 12:00 a.m. R1 was not in his room. NA-B indicated NA-B checked in the therapy department and heard the WG system alarm but it was very faint. NA-B observed R1's wheelchair at the door with the WG attached and R1 was outside by the main entrance. In addition, NA-B indicated following the incident 15- minute visual checks were implemented for R1, but was unsure if they were still in place.

On 10/11/22, at 5:00 p.m. nurse manager (NM)

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2 830	Continued From page 10 indicated residents are assessed for elopement risk on admission and interventions were determined by the providers and nursing staff. NM was not aware of interventions for R1's wandering and exit seeking behaviors other than a WG placed and reorientation or redirection. NM indicated R1 had an elopement from facility on 10/4/22, due to the WG system alarm did not sound because R1 left his wheelchair inside the facility. Further, NM confirmed R1 had a WG placed on his ankle following the incident rather than on his wheelchair and NM was unsure if R1 was on visual safety checks following R1's elopement incident. NM indicated placement of a WG is determined by the least restrictive placement which is typically the wheelchair unless the resident is ambulatory then it would be placed on their ankle. NM confirmed R1 did not have WG daily function monitoring and placement check in his record and indicated the nurse practitioner typically puts in an order for staff to complete this. On 10/11/22, at 5:34 p.m. director of nursing (DON) indicated since R1's elopement on 10/4/22, R1's WG was placed on his ankle and 15-minute safety checks were implemented to prevent future elopements. DON confirmed R1's care plan was not revised with new interventions and the interventions were only communicated verbally to nursing care staff. In addition, DON indicated the 15-minute checks were being completed by paper form by R1's nursing care staff. At 6:02 p.m. DON confirmed the 15-minute checks were not being implemented due to not being able to find the documentation at either nursing stations. Review of facility policy titled Elopements dated 5/22, indicated all residents shall be screened	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11	2 830		

during admission and annually reviewed or with significant change for potential for elopement on the elopement assessment. Further, policy directed staff to implement the following safety measures for residents who are identified to be at risk for elopement: WanderGuard bracelets for each resident will be tested weekly, WanderGuard doors will be tested monthly, a log of residents with WanderGuard bracelets will be kept by nursing with expiration dates of the WanderGuard, and if the WanderGuard system is down visual checks of the residents with WanderGuard bracelets would be done every 30 minutes.

The immediate jeopardy that began on 10/4/22, was removed on 10/13/22, when R1's wander guard was tested for function and placement daily and an order was placed in his chart, R1 was assessed for appropriate interventions related to elopement risk and his care plan was revised, all residents at risk of elopement were assessed, WGs were placed correctly according to manufacturer's instructions, elopement policy was reviewed and revised, education provided to all staff regarding elopement before staff started their shift.

In addition:

R2's quarterly MDS dated 8/22/22, indicated R2's diagnoses included depression, psychotic disorder and had moderate cognitive impairment. Further, R2 did not exhibit behaviors but required the use of a WG alarm daily.

R3's quarterly MDS dated 9/21/22, indicated R3 had a diagnosis of delirium and moderately impaired cognition. R3 did not exhibit wandering behavior but required the use of a WG alarm

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	00938	A. BUILDING: ______ B. WING ______	C 10/14/2022

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daily.

R4's quarterly MDS dated 8/18/22, indicated R4's diagnoses included stroke, anxiety and had severely impaired cognition. R4 did not exhibit wandering behavior but required the use of a WG alarm daily.

On 10/11/22, at 2:53 p.m. LPN-B stated there are currently four residents in the facility who are considered high risk for elopement, and they all have a WG in place. Further, LPN-B indicated WGs are monitored daily for placement and functioning by bringing each resident to the door that is alarmed.

On 10/11/22, at 3:08 p.m. RN-A indicated placement of a WG was determined by assessing each resident and place the WG in a least restrictive area, typically on their ankle or wheelchair.

On 10/11/22, at 5:00 p.m. NM indicated nursing staff are expected to monitor each resident's WG functioning and placement daily by bringing each resident to the door to ensure the alarm will sound.

On 10/12/22, at 9:15 a.m. R2 was observed laying in bed in room with a circle WG on left ankle, confirmed by DON.

On 10/12/22, at 9:17 a.m. R3 was observed in his room in bed with a circle WG on left ankle and a second WG placed on the back of his wheelchair on the metal frame, confirmed by DON

On 10/12/22, at 9:19 a.m. R4 was observed self-propelling in hallway in his wheelchair with a circle WG on his ankle, confirmed by DON.

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On 10/12/22, at approximately 9:19 a.m. DON indicated staff were expected to monitor each resident's WG daily by bringing each resident to the door to ensure it is functioning and in place daily.

