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	11/05/2021

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 32600 Based on interview and document review, the facility failed to promptly resolve resident grievances for 5 of 5 residents (R14, R15, R16, R17, R18) with concerns of inadequate assistance with resident cares. Findings include: Review of Grievance/Concern or Problem Resolution Forms from 10/14/21, to 11/2/21, revealed the following: - on 10/14/21, R17 had been brought to the front door of the building without a coat on and was noted to be only wearing a t-shirt and shorts. R17 was leaving for an appointment and the temperature outside was 47 degrees Fahrenheit. A resolution had not been documented on the grievance form for R17. - on 10/19/21, R17 expressed concerns regarding his briefs were not within reach, regarding physical therapy services, felt he was not being listened to, and wanted to go home to see his pet. A resolution had not been documented on the grievance form for R17. - on 10/25/21, R16 expressed concern she had received her blood pressure pills twice today. A resolution had not been documented on the grievance form for R16. - on 10/26/21, R15 expressed concern about not having the proper leg wraps for his legs. R15 was concerned the facility did not have the proper supplies to care for COVID-19 residents. Additionally, R15 stated he did not understand why the residents needed to quarantine if they were able to go out for appointments. A resolution had not been documented on the grievance form for R15. - on 10/26/21, R18 expressed concern about not having her utensils or straws available during her meals. R18 indicated she needed these to eat independently with. A resolution had not been documented on the grievance form for R18. - on 10/26/21, R14 expressed concern about the nursing care he had received. R14 indicated he preferred to have his nebulizer before his pain pill to help him fall asleep. R14 stated he had not received his pain pill until after 11:30 p.m. and he preferred to have it between 9:00 p.m. and 10:00 p.m. A resolution had not been documented on the grievance form for R14. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/2/21, at 3:17 p.m. licensed social worker (LSW)-A confirmed the above findings and indicated the process was to make a copy of the grievance and to provide it to the department head responsible for resolving it. LSW-A stated she typically followed up with the department head regarding the grievance and indicated staff had five days to resolve the grievance. At 4:20 p.m. LSW-A was observed to be seated at the nursing station at the main entrance of the building and attempted to document the resolutions for the grievances listed above. LSW-A verified the grievances had not been resolved by the department heads responsible for them. On 11/2/21, at 3:56 the director of nursing (DON) confirmed the above findings and indicated the facility staff had five days to complete the grievances and to find a resolution. The DON indicated the facility had too many staff completing the grievances and it had become confusing. The DON stated the grievance were not stored in one location and as a result were not completed in a timely manner. On 11/4/21, at 2:21 p.m. the administrator verified the above findings and indicated if the complaints were not required to be reported to the state, then staff were expected to complete a grievance form. The administrator stated facility staff had three days to find a resolution and confirmed staff had not been completing the grievances on time. Review of the facility policy titled, Grievance Policy reviewed on 2/18/21, indicated all concerns to be submitted in written form using a document called Resident Grievance Report. This form when completed by either the resident/patient or family member, was to be used as a tool to investigate the issue at hand and to initiate the problem solving process. The person filling out a written report would have been informed of the resolution in a timely manner.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32600 Based on interview and document review, the facility failed to immediately report to the State Agency (SA) and immediately report to the administrator an allegation of physical abuse, no later than 2 hours, for 1 of 3 resident (R3) who was dependent on staff for assistance with activities of daily living (ADL). Findings include: R3's significant change Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact and had diagnoses which included: multiple sclerosis, anxiety, depression. The MDS identified R3 required extensive assistance of one to two staff with all ADL's. A review of the facility Concern or Problem Resolution Form dated 10/12/21, at 4:00 a.m. indicated R3 had reported nursing assistant (NA)-G and NA-H from the evening shift had attempted to apply her incontinent brief while she was hanging in the air from the mechanical standing lift. R3 stated she had told them not to do that however NA-G and NA-H stated it was more convenient for them and proceeded to apply the brief. R3 indicated she resisted and one of the NA's slapped her hand. Review of the Nursing Home Incident Report #344436 submitted to the SA identified physical abuse (slapping) occurred when R3 reported two NA's from the evening shift insisted on placing her incontinent brief on while she was hanging in the air from the standing mechanical lift. R3 stated she had told them not to place her brief on while she was still in the lift as she preferred to have it applied when she was laying in bed. The two NA's continued to apply the incontinent brief indicating it was more convenient for them to place it while she was still in the lift. When R3 resisted, NA-G tapped her hand. The report identified the incident occurred on 10/12/21, at 4:00 a.m. and