STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	03/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOORHEAD REHABILITATION & HEALTHCARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement appropriate medically related social service interventions for 1 of 1 residents (R45) with repeated behaviors and resident to resident altercations. Findings include: R45's five day prospective payment system (PPS) Minimum Data Set ((MDS) dated [DATE], identified R45 was cognitively intact and had [DIAGNOSES REDACTED]. The MDS indicated R45 required extensive assistance with activites of daily living (ADL's) which included bed mobility, transfers and dressing. The MDS identified R45 had moderate symptoms of depression and had no physical or verbal behaviors towards himself or others. R45's significant change of status assessment (SCSA) MDS dated [DATE], identified R45 had [DIAGNOSES REDACTED]. The MDS revealed R45 had moderate symptoms of depression and had no verbal or physical behavioral symptoms displayed. The MDS identified R45 had rejected cares one (1) to three (3) days out of the assessment period. R45's SCSA Care Area Assessment (CAA) dated 2/21/20, identified R45's behavior has worsened since his last MDS assessment and had rejected cares which were necessary for his health and well being. The CAA revealed R45 was on an anti-depressant medication and had difficulties with sleep. The CAA failed to address R45's symptoms of depression, specific behaviors and individualized interventions. R45's care plan revised 2/28/20, identified R45 had behaviors which included; threatening other residents, staff, hitting out, shouting and repetitive attempts to get something which had already been addressed or discussed with staff such as medication and discharge plans. The care plan listed various interventions which included; attempt to intervene before R45's behaviors begin, do not seat R45 around others who disturbed him, administer meds as ordered. R45's care plan revealed the licensed social worker (LSW) was to talk to R45 about any concerns, complaints or grievances he had, offer R45 something he liked for diversion and speak to R45 unhurriedly and in a calm voice. Furhter, the care plan directed staff to refer R45 to his psychologist/psychiatrist as needed. Review of the untitled nursing assistant (NA) care guide undated, revealed R45 required assistance of one staff with most ADL's, however, did not address R45's behaviors and how to manage them. Review of the social services psychosocial quarterly assessments from 11/18/19, to 2/25/20, revealed the following: - 11/18/19, was blank and unsigned. - 2/25/20, identified R45 was cognitively intact, had moderate depression and was on Trazadone (an antidepressant medication used for depression and [MEDICAL CONDITION]) for [MEDICAL CONDITION]. The assessment identified R45 had no need for mental health services and listed going to the dining room for meal time and attending some facility activities as non- pharmacological interventions utilized. The social service psychological assessment did not address R45's behaviors, depressive symptoms, potential causative factors of his aggression, or any interventions. On 3/19/20, at 10:01 a.m., R45 was seated in his wheelchair in the therapy gym, completed left arm weighted exercises independently. R45 was not conversing with others while he was completing the exercises and had no discernible expression on his face. - at 10:11 a.m., R45 remained in the therapy gym, R45 stood up from his wheelchair with assistance of one staff, a transfer belt and a four wheeled walker (FWW). R45 walked down the hallway with a steady gait back to his room using the FWW and staff standing beside him. On 3/19/20, at 2:23 p.m R45 was lying in his bed watching the television (TV). At that time, R45 stated he had an incident with R19 the other day when R19 shoved the back of his wheelchair. R45 stated he finally got him to stop by telling him to stop. R45 would not admit or deny punching the other resident in the face and indicated it was more of a shouting match. R45 stated he later approached the other resident and apologized. R45 stated he felt he did not have problems with other residents in the facility. Review of R45's facility incident reports from 11/8/19, to 3/17/20, revealed the following: - 11/8/19, at 1:02 p.m., R45 wanted to sit in a specific spot next to his girlfriend, asked the resident seated next to his girlfriend to move and she indicated she did not want to move. R45 became upset and poked the resident in her shoulder. The administrator and assistant director of nursing (ADON) were notified. Staff intervened and ensured the safety of the residents. The report lacked any new interventions or revision of R45's care plan to address his aggressive behaviors. - 11/28/19, at 4:20 p.m., another resident entered R45's room and threatened to beat up R45 due to his TV being too loud. Staff separated the residents and ensured their safety. The report lacked any new interventions or revision of R45's care plan to address his aggressive behaviors. - 3/17/20, at 9:20 a.m., R45 was in his wheelchair in hallway three when another resident came up behind him and asked R45 to move since he was unable to get by. R45 refused, the other resident ran into R45's wheelchair with his power chair and R45 punched the resident in his face. Staff separated the residents immediately, provided