

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
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 31, 2022, we informed you of imposed enforcement remedies.

On November 16, 2022, the Minnesota Department of Health completed a survey 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.

As a result of the survey 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

Moorhead Restorative Care Center

November 22, 2022

Page 2

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 November 15, 2022. **However, due to the extended survey the new NATCEP loss date is 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 Huseh, 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.huseh@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.

Moorhead Restorative Care Center

November 22, 2022

Page 4

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**

Moorhead Restorative Care Center

November 22, 2022

Page 5

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,

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke extending to the right.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 22, 2022

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

Re: Event ID: DFEF11

Dear Administrator:

The above facility survey was completed on November 16, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2022
--	---	--	---

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

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

F 000	<p>INITIAL COMMENTS</p> <p>Moorhead Restorative Care Center is a Special Focus Facility (SFF). On 11/15/22, to 11/16/22, 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.</p> <p>The following complaints were found to be SUBSTANTIATED: H50525941C (MN00088324), with a deficiency cited at F940. H50525939C (MN00088323), with a deficiency cited at F940. H50525722C(MN00088322), with a deficiency cited at F940. H50525940C (MN00088321), with a deficiency cited at F940. H50525942C (MN00088326), with a deficiency cited at F940.</p> <p>The following complaint was found to be UNSUBSTANTIATED: H50525571C (MN00088006)</p> <p>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.</p> <p>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.</p>	F 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/23/2022
---	-------	------------------------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2022
NAME OF PROVIDER OR SUPPLIER MOORHEAD RESTORATIVE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 940 SS=D	<p>Training Requirements CFR(s): 483.95</p> <p>§483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to-</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to assure new employee training and education was completed prior to working independently for 3 of 3 (LPN-A, LPN-B, RN-A) licensed staff reviewed for training and education.</p> <p>Findings include:</p> <p>Review of personnel records identified the following:</p> <ul style="list-style-type: none"> -Licensed practical nurse (LPN)-A hire date of 8/22/22, personnel records lacked documentation of any training or education. -Registered nurse (RN)-A hire date of 11/4/22, personnel records lacked documentation of any training or education. -LPN-B- hire date of 10/14/22, personnel records lacked documentation of any training or education. <p>Review of staff schedules from 10/23/22, to 11/16/22, identified the following:</p>	F 940	<p>The 3 staff members will have a new employee education checklist completed prior to their next shift with the facility.</p> <p>All nursing staff files will be audited to ensure a new employee education checklist has been completed. If not completed, a new employee education checklist will be completed prior to working any future shifts</p> <p>Facility has created access to training for all staff at the facility and implemented a new employee education checklist for all new staff.</p> <p>HR, scheduler, director of nursing, or designee will audit all employee files for new employee education checklist completion weekly x 4 weeks and Monthly x 2 months.</p> <p>Date of completion: 11/23/2022</p>	11/23/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2022
NAME OF PROVIDER OR SUPPLIER MOORHEAD RESTORATIVE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 940	<p>Continued From page 2</p> <p>-LPN-A, worked 10/23/22, 10/25/22, 10/26/22, 11/2/22, 11/2/22, and 11/4/22.</p> <p>-RN-A worked 11/4/22, 11/5/22, 11/6/22, 11/9/22, 11/10/22, 11/11/22, 11/15/22, 11/16/22.</p> <p>-LPN-B worked 10/28/22, 10/29/22, 10/30/22, 11/4/22, 11/5/22, 11/6/22, 11/12/22.</p> <p>During an interview on 11/15/22, at 2:06 p.m. business office manager (BOM)-A confirmed the above staff had not completed any of their on-line Relias required education.</p> <p>During a follow-up interview on 11/15/22, at 2:20 p.m. BOM-A confirmed the personnel files requested lacked any education or training. BOM-A stated she provided the new employees the Core Nurse Orientation Checklist (CNOC) upon hire and would have expected them to have been completed and present in their personnel files.</p> <p>During a follow-up interview on 11/15/22, at 2:27 p.m. BOM-A stated new staff had not been returning the orientation checklists over the past couple of months. BOM-A indicated the facility cooperate nurse, who no longer worked with the facility, had been completing new staff orientation however she was not aware of who was currently responsible to oversee and ensure new employee orientation had been completed. BOM-A stated she had informed the director of nursing (DON) during management meetings the forms had not been returned.</p> <p>Review of facility form titled CNOC undated, revealed it contained 4 pages of competency</p>	F 940		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2022