was reported to the SA on 10/12/21, at 9:17 a.m. over five hours and 17 minutes after the incident had been reported to staff. On 11/2/21, at 3:17 p.m. the licensed social worker (LSW)-A confirmed staff had completed a facility grievance form for the incident with R3 and was not certain when the incident had occurred. LSW-A verified the facility's normal process was to report any allegation of abuse to the SA within that 2 hour window and to report it immediately to the director of nursing (DON). LSW-A indicated staff should have followed the facility's policy and reported the incident immediately to the SA. On 11/2/21, at 3:56 p.m. the DON verified the above findings and indicated R3 stated she had been touched in a manner she did not like. The DON indicated the incident should have been reported to her and the administrator right away and should have been reported to the SA within 2 hours of the allegation. The DON stated the staff member thought he had 24 hours to report the allegation instead of 2 hours. The DON indicated she expected staff to follow the facility policy and to report any allegation of abuse to the SA within 2 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/21, at 2:21 p.m. the administrator confirmed the above finding and indicated staff were to notify her or the DON immediately with any allegations of abuse. The administrator indicated the incident should have been reported to the SA within 2 hours and her expectation was for staff to follow the facility policy and report any incidences of abuse within 2 hours to the SA and to notify her immediately. Review of the facility's policy titled, Abuse Investigation dated 4/24/20, indicated all alleged violations involving abuse, neglect, mistreatment should have been reported, to the administrator, or his/her designee. The administrator was to initiate a report to the SA immediately but no later than 2 hours after the allegation was made if the events that caused the allegation involved abuse or resulted in serious bodily injury.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32600 Based on interview and document review, the facility failed to ensure the infection control program included ongoing surveillance, trending and analysis of resident infections. This had the potential to affect all 30 residents currently residing in the facility. Findings include: Review of the facility's Monthly Breakdown of Antibiotic Use For Infection Tracking Tools included the following information: Gastrointestinal/vomiting/nausea/diarrhea, skin/wound/rash, urinary tract infection (UTI), upper respiratory infection (UR), COVID signs/symptoms and other. The tool identified if the resident was admitted with an infection or acquired while in the facility. Review of the infection tracking tools from 7/1/21, to 11/2/21, revealed the following: July 2021,- no logs or no data were provided. August 2021,- indicated one resident was admitted to the facility with a skin/wound/rash, two residents had UTI's while in the facility, two residents were admitted to the facility with UR infections and one resident had an UR infection while in the facility and four other residents had other infections that were not identified. September 2021,- indicated one resident was admitted to the facility with a skin/wound/rash, one resident had a skin/wound/rash while in the facility, one resident was admitted to the facility with UTI and three other residents had other infections that were either viral infections or were not identified. October 2021,- indicated one resident had a skin/wound/rash while in the facility, one resident had an UR infection while in the facility, one resident had COVID signs/symptoms while in the facility, three other residents had other infections that were either pre-dental, sinus infection and hepatic encephalopathy. November 2021,- indicated one resident had a UTI while in the facility and two residents had COVID-19 signs/symptoms. The logs lacked ongoing surveillance and trending of all infections which included food-borne illness, and other illnesses caused by other viruses or infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/4/21, at 12:53 p.m. the infection control program was reviewed with the director of nursing (DON). The DON confirmed she was responsible for the facility's current infection control program and was currently taking the infection prevention program course on line. The DON verified she had not been tracking and trending all infections in the facility. The DON indicated the only infections she had been tracking were listed on the infection control logs which included: UTI's, UR infections, skin/wound infections and COVID-19 infections. The DON indicated the tracking and trending of all infections should have been completed to prevent or catch any outbreaks, to find out the root cause and to prevent cross contamination. The DON confirmed ongoing surveillance had not been completed and the infection control program had been completed. 11/4/21, at 2:29 p.m. the administrator confirmed the above findings and indicated the DON was currently enrolled in the infection preventionist course. The administrator indicated she expected staff to be monitoring and doing facility wide surveillance on all infections in the building. Additionally, the administrator stated she expected the DON to be teaching staff how to prevent infections in the building. The administrator stated nursing staff should have been tracking and recording all infections and she indicated she had just been informed the facility had not been doing that. The administrator indicated she provided the DON a log to use from that point forward and stated she expected staff to follow the facility policies. On 11/3/21, and 11/4/21, a policy was requested related to infection control surveillance and one was not provided.

