Electronically Submitted
August 18, 2020

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

RE: CCN: 245052
Cycle Start Date: July 31, 2020

Dear Administrator:

On July 31, 2020, 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 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 July 31, 2020, the situation of immediate jeopardy to potential health and safety cited at F 622 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 September 2, 2020.

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 September 2, 2020 (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 September 2, 2020,(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 $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 31, 2020. 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.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 31, 2021 (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, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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|---|---|---|---|
| | 245052 | A. BUILDING _____ B. WING _____ | C 07/31/2020 |

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| **MOORHEAD REHABILITATION & HEALTHCARE CENTER** | **2810 SECOND AVENUE NORTH MOORHEAD, MN 56560** |

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| F 000 | INITIAL COMMENTS<br><br>On 7/21/20, to 7/31/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F622 began on 7/28/20, when the facility involuntarily discharged R8 from the facility and rendering him homeless. On 7/28/20, at 3:53 p.m. the administrator, and interim director of nursing (DON) were notified of the IJ situation. The facility removed the immediacy on 7/31/20 at 12:38 p.m.<br><br>Complaint H5052119C was substantiated at F622.<br><br>Additionally, the following complaint was found to be substantiated:<br>H5052125C at F550.<br><br>The following complaints were found to be substantiated with no deficiencies cited:<br>H5052120C<br>H5052122C<br><br>Additionally, the following complaints were found to be unsubstantiated:<br>H5052117C<br>H5052118C<br>H5052121C<br>H5052123C<br>H5052124C<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the | F 000 | | |

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

Electronically Signed | 08/28/2020

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| F 000 | Continued From page 1<br>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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her | F 550 | | 9/2/20 |

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| F 550 | Continued From page 2<br>rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and document review, the facility failed to provide services in a respectful manner for 1 of 1 residents (R3) during staff interactions while assisting with cares.<br><br>Finding include:<br><br>R3's quarterly Minimum Data Set (MDS) dated 5/30/20, indicated R3 had diagnoses which included renal insufficiency, diabetes and depression. The MDS indicated R3 had intact cognition and was independent with bed mobility, transfer, dressing, toilet use and personal hygiene.<br><br>R3's care plan revised on 6/17/20, indicated R3 was at risk for activities of daily living (ADL's) self care needs due to disease process, amputee and impaired balance. R3's care plan indicated R3 was independent with bathing/showering, bed mobility, transfers, dressing, eating and toilet use. Further, the care plan indicated R3 was hispanic, required considerations with communication and | F 550 | F- 550<br><br>1. R3 clothing was inspected to be properly labeled and placed in his room and any unlabeled or improperly placed items were removed. R3 care plan reviewed and no adjustments were needed. R3 via interpreter reported feeling safe in the facility. All other residents with communication barriers were reviewed and care plans were updated as needed. Residents were interviewed and there were no reports of dignity, respect or mistreatment were voiced.<br><br>2. All residents have a right to dignity in the facility and have the potential to be affected.<br><br>3. An all staff in-service was conducted 8/6/20 to review the policies on Resident | |

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| F 550 | Continued From page 3<br>required clear explanation of situation and choices for intervention. Further, the care plan indicated R3 had refusals, and directed staff to explain all procedures before starting and allow the resident time to adjust to changes.<br><br>Review of 3's Moorhead Rehabilitation and Healthcare Concern and Problem Resolution Form, indicated on 6/22/20 at 11:45 a.m. R3 stated to nursing assistant (NA)-A he was embarrassed by occupational therapist assistant (OTA). R3 indicated he was in the doorway entrance of his room, when the OTA was walking by and she noticed R3 was wearing a t-shirt that was not his. R3 indicated OTA yanked the t-shirt off him without saying anything. R3 indicated he was very embarrassed and at times she can be rough. NA-A told R3 she would pass it along and apologized to R3. The form indicated a vulnerable adult report was submitted.<br><br>On 7/22/20 at 1:29 p.m. R3 indicated he was sitting in his wheelchair in the doorway of his room looking around, when OTA pulled a t-shirt off of him that was not his. R3 indicated he thought someone had given him the t-shirt and did not know it was not his. R3 indicated OTA did not explain what she was doing and just took the t-shirt off of him. R3 indicated he was embarrassed because there were other residents present in the hallway. R3 indicated after OTA took the t-shirt off of him, she got a shirt out of his closet and told him to put it on. R3 indicated he felt humiliated but he was not hurt or abused. R3 indicated OTA took the shirt off so quick, it kind of scared him at the time and caught him off guard. R3 indicated it happened so quick he did not even have a chance to fight for the t-shirt. | F 550 | Rights and Dignity along with instruction on how to utilize the language line for interpreter assistance and where this number is located within the facility. The administrative staff will continue to conduct Ambassador rounds to meet regularly with the residents to discuss any concerns including respect/dignity. Resident Council meeting on 8/14/20 went over all Resident Rights with an emphasis on Dignity and Respect. A meeting with all Laundry Staff will be held 8/28/20 to review clothing labeling and distribution routines.<br><br>4. An audit has been developed to monitor completion of Ambassador Rounds with managers to identify any areas of dignity/respect and audits on laundry to ensure resident clothing delivered to the right resident. The audit will be completed weekly times 2 months then monthly to ensure compliance. The results of the audits will be reported to the QAPI committee for future recommendations. The audit will be completed by the Administrator or her designee.<br><br>Compliance: September 2, 2020 | |

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| F 550 | Continued From page 4 | F 550 | | |

On 7/22/20 at 4:55 p.m. OTA indicated she was walking by R3's room and noticed he had another resident t-shirt on and asked R3 if she could look at the tag. OTA indicated R3 started taking the t-shirt off in the hallway and she got him another t-shirt out of his closet and he put it on in the hallway. OTA indicated she could not remember if other residents were in the hallway or not. OTA indicated she felt R3 understood what she was trying to say to him and what she was doing. OTA indicated she did not speak Spanish and did not use an interpreter to communicate with R3 at the time of the incident and felt it was a miscommunication.

On 7/22/20 at 9:35 a.m. NA-A stated R3's memory was intact and confirmed he had reported to her the next day that he was sitting out in the hallway, when OTA took a t-shirt off of him and did not say anything. NA-A indicated R3 told her he was embarrassed and humiliated after the incident because it caught him off guard and he did not know what she was doing. NA-A indicated R3 told her he put on another t-shirt, went back in his room and stayed in his room after the incident because other residents had seen him. NA-A indicated she apologized to R3, told him she would report the incident to the nurse and the nurse had filed a grievance.

On 7/22/20 at 9:45 a.m., director of nursing (DON) indicated she was not here at the time of the incident, did not know anything about the incident and could not speak to what happened. The DON indicated she would expect staff to treat the residents with respect and dignity.