education and reviewed care plans. The report lacked any review or revision to R45's care plan to address R45's repeated aggressive behaviors. The facility incident reports did not include comprehensive assessments for potential causative factors, appropriate, individualized interventions of R45's repeated episodes of angry behavior. Review of the NHIR's reported to the State Agency (SA) from 11/7/19, to 3/17/20, revealed the following: - 11/7/19, at 6:53 p.m, NHIR indicated R45 wanted to sit near his girlfriend and another resident was in his way. R45 asked the resident to move and she did not want to move. R45 became upset and poked the resident in her left shoulder. Staff separated the residents, the other resident was discharged as planned the following morning and R45 was moved to another dining room table. - 11/10/19, at 1:32 p.m., NHIR revealed another resident approached R45 and told him R45 had been picking on his tablemate. R45 became agitated and shouted, I will punch you in the face to which the other resident responded, Let's take this outside. Staff intervened, separated both residents and were instructed to stay away from each other. - 11/28/19, at 4:20 a.m., NHIR indicated another resident threatened to beat up R45 due to the volume of R45's TV being too loud. R45 became agitated and began cursing at the other resident. Staff separated the residents and both residents were instructed by staff to stay away from each other. - 3/17/20, at 9:20 a.m., NHIR identified R45 was seated in his wheelchair when another resident came up behind him and told R45 to move out of his way. R45 refused and the other resident asked R45 to move two additional times and R45 continued to refuse. The other resident hit R45's wheelchair from behind and R45 punched him in the face. Staff separated the residents. The NHIR's did not include assessments or appropriate interventions to manage R45's repeated angry behaviors. Review of R45's progress notes from 8/20/19, to 3/19/20, revealed the following: - 8/23/19, R45 informed LSW he was upset about getting a new roommate. LSW informed R45 he was in a double room and due to increased admissions the facility needed to accommodate the new residents. In a later note, R45 told staff he would punch his roommate and staff replied, fighting would not be tolerated at the facility. R45 stated, I don't care and stated if his roommate did not move out, R45 would punch him. R45 then punched the staff member very hard on his left jaw and staff member grabbed the railing on the wall to stabilize his position. Staff asked R45 why he punched him and R45 stated, because I can. Staff informed R45 he was not allowed to punch him and walked away from R45. Later in the shift, R45 approached staff and apologized and stated it would not happen again. In a later note, R45 remained agitated. The evening nurse assigned a NA to sit with R45 to provide protection for the other residents. R45 was moved to another room. - 8/27/19, R45 approached staff and stated his roommate threatened to throw things at him and he felt unsafe.

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

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 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Staff kept R45 at the nurses's station for his own safety. A later note revealed staff brought R45 to different rooms that were available to move into, R45 chose to move into room [ROOM NUMBER] and staff assisted with moving him into another room. - 10/15/19, facility received a call from the local hospital's emergency department (ED) with the following information: R45 had been at [MEDICAL TREATMENT], became angry, called the ambulance and was sent to the ED. The note identified R45 had abnormal labs and was admitted for observation. - 10/17/19, R45 returned to the facility in stable condition and his labs were now within normal limits (WNL). - 10/30/19, staff indicated R45 could be demanding and short tempered of staff and other residents when he became upset. The note lacked identification of any interventions attempted to decrease R45's behavior. - 11/7/19, R45 was involved in an altercation with another resident in which he lost his temper and poked her with his finger due to the resident was speaking with his girlfriend. The note lacked identification of any interventions attempted to decrease R45's behavior. - 11/7/19, R45 refused medication, treatment and stated to staff, I want all of you to go to hell, I don't want to go to jail, she is my girlfriend. Staff asked R45 to explain his emotions and used therapeutic conversation as an intervention. - 11/28/19, another resident from room [ROOM NUMBER] came into R45's room and yelled at him to turn off his radio/TV and threatened to beat him up. R45 agreed to turn TV down after exchanging profanity between the two of them for three minutes. Staff separated both residents and provided redirection. - 12/24/19, staff noted R45 had a spot on his pants and quietly informed R45 of the need to change his pants. R45 was angry, argumentative and was using statements which indicated he was a victim. Staff offered assistance and notified the administrator. The note lacked identification of any new interventions attempted to decrease R45's behavior. - 3/10/20, R45 was taking his medications by the medication cart when two other residents approached and asked R45 to hurry up and take his medications so they could