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Perform COVID19 testing on residents and staff. 32600 Based on interview and document review, the facility failed to ensure routine COVID-19 testing occurred for unvaccinated staff according to the community positivity rates identified in CMS (Centers for Medicare and Medicaid Services) guidelines. Additionally, the facility failed to ensure COVID-19 testing occurred during an outbreak according to CMS guidelines for outbreak testing. This deficient practice resulted in an immediate jeopardy (IJ) situation which had the potential to affect all 30 residents, staff, family, and visitors in the facility. The immediate jeopardy began on 10/26/21, when a COVID-19 outbreak occurred and the facility failed to test all residents and staff. The administrator and the director of nursing (DON) were notified of the immediate jeopardy at 7:05 p.m. on 11/4/21. The immediate jeopardy was removed on 11/5/21, at 4:01 p.m. when the facility implemented interventions to ensure all staff and residents were tested for COVID-19 with a recent outbreak and all staff unvaccinated were being tested according to the community transmission rate, however, noncompliance remained at the lower pattern scope and severity level F, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: CMS QSO-20-38-NH Memo revised on 09/10/2021, identified routine testing of unvaccinated staff should be based on the extent of the virus in the community. The memo indicated facilities should use their community transmission level as the trigger for staff testing frequency. The memo identified Routine Testing Intervals were to be twice a week for unvaccinated staff when the county COVID-19 Level of Community Transmission rate was at red (high) level. The memo instructed facilities to conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests. For each instance of testing: Document that testing was completed and the results of each staff test; and document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. The memo identified an outbreak as any new case of COVID-19 that arose in the facility. Upon identification of a single new case of COVID-19 infection in any staff or resident, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (facility-wide) testing. Review of R8's progress notes indicated on 10/27/21, R8 had a temperature of 102.1, had no pain and was given Tylenol for his temperature. The medical record identified R8 was isolated to his room per facility protocol due to testing positive for COVID-19. Review of the facility's community transmission rates from 9/27/21, to 11/4/21, indicated the facility was in the red (high) level which required COVID-19 testing two times a week for unvaccinated staff. Review of the facility's COVID-19 testing logs for residents and staff revealed the following: (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-10/22/21, the facility tested on e staff member with negative COVID-19 results. -10/25/21, the facility tested on e staff member with negative COVID-19 results. -10/26/21, the facility tested 25 staff members and 24 had negative COVID-19 results and one had no results listed. -10/27/21, the facility tested two staff members and one tested negative for COVID-19 and the other had no results listed. -10/31/21, the facility tested two staff members and two tested positive for COVID-19. -11/1/21, the facility tested nine staff members for COVID-19, no results were listed. -11/2/21, the facility tested on e resident for COVID-19, no results were listed. The testing logs had 19 other residents names listed, however, the logs lacked evidence of what date the residents had been tested for COVID-19 and the results indicating if they were positive or negative for COVID-19. Additionally, 14 other residents names were listed on the testing logs and had tested negative for COVID-19, however, the logs lacked evidence of what date those residents had been tested for COVID-19. Further review of the testing logs revealed, 21 other staff members were listed on the testing logs, however, the logs lacked evidence of what date the staff members were tested . The testing logs indicated 20 of the staff members tested negative for COVID-19 and there was one staff member who had tested positive for COVID-19 however lacked the date the test had been completed. The facility testing logs lacked evidence the facility tested unvaccinated staff for COVID-19 two times a week according to CMS guidance. Additionally, the logs lacked evidence the facility tested all staff and residents according to CMS guidance when a COVID-19 outbreak was identified on 10/26/21. On 11/4/21, at 9:36 a.m. licensed practical nurse LPN- C indicated staff testing for COVID-19 had occurred weekly for staff. On 11/4/21, at 9:45 a.m. nursing assistant (NA)-B stated staff testing for COVID-19 had occurred on a weekly basis. On 11/4/21, at 9:53 a.m. NA-C stated staff testing for COVID-19 had occurred on a weekly basis. On 11/4/21, at 10:37 a.m. NA-D stated staff testing for COVID-19 had staff testing occurred every week on Wednesday. On 11/4/21, at 1:44 p.m. LPN-A stated that staff testing for COVID-19 had occurred on a weekly basis. On 11/4/21, at 1:46 p.m. NA-E stated that unvaccinated staff testing for COVID-19 had occurred every week on Wednesday. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/4/21, at 1:34 p.m. NA-A confirmed he tested positive for COVID-19 on 10/26/21, and indicated he was being tested in the facility once a week on Tuesdays due to not being vaccinated. On 11/4/21, 3:21 p.m. the DON confirmed the facility lacked evidence of testing of unvaccinated staff prior to 10/22/21, and verified not all staff and residents had been tested for COVID-19 per CMS guidance following an outbreak which started on 10/26/21. The DON indicated testing should have been completed according to the county positivity rate which had green, yellow and red indicators to guide facilities. The DON confirmed she was not aware of the facility's current community transmission rate and the facility had not been testing unvaccinated staff two times a week. The DON verified the facility currently had five residents and three staff members who had tested positive for COVID-19 and confirmed not all staff and residents had been tested following the outbreak. On 11/4/21, at 5:58 p.m. the DON and cooperate director of nursing (CDON) confirmed the usual facility practice was to conduct routine testing of staff weekly, on only the staff who were working in the building the day the testing was conducted. The DON and CDON verified not all staff and residents had been tested during the outbreak testing and confirmed they had only tested the staff who had worked in the building the day of the outbreak. DON and CDON indicated they were not aware of the testing requirements per CMS guidance and confirmed the facility had not been testing all unvaccinated staff two times a week. Additionally, the DON and CDON confirmed the facility had not tested all staff and residents per CMS guidelines when an outbreak of COVID-19 occurred in the facility and had only tested the staff who were working in the facility at the time of outbreak testing. Review of facility policy titled, COVID-19 Testing Residents dated 8/2020, indicated viral testing of all residents would be completed when there was an outbreak in the facility. An outbreak had been defined as: any new single onset of SARS-CoV-2 infection in a resident or any new single case of infection in a health care personnel. Testing was to be conducted as soon as a new case had been confirmed. On 11/4/21, a policy had been requested regarding COVID-19 testing of unvaccinated staff however one was not provided. The immediate jeopardy that began on 10/26/21, was removed on 11/5/21, when the facility implemented the following interventions which were verified to be in place: - the testing policy was updated with reference to CMS QSO Memo 20-38. - on 11/4/21,all staff and residents were screened for symptoms of COVID-19 and tested for COVID-19. All testing result information was logged and recorded on the testing logs with any positive or negative results of COVID-19. - outbreak testing was completed every 3 to 4 days or until no new cases of COVID-19 were identified after a 14 day period. - one staff member was assigned to outbreak testing to ensure all staff and resident's were being tested for COVID-19. - unvaccinated staff were tested according to CMS guidance and testing was conducted prior to staff working. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- staff were notified prior to testing dates and testing information was posted through out facility and via mass communication method. - The DON performed audits after all COVID-19 testing had been completed to verify completion. - staff were educated on infection control, testing requirements, and symptoms related to COVID-19. The information was provided via messaging, in printed form and by mail. The information was available at the nurses station, the break room and in person. - regional (with parent company) calls were to be held daily to ensure that staff were reviewing and monitoring all new symptoms of COVID-19 for residents and staff. Additionally, the calls were to ensure all testing information had been logged. - vaccination rates were being monitored for both staff and residents.