On 7/22/20 at 10:41 a.m. administrator indicated she thought OTA took R3's t-shirt off of him

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| F 550 | Continued From page 5<br>without talking to him. The administrator indicated she felt there was a misunderstanding between the R3 and OTA. The administrator indicated R3 felt rushed and was not able to understand the OTA and this was un-dignified. The administrator indicated she would expect staff to treat the residents with respect and dignity while providing cares. She indicated staff cannot make assumptions and indicated this situation could have been avoided.<br><br>Review of facility policy titled, Dignity Of The Resident reviewed on 4/12/18, indicated all resident will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality. | F 550 | | |
| F 622 SS=J | Transfer and Discharge Requirements<br>CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br><br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered;<br>(E) The resident has failed, after reasonable and | F 622 | | 9/2/20 |

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| F 622 | Continued From page 6 | F 622 | | |

appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot

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| F 622 | Continued From page 7<br>be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).<br>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-<br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and<br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.<br>(iii) Information provided to the receiving provider must include a minimum of the following:<br>(A) Contact information of the practitioner responsible for the care of the resident.<br>(B) Resident representative information including contact information<br>(C) Advance Directive information<br>(D) All special instructions or precautions for ongoing care, as appropriate.<br>(E) Comprehensive care plan goals;<br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to allow 1 of 1 residents (R8) who had insulin dependent Diabetes Mellitus reviewed for appropriate discharge to remain in the facility while a discharge appeal was pending. This deficient practice resulted in an immediate jeopardy (IJ) situation when R8 was discharged from the facility to a hotel for a two week stay and no housing or community services secured for after the two week hotel stay, subsequently rendering him homeless. | F 622 | F- 622<br><br>1. R8 is no longer a resident at the facility. The Moorhead County caseworker and the Moorhead and North Dakota police departments were contacted on 7/30/20 to conduct a well check for R8. Per MD order, R8 will be considered for readmission to the facility after having been seen in the emergency room and is medically safe and | |

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| F 622 | Continued From page 8<br><br>The IJ began on 6/29/20, at 1:00 p.m. when the facility discharged R8 from the facility to a local hotel for a two week stay with no secured housing in place after the two week stay. On 7/28/20, at 3:53 p.m. the administrator and interim director of nursing (DON) were notified of the IJ situation. The facility implemented corrective action and the IJ was removed on 7/31/20, at 12:38 p.m., when the facility made attempts to locate R8 and the majority of the staff had been re-educated and appropriate discharge procedures were in place. The noncompliance remained at the lower scope and severity level D, iolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>R8's quarterly Minimum Data Set (MDS) dated 4/7/20, identified R8 was cognitively intact and had diagnoses which included Diabetes Mellitus, left below the knee amputation, viral hepatitis and high blood pressure. The MDS identified R8 did not walk and was independent with most activities of daily living (ADL's) which included transfers, toileting, grooming and bathing tasks. Further, the MDS identified R8 had no behaviors and received seven days of insulin injections during the seven day assessment reference period.<br><br>R8's admission Care Area Assessment (CAA) dated 1/18/20, identified R8 had recently been admitted to the facility after surgery for a left below the knee amputation and was independent with most ADL's. The CAA indicated R8 was able to make his needs known and was on a consistent carbohydrate controlled diet for his diabetes. The CAA indicated R8 had little interest | F 622 | appropriate for readmission to the facility.<br><br>2. All residents in the facility with a discharge anticipated back into the community have the potential to be affected.<br><br>3. 7.29.20 the IDT and Licensed Nursing Staff were in-serviced on policies Resident Transfer/Discharge, Leave Against Medical Advice and Leave of Absence. No policy changes were warranted. IDT team was in-serviced on discharge planning to begin at admission and include: resident social support, educational needs, any clinical support that will be needed with the goal of ensuring a safe discharge for the residents to a community of their choice. All discharges since survey exit were reviewed by the IDT team and are complete.<br><br>4. An audit has been developed to monitor the date of anticipated discharge, IDT meeting related to discharge to confirm discharge address, necessary equipment (DME) required, medications, transportation, community services, physician notification with orders and reason for discharge. The audit will be completed daily x 10 days, weekly x 4 weeks then monthly. The results of the audits will be reported to the QAPI committee for future recommendations. The audit will be completed by the Administrator or her designee. | |

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| F 622 | Continued From page 9<br>or pleasures in doing things and the facility had offered mental health services upon admission.<br><br>Review of R8's Self Administration of Medication Assessment form dated 6/17/20, revealed it was not appropriate for R8 to self administer medications.<br><br>R8's care plan, revised 7/14/20, identified R8 was independent with most ADL's including: bed mobility, transfers and eating. The care plan identified R8 had Diabetes Mellitus, received insulin, blood glucose checks and was to be monitored for signs and symptoms for hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). The care plan indicated R8 intermittently refused cares and left the building without notifying staff. The care plan identified R8 did not self administer his own medications and indicated social services would coordinate services necessary for a community discharge.<br><br>Review of R8's progress notes from 2/24/20, to 6/30/20, revealed the following:<br><br>- 2/24/20, late entry, the administrator provided R8 with a 30 day notice of discharge due to his health improving sufficiently, no longer in need of service from the facility and indicated R8 would be discharged to Meadowlane Board and Care home in Benson.<br><br>- 3/9/20, former licensed social worker (LSW) and administrator met with R8 to obtain consent to send documentation requested by the regional ombudsman for long term care (ROLTC) and former LSW along with R8 contacted Lakes and Prairie Community Action to follow-up on | F 622 | Compliance: September 2, 2020 | |

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| F 622 | Continued From page 10<br>financial/housing assistance.<br><br>- 3/11/20, R8 left the facility without notifying staff. Former registered nurse (RN)-A contacted medical doctor (MD) regarding R8's leave.<br><br>- 3/12/20, Clay county report completed by former LSW to report R8's leave.<br><br>- 3/13/20, phone calls made by facility staff of contacts listed on file with voice mails left. R8's brother stated he had not seen or heard from R8 in two weeks. Moorhead police department (PD) notified too. Later that day at 3:41 p.m., former LSW received a phone call from staff from Lakes and Prairie Community Action Partnership indicating R8 showed up at their office at 2:30 p.m. requesting assistance with housing and stated R8 appeared very ill looking and was extremely difficult to get information from.<br><br>- 3/14/20- R8 returned to the facility and was sent to emergency room (ER) for evaluation and refused the evaluation and was returned to the facility.<br><br>- 3/17/20, former LSW met with R8 to discuss transfer to Meadowlane and R8 declined the transfer. Other options presented to R8.<br><br>- 3/19/20, former LSW assisted R8 with completing MNChoices assessment (application for disability) with Clay County Public Health over the phone.<br><br>- 3/25/20, former LSW received message from Clay County Public Health R8 was accepted for relocation services. R8 was informed and stated "you put a smile on my face." | F 622 | | |

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- 4/9/20, former LSW stated she received phone call from Opportunity Community Services(company certified to provide relocation service corrdination to individuals with limited income, and abilities to re-establish themselves within the community) and they accepted R8 to assist with relocation services.

- 4/21/20, R8 was seen by nurse practitioner (NP) for hyperglycemia episodes and A1C (the A1C test is a blood test that provides information about average levels of blood glucose over the past three months) noted to be 9.5. Provider ordered an increase in insulin.

(The American Diabetes Association [ADA] guidelines 1/1/20, suggested the following targets for most nonpregnant adults with diabetes. A1C targets differ based on age and health. Also, more or less stringent glycemic goals may be appropriate for each individual: A1C: Less than 7%. A1C may also be reported as eAG: Less than 154 mg/dL Before a meal (preprandial plasma glucose): 80-130 mg/dL. 1-2 hours after beginning of the meal (postprandial plasma glucose): Less than 180 mg/dL)

- 5/5/20, R8 completed phone application for social security disability.

- 5/20/20, seen by NP for evaluation of hyperglycemia and indicated suboptimal control due to diet noncompliance and inability to to titrate insulin due to improper timing of blood glucose monitoring. Orders obtained to repeat A1C tomorrow and to continue with Lantus insulin ( a long acting form of insulin used to treat Diabetes Mellitus) twice daily and once daily

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Glipizide (an oral medication used to treat Diabetes Mellitus).