take theirs. R45 turned around and started to yell repeatedly, you need to stop it at the other residents. Staff redirected R45 to ignore the other residents and R45 continued to yell at them. Staff removed R45 from the area and brought him to the dining room. R45's progress notes lacked documentation of potential causative factors, implementation of routine appropriate interventions to manage R45's aggressive behaviors and whether the interventions were effective. On 3/19/20, at 12:31 p.m. trained medication aid (TMA)-A stated R45 and another resident had an altercation a few days ago. TMA-A stated staff separated R45 from the other resident and provided redirection to R45 and the other resident. TMA-A stated she was aware R45 had complained of other residents in the past but was not aware of behaviors of yelling or hitting. TMA-A stated providing staff redirection was the only intervention she was aware of for R45. On 3/19/20, at 2:16 p.m. licensed practical nurse (LPN)-A stated she was not aware of any altercations R45 had with other residents or staff. LPN-A stated R45 was impatient at times and wanted his requests accommodated quickly, however, felt he had no behavior problems. LPN-A stated she was not aware of any other interventions for R45 sine R45 had no behavior problems. On 3/19/20, at 2:27 p.m. MDS coordinator (MDSC) stated R45 had an altercation on the previous Monday with another resident which resulted in R45 punching the other resident. MDSC stated staff separated both residents and indicated no other interventions were implemented beyond resident separation. MDSC stated R45 had no other behavioral incidents with other residents she was aware of and stated R45's interventions included to attempt to intervene and to notify the primary physican of the incident. On 3/19/20, at 2:31 p.m. interim director of nursing (DON) stated she was not sure if R45 had any other resident to resident incidents, however, did remember an incident which involved R45 striking a staff member the previous summer. DON reviewed R45's incidents and verified he had incidents on 8/23/19, 11/7/19, 11/28/19, and 3/17/20. DON stated it was expected staff separate R45 from the other resident when these incidents occur, switch rooms if indicated, notify the physician about the incident and talk to the residents about it. DON stated the facility was not sure what else to do with R45's behaviors. DON confirmed R45's care plan, and stated the interventions currently in place had not been successful in managing his aggressive behaviors. DON stated the interdisciplinary team (IDT) met after the most recent incident and determined they may have to consider psychiatric services and anger management courses. DON confirmed these interventions were not currently in place. On 3/19/20, at 3:03 p.m. LSW stated she was aware of R45's repeated episodes of aggressive behavior. LSW stated her door was always open and R45 could stop in and visit with her anytime, however, did not have a formal plan for social service interventions for R45. LSW confirmed R45 had a history of [REDACTED]. LSW confirmed staff were not aware of what triggered R45's aggressive behaviors and as a result staff were not able to anticipate when R45 would become aggressive. LSW stated R45 was not currently receiving psychiatric services and indicated she planned to refer R45 to a psychiatrist in the near future. On 3/19/20, at 3:56 p.m. in a follow-up interview with LSW, she confirmed the current services provided to R45 were visits in her office when R45 wheeled himself there or in the hallway when they encountered one another. LSW stated R45 enjoyed visiting about different states and most recently about his interest in the political campaign. LSW confirmed R45 had not been offered nor was he currently receiving any psychiatric services. LSW stated she was not a licensed counselor and therefore was not able to provide those services on her own. LSW was not able to explain why psychiatric services was listed on R45's care plan. LSW verified she had not provided psychosocial counseling to assist R45 in determining causative factors of his repeated angry behaviors, implemented appropriate interventions to manage his behaviors or offered outside psychiatric services to R45 to assist in managing his behaviors. On 3/19/20, at 4:06 p.m. in a follow-up interview DON stated it was expected staff attempt to determine the cause of the behavior and to identify new interventions in an attempt to prevent reoccurrence. DON confirmed R45's current care plan and confirmed R45 had not been offered nor currently was receiving psychiatric services to address or manage his behaviors. Review of facility policy titled Behavioral Assessment, Intervention, and Monitoring dated 8/8/16, indicated the facility would identify and manage behaviors appropriately. The policy indicated interventions and approaches would be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying cause. Review of facility policy titled Social Services dated 1/9/20, identified the facility would provide medically-related social services to assure each resident would attain or maintain highest practical physical, mental or psychosocial well-being. The policy identified social services provided supportive visits to residents and works with individuals or groups in developing supportive services for residents according to their individual needs and interests.