On 10/12/22, at 9:42 a.m. RSM at RF Technologies (WG manufacturer) indicated the circle WG should be placed on the resident's wrist only due to less transmission and placing the circle WG on an ankle it is further from the receiver which places the resident at greater risk of getting out of the facility. Further, RSM indicated testing the WGs should be completed using a tester provided by RF technologies and not bringing the resident to the door due to inconvenience to the resident as well as safety concerns with showing the resident the exits and functioning.

Review of WG manual titled, Wander Management Transmitters User Guide dated on page 10 directs a CodeWatch (circle WGs) was smaller than a transmitter and is placed on the wrist of a resident. Further, WG User Guide directed to test operation of transmitters using the transmitter tester and never take a resident to a door to test their transmitter.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could review/revise policies and procedures related to appropriate supervision to prevent elopement. The DON or designee could also ensure appropriate comprehensive assessments and interventions were developed and implemented for all residents with the potential to be affected. The DON or designee could re-educate all staff on policies and procedures, changes to care

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2 830	Continued From page 14 plans, and the results of assessments for those identified at risk for exit-seeking behaviors and elopement. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures and audit to prevent potential elopements and/identify exit-seeking behaviors. The DON or designee should also ensure staff perform a comprehensive assessment or root cause analysis as needed to ensure interventions are effective, in place and re-evaluated as often as necessary. The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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{2 000}	Initial Comments	{2 000}		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 11/28/22, to 12/1/22, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 10/14/22, by the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Licensure and were found to be NOT to be corrected. The original licensing

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{2 000}	Continued From page 1 order issued will remain in effect. Penalty assessment issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	{2 000}		

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{2 000}	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	{2 000}		
{2 265}	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	{2 265}		12/20/22

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{2 265}	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 10/14/22, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to ensure the physician and power of attorney were notified of newly developed pressure ulcers for 1 of 1 resident (R33) reviewed for facility acquired pressure ulcers. R33's admission Minimum Data Set (MDS) dated 11/6/22, identified R33 had diagnoses which included debility (physical weakness), atrial fibrillation, and hypertension. Identified R33 had moderately impaired cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and bathing. Identified R33 was always incontinent of bowel and bladder and was not on a toileting plan. Identified R33 was at risk for pressure ulcers and had a pressure relieving device for his bed and chair and was not on a turning and repositioning program. R33's admission Care Area Assessment (CAA) dated 11/6/22, revealed R33 had moderate cognitive impairment which limited his abilities to recognize his needs. Identified R33 required extensive assistance with ADL's, and was not able to remember the need to change position. Revealed R33 preferred to be lying in his bed or seated in a wheelchair and was to have a pressure relieving device on his bed and his wheelchair. Identified R33 was at risk for	{2 265}	Facility notified R33's POA and Physician of pressure ulcer An audit has been done to ensure notification to responsible party and physician has been completed for patients as necessary Staff has been educated on notifying of responsible party and physician as needed for all patients. An audit on notification of responsible party and physician will be done weekly x 4 weeks and monthly x 3 months.	

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{2 265}	Continued From page 4	{2 265}		

developing pressure ulcers and had no pressure ulcers at the time of the assessment.

R33's admission skin assessment dated 10/31/22, revealed R33's skin was intact.

R33's weekly skin review form dated 11/25/22, identified R33 had a small open area on his sacrum in which barrier cream was applied.

During an interview on 11/30/22, at 9:05 a.m. with nurse manager (NM)-A, stated R33 had no pressure ulcers when he was admitted to the facility approximately one month prior. NM-A confirmed R33 currently had facility acquired pressure ulcers, one stage two on his sacrum and pressure ulcers to both heels which were unstagable due to deep tissue injury. NM-A stated she was not aware if R33's family had been notified of the pressure ulcers.

During an interview on 11/30/22, at 9:16 a.m. Certified Nurse Practioner (NP)-A, stated she had met with R33 several times since his admission and was familiar with him. NP-A indicated she had been notified approximately a week ago R33 had redness on his buttocks, and felt it was due to R33's bowel and bladder incontinence. NP-A confirmed she had not been notified R33's sacrum was noted to have an open area on 11/25/22, and had not been notified of R33's bilateral heel deep tissue injury.

R33's medical record lacked any documentation R33's practioner or family member/power of attorney had been notified of his pressure ulcers.

During an interview on 12/1/22, at 10:29 a.m. the director of nursing (DON) indicated she would have expected R33's practioner and family

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{2 265}	Continued From page 5 member to be notified of any changes in R33's condition, which included newly developed pressure ulcers. During a telephone interview on 12/1/22, at 10:44 a.m. R33's family member (FM)-A indicated she was not been notified R33 had any pressure ulcers. FM-A stated she would have wanted to have been notified of any changes in R33's condition. Review of a facility policy titled, Change in a Resident's Condition or Status reviewed 11/30/21, identified it was the purpose of the policy the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the residents's medical/mental condition and/or status. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to the physician notification. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	{2 265}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	{2 830}		12/20/22