- 5/22/20, A1C results came back at 8.8, NP notified with no new orders obtained.

- 6/4/20, seen by NP, type 2 Diabetes Mellitus with foor ulcer and noted blood glucose improved but continued elevations related to timing of blood glucose monitoring. Diagnosis of major depressive disorder, recurrent, mild and R8 reported increasing depression, however, he declined medications at that time. Plan to repeat A1C in one month, continue with Lantus insulin twice a day and continue with Glipizide daily.

- 6/10/20, NP changed insulin from twice daily to daily and to check A1C next week.

- 6/17/20, staff noted an empty vodka bottle in room and R8 had slurred speech and appeared lethargic. On call MD notified and interim DON notified. NP examined R8 and placed diabetic meds on hold and handed over care to emergency medical services (EMS) staff. R8 was sent to the ER for evaluation and R8's brother notified. R8 returned to the facility after being evaluated with a new diagnosis of dehydration and alcohol intoxication.

- 6/19/20, staff attempted times three to draw blood to check A1C and were unsuccessful.

- 6/20/20, R8 left the facility at 4:26 p.m. and returned to the facility at 6:58 p.m. with alcohol in his possession. Staff removed the alcohol.

- 6/21/20, at 2:10 a.m. R8 was noted to be outside in the smoking area outside his

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designated time. Staff suspected R8 had possession of the keys. At 7:57 a.m. MD notified and had no orders and indicated the facility handle it according to facility protocols.

- 6/23/20, former LSW, administrator, interim DON and ROLTC (via the telephone) met with R8 to discuss behavioral concerns, leaving the facility against medical advice and safety issues. R8 was notified if he left the facility against medical advice or went outside to smoke outside of his designated times he would be discharged from the facility. Discussion continued regarding R8's goal to obtain housing and continue working with relocation services. R8 verbally agreed to follow rules and expectations.

- 6/29/20, late entry at 12:51 p.m. administrator met with R8 to discuss behaviors he continued to have since the 6/22/20, meeting with administrator, interim DON, former LSW and ROLTC. Administrator informed R8 "since he had behaviors after hours and over the weekend the result would be immediate discharge from the facility for failing to agree to the verbal agreement." R8 nodded his head yes and then stated he did not understand. Administrator repeated the "violations of the agreement made the previous week have now resulted in immediate discharge" and R8 stated he would pack his own things. R8 made no attempt to pack his own belongings and staff were asked to assist with packing up belongings. R8 made no attempt to pack up anything until a dresser drawer had been opened and a red cloth item with a red tie wrapped around it was picked up by the administrator and placed into a bag. R8 approached nursing assistant (NA)-B and the administrator and quickly pushed the drawer shut,

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| F 622 | Continued From page 14<br>put his hands in the air and cursed at them. The administrator advised R8 one more attempt like that and the police would be contacted. The administrator handed R8 the red bag and R8 continued to argue and become aggressive and extra staff were called in to assist. While packing R8 up and waiting for transport, R8 opted to discharge to the Motel 6 in Fargo, ND, signed the AMA paperwork and stated he would "rather go to a hotel then to a shelter." R8's final items were packed up and he was taken by transport to Motel 6.<br><br>- 6/29/20, at 12:57 p.m. interim DON indicated the interdisciplinary team (IDT) team spoke with R8 regarding noted behaviors which occurred over the weekend. R8 was noted to be non responsive and very dismissive during the meeting. The former LSW and interim DON offered R8 the opportunity to elaborate on behaviors in question but R8 remained non verbal only using his body language. "R8 was reminded about previous IDT meeting regarding consequences related to poor behaviors towards staff and other residents"and R8 stated understanding. "Immediate discharge to shelter was discussed with R8 but R8 opted to go AMA to the Motel 6 in Fargo." R8 was noted to be cognitively intact and R8 left the facility with medications and personal belongings via facility transport. Female friend was noted to be present at the time of the AMA.<br><br>- 6/29/20, late entry, at 12:59 p.m. former LSW notified R8's relocation agency and Clay County caseworker of AMA discharge.<br><br>- 6/29/20, at 15:09 p.m. licensed practical nurse (LPN)-A indicated R8 discharged AMA from the facility at approximately 1:00 p.m. | F 622 | | |

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- 6/30/20, at 9:23 a.m. Recapitulation of stay note, interim DON indicated R8 required ongoing assist with ADL care, medication administration and blood sugar monitoring. Former LSW continued to work on community resources to assist R8 with housing.

- 6/30/20, at 2:20 p.m. (greater than 1 day after discharge) LPN-A indicated R8 refused education on medication administration times and R8 stated "he did not need to be told how and when to take his medications." R8 was educated on the risks and benefits of the decision.

The progress notes lacked documentation of behaviors exhibited by R8 from 6/22/20, to 6/29/20, day of discharge although the administrator indicated R8 had violated the verbal agreement from the previous week.

Review of MD and NP progress notes from 5/14/20, to 6/24/20, revealed the following:

- 5/14/20- telemedicine nursing home visit, NP identified R8 had uncontrolled type 2 Diabetes Mellitus with hyperglycemia and last A1C was 9.4. R8 received Lantus insulin and Glipizide and blood glucose monitoring was ordered for four times a day.

- 5/27/20, telemedicine nursing home visit, MD indicated R8 had uncontrolled Diabetes Mellitus type 2. Plan to continue present care.

- 6/17/20, ER visit indicated R8 had alcohol intoxication with a blood alcohol level of .212 and low blood pressure. R8 was kept in the ER for an extended period of time and given intravenous

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(IV) fluids and sent back to the facility.

- 6/24/20, telemedicine nursing home visit, MD indicated R8's A1C was 8.8 on 5/22/20 and R8 had uncontrolled Diabetes Mellitus and no changes were made.

Review of R8's laboratory test A1C, from 2/28/20, to 6/29/20, revealed the following:

- 2/28/20, R8's A1C was 6.9.

- 4/21/20, R8's A1C was 9.5.

- 5/22/20, R8's A1C was 8.8.

No further A1C labs were found in R8's record after 5/22/20.

Review of R8's unsigned Physician Orders, identified by facility as R8's current orders, included Lantus SoloStar Solution Pen-injector Insulin 10 units (a unit of measurement in insulin administration 100 units per milliliter [ml]) subcutaneously (tissue layer between the skin and muscle) daily in the morning for Diabetes Mellitus.

Review of R8's Medication Administration Record (MAR) dated 6/1/20, to 6/29/20, revealed the following:

-blood glucose checks ordered four times a day and was last checked on 6/29/20, at 8:00 a.m. with the results of 197

-blood glucose results ranged from 66-463

- R8 did not have his blood glucose checked 39

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times due to various reasons ranging from R8's refusal or absence from the facility.

- R8 received Glypizide 5 mg. (milligrams) daily and last received it on 6/29/20, at 8:00 a.m.

- R8 received Lantus SoloStar Solution Pen-injector insulin 10 units subcutaneously daily in the morning for Diabetes Mellitus and last received on 6/29/20, at 8:00 a.m.

R8's Notice of Discharge dated 2/24/20, identified R8's health had improved sufficiently and R8 no longer needed the services of the facility and R8 would be discharged to another facility on 3/24/20.

R8's Continuance Order related to involuntary discharge and transfer dated 3/30/20, was provided to the facility on 3/30/20. The order identified a hearing had been scheduled for 4/7/20, to determine if the facility could lawfully discharge R8.