NAME OF PROVIDER OR SUPPLIER MOORHEAD RESTORATIVE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 940	<p>Continued From page 3</p> <p>tasks listed, with completion date and staff initial areas to be completed for each competency. At the bottom of the form, it contained areas for signatures of DON, New Hire, Human Resource (HR), Administrator, and Staff Development.</p> <p>During an interview on 11/16/22, at 10:34 a.m. RN-B stated she was not aware of the process for new hire orientation which included education and training. RN-B indicated the new nurses had a checklist they were expected to complete and the nurse who trained them would initial and date the areas they had verified staff competency in. RN-B stated once their forms were completed, the new staff were expected to turn their forms in and the DON was responsible to assure they were completed as required.</p> <p>On 11/16/22, at 2:19 p.m. a phone call was made to LPN-A for interview, however no answer or return call was received.</p> <p>On 11/16/22, at 2:26 p.m. a phone call was made to RN-A for interview, however no answer or return call was received.</p> <p>On 11/16/22, at 2:29 p.m. a phone call was made to LPN-B for interview and a message was left to return the call.</p> <p>Review of the facility form titled General Orientation Schedule, undated, identified the following:</p> <ul style="list-style-type: none"> -scheduled times from 8:00 a.m. to 3:30 p.m. -facility staff titles completing areas of orientation including: business manager, human resources, nurse educator, administrator, director of social services, director of housekeeping, dietician, Minimum Data Set (MDS) coordinator, 	F 940		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2022
NAME OF PROVIDER OR SUPPLIER MOORHEAD RESTORATIVE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 940	<p>Continued From page 4</p> <p>maintenance director, nurse, therapy, and DON. -topics covered which included: new hire information and paperwork, infection control, hazardous chemicals, fire safety and tour, abuse & neglect, Alzheimer's & dementia, and meet with your department head.</p> <p>During a follow up interview on 11/16/22, at 3:09 p.m. BOM-A confirmed the General Orientation Schedule form had not been used by the facility for orientation since May 2021, and stated she was not aware of any other forms the facility had utilized since that time.</p> <p>During a telephone interview on 11/17/22, at 11:07 a.m. LPN-B indicated her first day working in the facility was on 10/13/22. LPN-B stated on her first day, she worked with another nurse and then worked independently thereafter. LPN-B indicated she was still in the process of learning the facility's various systems and protocols. LPN-B confirmed she had not completed any of the Relias on-line education. Additionally, LPN-B confirmed she was unaware the CNOC was a requirement or that it even existed.</p> <p>The facility policy titled Orientation Program For Newly Hired Employees, Transfers, Volunteers, undated, identified all newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five days of employment. The policy identified items included in the orientation program which included: disaster preparedness, infection control, nursing services policy and procedure manual, resident rights and job description. The policy further identified each department would orientate the newly hired employee/transfer/volunteer to his department's policies and procedures as well as</p>	F 940		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2022
NAME OF PROVIDER OR SUPPLIER MOORHEAD RESTORATIVE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 940	<p>Continued From page 5</p> <p>other data to aid him/her in understanding team concept, attitudes, and approaches to resident care. The policy identified a checklist was used to record materials reviewed with each employee/transfer/volunteer and a written record would be maintained in their personnel file upon completion of the orientation program.</p> <p>The facility policy titled On-The-Job Training, undated, identified on the job training programs would be conducted when necessary to assist employees in performing their assigned tasks. The policy indicated on the job training began on the first day of employment and was completed when the department director was satisfied the employee could perform his/her assigned duties, within the time frame allotted for each particular function, without any further supervision. The policy identified training records would be filed in the employee's personnel file or may be maintained by the department supervisor.</p>	F 940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00938	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2022
--	--	---	---

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

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

2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 11/15/22, to 11/16/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaints were found to be</p>	2 000		
-------	--	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/23/22
---	-------	------------------------------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00938	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2022
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>SUBSTANTIATED: H50525941C (MN00088324), H50525939C (MN00088323), H50525722C(MN00088322), H50525940C (MN00088321), H50525942C (MN00088326), however NO licensing orders were issued.</p> <p>The following complaint was found to be UNSUBSTANTIATED: H50525571C (MN00088006)</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		