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{2 830}	Continued From page 6 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 10/14/22, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 3 (R8) residents identified at risk for falls to prevent further falls. Findings include: R8's quarterly Minimum Data Set (MDS) dated 11/3/22, identified R1 had moderate impaired cognition and had diagnoses which included diabetes mellitus, borderline personality disorder (a mental illness characterized by a distorted self-image, impulsiveness, unstable and intense relationships, and extreme emotions) and depression. Indicated R1 required limited assistance for transfers and extensive assistance for toileting. R8's fall assessment dated 10/28/22, identified R1 was at high risk for falls due to impaired cognition, medications, and previous falls. R8's fall assessment indicated R8 was incontinent of bladder and required staff assistance with transfers.	{2 830}	Interventions have been placed on this patient to prevent further falls. Staff educated to ensure following of interventions Patients were reviewed to ensure all fall risks are in place and being followed as directed to prevent falls. Staff educated on the need for fall interventions on patients to prevent falls and following them as indicated. Audit will be completed weekly x 4 weeks and monthly x 3 months. Audit results will be presented at QAPI	

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{2 830}	Continued From page 7	{2 830}		

Review of R8's care plan revised 10/20/22, revealed R8 was at high risk for falls related to immobility and weakness. The care plan revealed fall interventions which included call light in reach, bed in low position at night and a fall mat next to the bed.

Review of 8's adverse event reports from 10/13/22, to 11/29/22, revealed the following:

-10/13/22, R8 had an unwitnessed fall at 10:30 p.m. The event report identified staff found R8 on the floor The report revealed another resident informed staff R8 had self transferred from her bed and fell onto the floor. The report identified R8 had been sent to the emergency room (ER) to be evaluated related to R8 having an unwitnessed fall. The report further reveled R8 had not received any injuries from the fall. The report lacked immediate interventions to prevent future falls.

-10/17/22, R8 had a witnessed fall at 9:30 p.m. event report revealed R8 had call light on and when staff entered the room R8 was standing by her bed and was starting to sit down so staff lowered R8 to the floor. The report lacked immediate interventions to prevent future falls.

-10/18/22, R8 had an unwitnessed fall at 4:20 a.m. The report revealed R8 was found on the floor next to her bed. The report revealed R8 stated "I don't like this bed it is possessed I'm not going back. The report revealed an immediate intervention to place a fall mat on the floor next to the bed.

During an observation on 11/28/22, at 7:00 p.m. R8 was lying in bed. No fall mat next to the bed.

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{2 830}	Continued From page 8 During an observation on 11/29/22, at 3:12 p.m. R8 was lying on her stomach in bed and slid to the floor to her knees next to the bed. No fall mat next to R8's bed. Surveyor alerted licensed practical nurse (LPN-A) that R8 was on the floor. When LPN-A arrived R8 had gotten to a standing position and was attempting to get back into bed so LPN-A assisted R8 into bed. R8 was assessed by nurse practioner (NP) and was sent to the ER for bilateral knee pain. X-ray report dated 11/29/22, revealed R8 had a contusion to her right knee. During an interview on 11/29/22, at 3:22 p.m. LPN-A indicated R8 was suppose to have a fall mat on the floor next to her bed due to R8 frequently puts herself on the floor and has had falls out of bed. LPN-A confirmed R8 did not have a fall mat next to the bed prior to her fall. During an interview on 11/30/22, at 1:01 p.m. nursing assistant (NA-D) indicated R8 has placed herself on the floor and has had some falls. NA-D further indicated she had not been aware R8 was supposed to have a fall mat on the floor next to the bed and stated she had never seen a mat on the floor next to R8's bed. During an interview on 11/30/22, at 1:13 p.m. clinical manager (CM) stated R8 has placed herself on the floor and has had falls out of bed. CM confirmed R8 was to have a fall mat on the floor next to her bed. CM confirmed there was no fall mat next to R8's bed at the time of the fall. During an interview on 11/30/22, at 1:29 p.m. director of nursing (DON) stated R8 had placed herself on the floor and has had falls. DON verified R8 was to have a fall mat next to her bed. DON confirmed R8 had not had a fall mat next to	{2 830}		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 9 her bed during her fall on 11/29/22. DON stated her expectation was R8's fall interventions including the fall mat would have been implemented. A facility policy titled Falls and Fall Risk, Managing reviewed 10/22, indicated according to the MDS, a fall was defined as: unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. The policy indicated in conjunction with the attending physician , staff would identify and implement relevant interventions, to try to minimize serious consequences of falling. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents with falls and alcohol usage receive the necessary services to keep them safe. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{2 830}		

This Letter will replace the letter sent on October 31, 2022. The Special Focus language has been added to this letter. Nothing else in the letter from October 31, 2022, changed; remedies remain the same.

Electronically Submitted
November 22, 2022

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

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

Dear Administrator:

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

On October 14, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On October 13, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 15, 2022, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 15, 2022, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 14, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Moorhead Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 14, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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" and/ or "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

Department of Health & 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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for

the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File