R8's second Continuance Order related to involuntary discharge transfer dated 5/5/20, was provided to the facility on 5/8/20. The order identified another continuance of the matter in order to prepare for an appropriate transfer to another facility. The order identified if the parties had not resolved the matter by 8/5/20, the matter would be placed back on the judge's docket for hearing.

R8's Release of Responsibility for Discharge against Medical Advice (AMA) form with illegible date, identified by the director of nursing as 6/29/20, signed by the resident indicated R8 had been informed of the risks and consequences of

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| F 622 | Continued From page 18<br>leaving the facility AMA.<br><br>R8's Transfer/ Discharge notice dated 6/30/20, identified the facility discharged R8 on 6/29/20, due to AMA discharge.<br><br>Review of R8's Social Services Care Conference Summary form dated 6/2/20, revealed R8's mood/behaviors showed improvement and indicated recommendations for discharge had been made on several occasions.<br><br>Review of R8's Social Services Discharge Summary form dated 6/29/20, signed on 6/30/20, by the interim DON, revealed R8 discharged AMA, required ongoing assistance with ADL's, medication administration and blood sugar monitoring. The form indicated the former LSW continued to work on community resources to assist R8 with obtaining housing.<br><br>On 7/21/20, at 10:15 a.m. LPN-B stated she reported to work on 6/29/20, and had been informed by other facility staff the administrator and DON had R8 sign the AMA form and discharged R8 from the facility. LPN-B was informed R8 had been brought to a local hotel to stay for a couple of weeks. LPN-B stated she had worked the previous weekend and R8 had exhibited no behaviors and expressed excitement over the potential to be fitted for a prosthesis and the goal of obtaining housing.<br><br>On 7/21/20, at 2:00 p.m. via telephone interview family member (FM) stated he received a telephone call from R8 a day or two after his discharge from the facility and stated he had been "kicked out" of the facility. R8 said he had a two week hotel stay and did not say where he | F 622 | | |

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would be staying after the hotel stay. FM stated he did not know where R8 currently was living or if he had housing.

On 7/21/20, at 3:06 p.m. former RN-A stated she had worked in the facility until approximatley the past couple of weeks prior. She stated she was aware R8 had behaviors in the past of leaving against facility policy and confirmed he had no behaviors since the facility met with him and informed him if he did not follow the rules he would be discharged. Former RN-A stated on 6/29/20, the administrator, interim DON and MDS Coordinator informed her R8 had left the facility on an unapproved leave over the weekend. Former RN-A reviewed R8's electronic health record (EHR) and confirmed the documentation lacked any leaves or behaviors for R8 occurring over the weekend. Former RN-A contacted staff over the telephone who had worked the previous weekend and confirmed R8 had not left the facility over the previous weekend and in fact it was another resident who did. Former RN-A entered R8's room where the administrator was packing R8's belongings and informed her R8 did not break the rules. Former RN-A stated she also notified interim DON R8 did not break the rules and R8 was still discharged. Former RN-A informed the interim DON R8 was on insulin, had not been administering his own insulin and interim DON stated R8 should be fine and should know what he was doing. Former RN-A stated the facility had set up a two week hotel stay for R8 and did not know where he went to after that. Former RN-A stated R8 did not initiate the discharge and had planned on being discharged in the future, when housing had been secured for him.

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| F 622 | Continued From page 20<br>On 7/21/20, at 3:50 p.m. during a telephone interview with the Motel 6 front desk staff (FDS) she indicated R8 had stayed at the hotel for a couple of weeks and had left the hotel. The FDS stated a man who she thought was his son picked him up and she was not certain where he went to from there.<br><br>On 7/22/20, at 11:55 a.m. during an telephone interview with the ROLTC, she indicated she had been involved with R1's discharge planning meetings with the facility. She confirmed she had assisted R8 to file a first and second appeal to his notice of discharge provided on 2/24/20. R8 stated he was happy the facility was required to keep him during the appeal process and stated he voiced he had hope for the first time in his life. ROLTC indicated R8 had been actively working on relocation services with a relocation specialist to obtain housing.<br><br>ROLTC indicated she had received a telephone call from the administrator on 6/22/20, who stated R8 had recently left the facility for a funeral and the facility questioned if he had followed the facility's COVID 19 precautions while he was at the funeral. The administrator stated because of the possible breach in COVID 19 precautions, the facility felt he needed to be discharged from the facility AMA. At that time, ROLTC contacted R8 via telephone and reviewed the facility concerns. R8 stated he wanted to leave the facility, but because there was a plan in place for long term housing after discharge, he did not want to jeopardize that plan. He stated he would follow the facility rules and not leave the facility.<br><br>ROLTC stated also that day the facility held a meeting with R8 and facility staff and reviewed | F 622 | | |

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the facility rules regarding resident leave of absences from the facility. R8 again stated he would follow the rules and did not want to jeopardize his long term housing plans. R8 stated "it is black and white" and " I will follow the rules." ROLTC stated she had contacted the interim DON and LSW on 6/26/20, and was told that R8 was doing much better, had struggled with quarantine but was redirectable.

ROLTC stated on 7/6/20, she had been made aware R8 had been discharged from the facility and she began calling and emailing the administrator on 7/6/20, 7/7/20, and did not receive a call back from the administrator until 7/8/20.
ROLTC stated she had been told by the administrator that R8 had informed them he was leaving the facility AMA on 6/29/20. The administrator stated because there were no openings at the homeless shelter, he went to a local hotel. ROLTC stated she had asked the administrator to clarify how this was an AMA discharge when the facility had packed up his belongings, and drove him to a hotel in another state in the midst of a discharge appeal. She stated the administrator was unable to explain R8's discharge and offered no further information. ROLTC informed the administrator she needed a copy of the AMA form and indicated she would be forwarding it to an appeal judge.

On 7/22/20, at 12:41 p.m. LPN-A stated on 6/29/20, when he arrived at the facility that morning there had been nothing reported to him about plans to discharge R8. LPN-A stated he was informed later in the morning by the former LSW R8 was being discharged and to give R8 his medications. LPN-A stated R8 appeared

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agitated,angry and was cursing after learning he was being discharged. LPN-A stated he talked to R8 and he did not know why he was being discharged. LPN-A offered medication education to R8 and he refused. LPN-A stated he was told the facility provided lodging and transportation for R8 to a local hotel. LPN-A stated R8 received routine insulin and confirmed R8 did not administer his own insulin.

On 7/22/20, at 1:37 p.m. interim DON stated the facility and ROLTC met with R8 on 6/23/20, to inform him if the behaviors of leaving the facility, smoking outside of designated times and alcohol intoxication continued he would be discharged from the facility. Interim DON stated R8 agreed to follow the rules of the facility. Interim DON stated on 6/29/20, the facility was made aware of R8 not following the facility rules over the weekend, she and former LSW met with R8 to discuss his behaviors and reminded R8 the facility had talked to him prior to this time of immediate discharge if behaviors continued. R8 responded by saying he did not care and he wanted to leave the facility and did not provide any other verbal communication about the behaviors. Interim DON stated the option of R8 going to a local homeless shelter was discussed and again R8 stated he did not care. The facility contacted the local homeless shelter and there were no beds available and only had chairs open. Interim DON stated the facility was not comfortable with that option and paid for a two week hotel stay for R8. R8 contacted a female friend to pick him up and she was at the facility when R8 left the facility. Interim DON confirmed there were no behaviors of R8 leaving the facility, smoking outside of designated times or alcohol intoxication in the progress notes documented since the meeting on

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6/23/20. Interim DON stated she was unsure, but either she or the administrator had R8 sign the AMA paperwork and she could not recall which one. Interim DON stated she had not been informed of R8 being on insulin and stated R8 must have been able to administer it since he went on leaves prior to the 6/29/20, discharge. Interim DON stated R8 was given his medications and refused the education offered by LPN-A. Interim DON stated the administrator met with R8 in his room after her and former LSW left R8's room.

On 7/22/20, at 2:29 p.m. MDS Coordinator (MDSC) stated she took call over the weekend prior to 6/29/20, and stated she had received a telephone call about R8 going outside unsupervised. MDSC stated she could not recall the specifics of the call and indicated she did not document it anywhere.

On 7/22/20, at 3:03 p.m. the administrator stated R8 was provided with a notice of discharge on 2/24/20, to Meadowlane nursing home in Benson. The ROLTC contacted the administrator sometime after the notice was given and stated R8 did not have an interest in going to Meadowlane and the first appeal had been filed on 3/30/20, followed by a second notice filed on 5/8/20. The administrator stated a hearing never happened due to COVID-19 restrictions and confirmed R8 was currently in the midst of a second appeal when he was discharged on 6/29/20. The administrator stated on 6/23/20, a meeting was held with R8, the facility and ROLTC to discuss concerns with behaviors of leaving the facility for days at a time, going out his window to the courtyard to smoke and lighting up substances in his room. The administrator stated

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| F 622 | Continued From page 24<br>R8 had agreed to follow the rules through conversations with ROLTC.<br><br>Administrator stated on 6/29/20, they were informed of R8's behaviors exhibited over the weekend and could not recall the details of the behaviors. Administrator stated interim DON and former LSW went in to R8's room to discuss behaviors and she was told R8 cursed at them and stated he was done with the facility. Administrator stated she entered R8's room and R8 was in the restroom at the time. When he came back out the administrator attempted to talk to R8 and he declined to discuss the situation further. R8 informed the administrator he would pack his own belongings and would leave the facility. Administrator stated she and NA-B assisted with packing R8's belongings and placed on a cart provided by the facility. Administrator stated while assisting with removing R8's belongings from the dresser, she noted a green leafy substance tied up in a red cloth and R8 informed her it was sage. R8 stated he was leaving repeatedly while the administrator and NA-B continued to pack R8's belongings. Administrator stated former LSW contacted a local shelter and no beds were available and the facility agreed to pay for a two week stay at a local hotel. R8 stated it was better than going to the local shelter and agreed. Administrator stated R8's girlfriend arrived and had wanted to transport R8 and the administrator offered facility transportation and R8 accepted that offer of transportation. Administrator stated LPN-A gave R8 a bag of medications and indicated she was not aware R8 had been on insulin. Administrator stated she was not sure who provided R8 with the AMA form to sign. | F 622 | | |

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| F 622 | Continued From page 25<br>On 7/22/20, at 4:04 p.m. maintenance supervisor (MS) stated he was asked by the administrator and interim DON to transport R8 to the Motel 6 in Fargo ND on 6/29/20. MS stated he stood by in R8's room while facility staff packed his belongings and the administrator approached him in R8's room and asked MS to bring R8's belongings out to the facility van. R8's girlfriend was present and took some of his belongings to her vehicle. MS transported R8 to the Motel 6 hotel in Fargo ND and stated the only thing R8 asked was why was he going to Fargo when he only had ties in Moorhead. MS stated he had repaired R8's window in the past due to R8 going out his window, and stated there had been no further repairs needed at the time of R8's discharge.<br><br>On 7/27/20, at 12:05 p.m. during telephone interview former LSW stated she had been working in the facility until the previous week. She stated she was aware R8 had been actively pursuing relocation assistance to obtain housing, was awaiting results of approval for disability and there were no plans to discharge him prior to 6/29/20. Former LSW confirmed R8 had been in the middle of a discharge appeal and had been informed the facility could not discharge R8 during the appeal process. Former LSW stated she was informed in the IDT meeting on 6/29/20, R8 had exhibited behaviors of taking the key from the nurses station to the activities room and leaving the facility to smoke over the weekend and the interim DON stated R8 needed to be discharged. Former LSW confirmed R8's EHR had lacked documentation of any behaviors R8 exhibited over the previous weekend. Former LSW indicated interim DON stated she had talked to regional clinical consultant (RCC) and the chief | F 622 | | |

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operating officer (COO) of the facility about R8's behavioral concerns and the need to discharge R8 from the facility and they responded the facility "would just take the tag." Interim DON and former LSW went to R8's room where R8 was sleeping in his bed with blankets covering his head and interim DON asked R8 about the smoking behaviors reported over the weekend. Interim DON reminded R8 of the 6/23/20, meeting where it was discussed he would be discharged if he exhibited further behaviors and R8 did not respond. Interim DON stated to R8 he needed to leave, informed him to get his belongings together and stated the facility was discharging R8 from the facility. R8 did not respond as he was still sleeping.

Former LSW stated she had contacted two local homeless shelters and was told there were no openings for beds and she reported this to the interim DON and expressed not feeling comfortable with the plan. Former LSW stated the facility paid for a two week stay at the Motel 6 hotel in Fargo ND. Former LSW stated the administrator and a NA packed up R8's belongings while R8 was seated in his wheelchair facing the door and was not talking. Former LSW stated the administrator and interim DON had R8 sign the AMA form. Former LSW stated MS drove R8 via facility transportation to the hotel and a female acquaintance of R8 arrived at the facility too. Former LSW stated on 6/30/20, she found out the behaviors reported about R8 were actually exhibited by another resident residing in the facility. Former LSW stated the interim DON, administrator and herself wrote the discharge note in R8's EHR on that same day. Former LSW stated she was informed by the administrator she received a telephone call a couple of weeks later

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from staff at the Motel 6 in Fargo ND to request an additional two weeks stay for R8 or R8 would be homeless and the facility denied the request. Former LSW stated she was aware the activities director (AD) received a phone call the previous week from R8, who indicated he was homeless and living under a bridge.

On 7/28/20, at 11:05 a.m. AD stated on 6/29/20, the administrator approached her and asked her to take R8 out for a cigarette. R8 informed AD he was being discharged by the facility, said a curse word about it and indicated he had nowhere else to go. R8 informed AD he had been working on disability and housing assistance with former LSW and they had been trying to find a place to live. AD stated R8 did not say what he had done over the weekend to cause the discharge to happen. R8 stated the interim DON had told him he did not follow the facility rules and as a result he would be discharged. AD stated R8 left the facility via the facility van driven by MS. On 7/21/20, AD stated she received a phone call from R8 and he stated he was homeless, back on drugs and needed to borrow money. AD informed R8 if he was hungry she would buy him some food and asked him where he was. AD bought food and brought it to R8 who was in his wheelchair under a bridge in Moorhead, MN.

On 7/28/20, at 11:13 a.m. NA-B stated on 6/29/20, the administrator asked her to assist her with packing up R8's belongings. NA-B stated while the administrator and herself packed up R8's belongings, R8 was upset, swearing and the administrator informed R8 to stop that behavior.

On 7/28/20, at 11:16 a.m. health unit coordinator (HUC) stated on 6/29/20, she heard discussion

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regarding R8's discharge and about an hour later R8 wheeled himself to the front desk and the administrator met him there. HUC stated R8 asked the administrator where he was going and identified he was homeless and had nowhere to go. Administrator told R8 the facility had paid for a two week stay at a hotel. R8 asked the administrator where he would go after that and the administrator replied he was on a waiting list and HUC was not sure what that meant. R8 asked for a third time where he was going after his two weeks were up and there was no response from the administrator. HUC stated she felt R8 "did not have a clue" he was being discharged and was cussing and swearing at the administrator and he told her she just discharged him. HUC stated the administrator had R8 sign the AMA form and at first R8 would not sign the form and then he said " forget it" and signed the form. HUC stated a couple of weeks later she received a phone call from the Motel 6 staff asking about an extension to keep R8's room and she forwarded the call to the administrator. HUC stated R8 did call up to the facility one day and asked to speak to AD. R8 informed HUC he was homeless, had no money and was thinking about going back on drugs again. HUC stated she had transferred the call to the AD.

On 7/31/20, at 10:09 a.m. the Fargo PD intake specialist (FPDIS) stated the facility had filed a report on 7/30/20, requesting a well check be completed on R8. The FPDIS stated at that time R8 had not been located by the PD.

On 7/31/20, at 10:46 a.m. the Moorhead PD dispatch (MPDD) stated the facility had filed a report on 7/30/20, requesting a well check be completed on R8. The MPDD stated the

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information had been transferred to the Fargo PD since his last known residence had been a hotel room in Fargo, ND.

Review of facility policy titled Resident Leave Against Medical Advice revised 5/15/20, identified an AMA discharge when a resident chooses to leave the facility. The policy indicated the LSW and administrator would be notified of any impending AMA discharges and would meet with the resident to discuss risks and benefits. The policy stated the facility was not to assist with durable medical equipment (DME), transportation or provide the resident with any medications.

The IJ that began on 7/28/20, was removed on 7/31/20, when the facility contacted the Moorhead, MN PD and the Fargo, ND PD to attempt to locate R8. Additionally, the facility developed a plan to accept R8 back as a resident to the facility if R8 decided he wanted to return. The facility provided education to the IDT members about the AMA procedure, transfer discharge policy and leave of absence policy. The facility provided education to licensed staff on the AMA procedure and the leave of absence policy. The noncompliance remained at the lower scope and severity level D.

Governor Tim Walz's Emergency Executive Order(EO) 20-14, signed March 23, 2020, identified beginning no later than March 24, 2020 and continuing for the duration of the peacetime emergency, all residential landlords must cease terminating residential leases during the pendency of the emergency, except where the termination is due to the tenant seriously endangering the safety of other residents. The EO identified restricting evictions was a vital tool

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 622 | Continued From page 30<br>to keep Minnesotans in their homes to mitigate the community spread of COVID-19 in Minnesota and nationwide. The EO indicated any person or household facing eviction would have assistance from the Attorney General to prevent this from happening.<br><br>Governor Tim Walz's Emergency EO 20-78, signed 7/13/20, identified the COVID-19 Peacetime Emergency was extended through 8/12/20. | F 622 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 14, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: 2TUO11

Dear Administrator:

The above facility was surveyed on July 21, 2020 through July 31, 2020 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:

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| MOORHEAD REHABILITATION & HEALTHCARI | 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 7/21/20, to 7/31/20, surveyors of this Department's staff visited the above provider for a complaint investigation and the following correction orders were issued.<br><br>The following complaints were found to be substantiated: | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>H5052119C with licensing order issued at 1925.<br>H5052120C with no licensing order issued.<br>H5052122C with no licensing order issued.<br>H5052125C with licensing order issued at 1805.<br><br>In addition, the following complaints were found to be unsubstantiated:<br>H5052117C<br>H5052118C<br>H5052121C<br>H5052123C<br>H5052124C<br><br>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.<br><br>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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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 | 2 000 | | |

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| 2 000 | Continued From page 2<br>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.<br><br>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. | 2 000 | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and document review, the facility failed to provide services in a respectful manner for 1 of 1 residents (R3) during staff interactions while assisting with cares.<br><br>Finding include:<br><br>R3's quarterly Minimum Data Set (MDS) dated 5/30/20, indicated R3 had diagnoses which included renal insufficiency, diabetes and depression. The MDS indicated R3 had intact cognition and was independent with bed mobility, | 21805 | F- 550<br><br>1. R3 clothing was inspected to be properly labeled and placed in his room and any unlabeled or improperly placed items were removed. R3 care plan reviewed and no adjustments were needed. R3 via interpreter reported feeling safe in the facility. All other residents with communication barriers were reviewed and care plans were updated as needed. | 9/2/20 |

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| 21805 | Continued From page 3<br>transfer, dressing, toilet use and personal hygiene.<br><br>R3's care plan revised on 6/17/20, indicated R3 was at risk for activities of daily living (ADL's) self care needs due to disease process, amputee and impaired balance. R3's care plan indicated R3 was independent with bathing/showering, bed mobility, transfers, dressing, eating and toilet use. Further, the care plan indicated R3 was hispanic, required considerations with communication and required clear explanation of situation and choices for intervention. Further, the care plan indicated R3 had refusals, and directed staff to explain all procedures before starting and allow the resident time to adjust to changes.<br><br>Review of 3's Moorhead Rehabilitation and Healthcare Concern and Problem Resolution Form, indicated on 6/22/20 at 11:45 a.m. R3 stated to nursing assistant (NA)-A he was embarrassed by occupational therapist assistant (OTA). R3 indicated he was in the doorway entrance of his room, when the OTA was walking by and she noticed R3 was wearing a t-shirt that was not his. R3 indicated OTA yanked the t-shirt off him without saying anything. R3 indicated he was very embarrassed and at times she can be rough. NA-A told R3 she would pass it along and apologized to R3. The form indicated a vulnerable adult report was submitted.<br><br>On 7/22/20 at 1:29 p.m. R3 indicated he was sitting in his wheelchair in the doorway of his room looking around, when OTA pulled a t-shirt off of him that was not his. R3 indicated he thought someone had given him the t-shirt and did not know it was not his. R3 indicated OTA did not explain what she was doing and just took the t-shirt off of him. R3 indicated he was | 21805 | 2. All residents have a right to dignity in the facility and have the potential to be affected.<br><br>3. An all staff in-service was conducted 8/6/20 to review the policies on Resident Rights and Dignity along with instruction on how to utilize the language line for interpreter assistance and where this number is located within the facility. The administrative staff will continue to conduct Ambassador rounds to meet regularly with the residents to discuss any concerns including respect/dignity. Resident Council meeting on 8/14/20 went over all Resident Rights with an emphasis on Dignity and Respect. A meeting with all Laundry Staff will be held 8/28/20 to review clothing labeling and distribution routines.<br><br>4. An audit has been developed to monitor completion of Ambassador Rounds with managers to identify any areas of dignity/respect and audits on laundry to ensure resident clothing delivered to the right resident. The audit will be completed weekly times 2 months then monthly to ensure compliance. The results of the audits will be reported to the QAPI committee for future recommendations. The audit will be completed by the Administrator or her designee.<br><br>Compliance: September 2, 2020 | |

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| 21805 | Continued From page 4 | 21805 | | |

embarrassed because there were other residents present in the hallway. R3 indicated after OTA took the t-shirt off of him, she got a shirt out of his closet and told him to put it on. R3 indicated he felt humiliated but he was not hurt or abused. R3 indicated OTA took the shirt off so quick, it kind of scared him at the time and caught him off guard. R3 indicated it happened so quick he did not even have a chance to fight for the t-shirt.

On 7/22/20 at 4:55 p.m. OTA indicated she was walking by R3's room and noticed he had another resident t-shirt on and asked R3 if she could look at the tag. OTA indicated R3 started taking the t-shirt off in the hallway and she got him another t-shirt out of his closet and he put it on in the hallway. OTA indicated she could not remember if other residents were in the hallway or not. OTA indicated she felt R3 understood what she was trying to say to him and what she was doing. OTA indicated she did not speak Spanish and did not use an interpreter to communicate with R3 at the time of the incident and felt it was a miscommunication.

On 7/22/20 at 9:35 a.m. NA-A stated R3's memory was intact and confirmed he had reported to her the next day that he was sitting out in the hallway, when OTA took a t-shirt off of him and did not say anything. NA-A indicated R3 told her he was embarrassed and humiliated after the incident because it caught him off guard and he did not know what she was doing. NA-A indicated R3 told her he put on another t-shirt, went back in his room and stayed in his room after the incident because other residents had seen him. NA-A indicated she apologized to R3, told him she would report the incident to the nurse and the nurse had filed a grievance.

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| 21805 | Continued From page 5<br><br>On 7/22/20 at 9:45 a.m., director of nursing (DON) indicated she was not here at the time of the incident, did not know anything about the incident and could not speak to what happened. The DON indicated she would expect staff to treat the residents with respect and dignity.<br><br>On 7/22/20 at 10:41 a.m. administrator indicated she thought OTA took R3's t-shirt off of him without talking to him. The administrator indicated she felt there was a misunderstanding between the R3 and OTA. The administrator indicated R3 felt rushed and was not able to understand the OTA and this was un-dignified. The administrator indicated she would expect staff to treat the residents with respect and dignity while providing cares. She indicated staff cannot make assumptions and indicated this situation could have been avoided.<br><br>Review of facility policy titled, Dignity Of The Resident reviewed on 4/12/18, indicated all resident will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) dignity are maintained. Audits could be completed, and results of these audits could be reviewed by the quality assessment and performance improvement (QAPI) committee to ensure compliance. | 21805 | | |

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| 21805 | Continued From page 6<br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21805 | | |
| 21925 | MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review the facility failed to allow 1 of 1 residents (R8) who had insulin dependent Diabetes Mellitus reviewed for appropriate discharge to remain in the facility while a discharge appeal was pending. This | 21925 | F- 622<br><br>1. R8 is no longer a resident at the facility. The Moorhead County caseworker and the Moorhead and North | 9/2/20 |

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| 21925 | Continued From page 7 | 21925 | | |

deficient practice resulted in an immediate jeopardy (IJ) situation when R8 was discharged from the facility to a hotel for a two week stay and no housing or community services secured for after the two week hotel stay, subsequently rendering him homeless.

The IJ began on 6/29/20, at 1:00 p.m. when the facility discharged R8 from the facility to a local hotel for a two week stay with no secured housing in place after the two week stay. On 7/28/20, at 3:53 p.m. the administrator and interim director of nursing (DON) were notified of the IJ situation. The facility implemented corrective action and the IJ was removed on 7/31/20, at 12:38 p.m., when the facility made attempts to locate R8 and the majority of the staff had been re-educated and appropriate discharge procedures were in place. The noncompliance remained at the lower scope and severity level D, iolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R8's quarterly Minimum Data Set (MDS) dated 4/7/20, identified R8 was cognitively intact and had diagnoses which included Diabetes Mellitus, left below the knee amputation, viral hepatitis and high blood pressure. The MDS identified R8 did not walk and was independent with most activities of daily living (ADL's) which included transfers, toileting, grooming and bathing tasks. Further, the MDS identified R8 had no behaviors and received seven days of insulin injections during the seven day assessment reference period.

R8's admission Care Area Assessment (CAA) dated 1/18/20, identified R8 had recently been admitted to the facility after surgery for a left

Dakota police departments were contacted on 7/30/20 to conduct a well check for R8. Per MD order, R8 will be considered for readmission to the facility after having been seen in the emergency room and is medically safe and appropriate for readmission to the facility.

2. All residents in the facility with a discharge anticipated back into the community have the potential to be affected.

3. 7.29.20 the IDT and Licensed Nursing Staff were in-serviced on policies Transfer/Discharge, Leave Against Medical Advice and Leave of Absence. Discharge planning for all admitted residents will be conducted with the goal of ensuring a safe discharge for the resident to a community of their choice. All discharges since survey exit were reviewed by the IDT team and are complete.

4. An audit has been developed to monitor the date of anticipated discharge, IDT meeting related to discharge to confirm discharge address, necessary equipment (DME) required, medications, transportation, community services, physician notification with orders and reason for discharge. The audit will be completed daily x 10 days, weekly x 4 weeks then monthly. The results of the audits will be reported to the QAPI committee for future recommendations. The audit will be completed by the

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| 21925 | Continued From page 8<br><br>below the knee amputation and was independent with most ADL's. The CAA indicated R8 was able to make his needs known and was on a consistent carbohydrate controlled diet for his diabetes. The CAA indicated R8 had little interest or pleasures in doing things and the facility had offered mental health services upon admission.<br><br>Review of R8's Self Administration of Medication Assessment form dated 6/17/20, revealed it was not appropriate for R8 to self administer medications.<br><br>R8's care plan, revised 7/14/20, identified R8 was independent with most ADL's including: bed mobility, transfers and eating. The care plan identified R8 had Diabetes Mellitus, received insulin, blood glucose checks and was to be monitored for signs and symptoms for hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). The care plan indicated R8 intermittently refused cares and left the building without notifying staff. The care plan identified R8 did not self administer his own medications and indicated social services would coordinate services necessary for a community discharge.<br><br>Review of R8's progress notes from 2/24/20, to 6/30/20, revealed the following:<br><br>- 2/24/20, late entry, the administrator provided R8 with a 30 day notice of discharge due to his health improving sufficiently, no longer in need of service from the facility and indicated R8 would be discharged to Meadowlane Board and Care home in Benson.<br><br>- 3/9/20, former licensed social worker (LSW) and administrator met with R8 to obtain consent to | 21925 | Administrator or her designee.<br><br>Compliance: September 2, 2020 | |

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send documentation requested by the regional ombudsman for long term care (ROLTC) and former LSW along with R8 contacted Lakes and Prairie Community Action to follow-up on financial/housing assistance.

- 3/11/20, R8 left the facility without notifying staff. Former registered nurse (RN)-A contacted medical doctor (MD) regarding R8's leave.

- 3/12/20, Clay county report completed by former LSW to report R8's leave.

- 3/13/20, phone calls made by facility staff of contacts listed on file with voice mails left. R8's brother stated he had not seen or heard from R8 in two weeks. Moorhead police department (PD) notified too. Later that day at 3:41 p.m., former LSW received a phone call from staff from Lakes and Prairie Community Action Partnership indicating R8 showed up at their office at 2:30 p.m. requesting assistance with housing and stated R8 appeared very ill looking and was extremely difficult to get information from.

- 3/14/20- R8 returned to the facility and was sent to emergency room (ER) for evaluation and refused the evaluation and was returned to the facility.

- 3/17/20, former LSW met with R8 to discuss transfer to Meadowlane and R8 declined the transfer. Other options presented to R8.

- 3/19/20, former LSW assisted R8 with completing MNChoices assessment (application for disability) with Clay County Public Health over the phone.

- 3/25/20, former LSW received message from

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Clay County Public Health R8 was accepted for relocation services. R8 was informed and stated "you put a smile on my face."

- 4/9/20, former LSW stated she received phone call from Opportunity Community Services(company certified to provide relocation service corrdination to individuals with limited income, and abilities to re-establish themselves within the community) and they accepted R8 to assist with relocation services.

- 4/21/20, R8 was seen by nurse practitioner (NP) for hyperglycemia episodes and A1C (the A1C test is a blood test that provides information about average levels of blood glucose over the past three months) noted to be 9.5. Provider ordered an increase in insulin.

(The American Diabetes Association [ADA] guidelines 1/1/20, suggested the following targets for most nonpregnant adults with diabetes. A1C targets differ based on age and health. Also, more or less stringent glycemic goals may be appropriate for each individual: A1C: Less than 7%. A1C may also be reported as eAG: Less than 154 mg/dL Before a meal (preprandial plasma glucose): 80-130 mg/dL. 1-2 hours after beginning of the meal (postprandial plasma glucose): Less than 180 mg/dL)

- 5/5/20, R8 completed phone application for social security disability.

- 5/20/20, seen by NP for evaluation of hyperglycemia and indicated suboptimal control due to diet noncompliance and inability to to titrate insulin due to improper timing of blood glucose monitoring. Orders obtained to repeat A1C tomorrow and to continue with Lantus insulin

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( a long acting form of insulin used to treat Diabetes Mellitus) twice daily and once daily Glipizide (an oral medication used to treat Diabetes Mellitus).

- 5/22/20, A1C results came back at 8.8, NP notified with no new orders obtained.

- 6/4/20, seen by NP, type 2 Diabetes Mellitus with foor ulcer and noted blood glucose improved but continued elevations related to timing of blood glucose monitoring. Diagnosis of major depressive disorder, recurrent, mild and R8 reported increasing depression, however, he declined medications at that time. Plan to repeat A1C in one month, continue with Lantus insulin twice a day and continue with Glipizide daily.

- 6/10/20, NP changed insulin from twice daily to daily and to check A1C next week.

- 6/17/20, staff noted an empty vodka bottle in room and R8 had slurred speech and appeared lethargic. On call MD notified and interim DON notified. NP examined R8 and placed diabetic meds on hold and handed over care to emergency medical services (EMS) staff. R8 was sent to the ER for evaluation and R8's brother notified. R8 returned to the facility after being evaluated with a new diagnosis of dehydration and alcohol intoxication.

- 6/19/20, staff attempted times three to draw blood to check A1C and were unsuccessful.

- 6/20/20, R8 left the facility at 4:26 p.m. and returned to the facility at 6:58 p.m. with alcohol in his possession. Staff removed the alcohol.

- 6/21/20, at 2:10 a.m. R8 was noted to be

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outside in the smoking area outside his designated time. Staff suspected R8 had possession of the keys. At 7:57 a.m. MD notified and had no orders and indicated the facility handle it according to facility protocols.

- 6/23/20, former LSW, administrator, interim DON and ROLTC (via the telephone) met with R8 to discuss behavioral concerns, leaving the facility against medical advice and safety issues. R8 was notified if he left the facility against medical advice or went outside to smoke outside of his designated times he would be discharged from the facility. Discussion continued regarding R8's goal to obtain housing and continue working with relocation services. R8 verbally agreed to follow rules and expectations.

- 6/29/20, late entry at 12:51 p.m. administrator met with R8 to discuss behaviors he continued to have since the 6/22/20, meeting with administrator, interim DON, former LSW and ROLTC. Administrator informed R8 "since he had behaviors after hours and over the weekend the result would be immediate discharge from the facility for failing to agree to the verbal agreement." R8 nodded his head yes and then stated he did not understand. Administrator repeated the "violations of the agreement made the previous week have now resulted in immediate discharge" and R8 stated he would pack his own things. R8 made no attempt to pack his own belongings and staff were asked to assist with packing up belongings. R8 made no attempt to pack up anything until a dresser drawer had been opened and a red cloth item with a red tie wrapped around it was picked up by the administrator and placed into a bag. R8 approached nursing assistant (NA)-B and the administrator and quickly pushed the drawer shut,

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put his hands in the air and cursed at them. The administrator advised R8 one more attempt like that and the police would be contacted. The administrator handed R8 the red bag and R8 continued to argue and become aggressive and extra staff were called in to assist. While packing R8 up and waiting for transport, R8 opted to discharge to the Motel 6 in Fargo, ND, signed the AMA paperwork and stated he would "rather go to a hotel then to a shelter." R8's final items were packed up and he was taken by transport to Motel 6.

- 6/29/20, at 12:57 p.m. interim DON indicated the interdisciplinary team (IDT) team spoke with R8 regarding noted behaviors which occurred over the weekend. R8 was noted to be non responsive and very dismissive during the meeting. The former LSW and interim DON offered R8 the opportunity to elaborate on behaviors in question but R8 remained non verbal only using his body language. "R8 was reminded about previous IDT meeting regarding consequences related to poor behaviors towards staff and other residents"and R8 stated understanding. "Immediate discharge to shelter was discussed with R8 but R8 opted to go AMA to the Motel 6 in Fargo." R8 was noted to be cognitively intact and R8 left the facility with medications and personal belongings via facility transport. Female friend was noted to be present at the time of the AMA.

- 6/29/20, late entry, at 12:59 p.m. former LSW notified R8's relocation agency and Clay County caseworker of AMA discharge.

- 6/29/20, at 15:09 p.m. licensed practical nurse (LPN)-A indicated R8 discharged AMA from the facility at approximately 1:00 p.m.

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| 21925 | Continued From page 14<br><br>- 6/30/20, at 9:23 a.m. Recapitulation of stay note, interim DON indicated R8 required ongoing assist with ADL care, medication administration and blood sugar monitoring. Former LSW continued to work on community resources to assist R8 with housing.<br><br>- 6/30/20, at 2:20 p.m. (greater than 1 day after discharge) LPN-A indicated R8 refused education on medication administration times and R8 stated "he did not need to be told how and when to take his medications." R8 was educated on the risks and benefits of the decision.<br><br>The progress notes lacked documentation of behaviors exhibited by R8 from 6/22/20, to 6/29/20, day of discharge although the administrator indicated R8 had violated the verbal agreement from the previous week.<br><br>Review of MD and NP progress notes from 5/14/20, to 6/24/20, revealed the following:<br><br>- 5/14/20- telemedicine nursing home visit, NP identified R8 had uncontrolled type 2 Diabetes Mellitus with hyperglycemia and last A1C was 9.4. R8 received Lantus insulin and Glipizide and blood glucose monitoring was ordered for four times a day.<br><br>- 5/27/20, telemedicine nursing home visit, MD indicated R8 had uncontrolled Diabetes Mellitus type 2. Plan to continue present care.<br><br>- 6/17/20, ER visit indicated R8 had alcohol intoxication with a blood alcohol level of .212 and low blood pressure. R8 was kept in the ER for an extended period of time and given intravenous (IV) fluids and sent back to the facility. | 21925 | | |

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- 6/24/20, telemedicine nursing home visit, MD indicated R8's A1C was 8.8 on 5/22/20 and R8 had uncontrolled Diabetes Mellitus and no changes were made.

Review of R8's laboratory test A1C, from 2/28/20, to 6/29/20, revealed the following:

- 2/28/20, R8's A1C was 6.9.

- 4/21/20, R8's A1C was 9.5.

- 5/22/20, R8's A1C was 8.8.

No further A1C labs were found in R8's record after 5/22/20.

Review of R8's unsigned Physician Orders, identified by facility as R8's current orders, included Lantus SoloStar Solution Pen-injector Insulin 10 units (a unit of measurement in insulin administration 100 units per milliliter [ml]) subcutaneously (tissue layer between the skin and muscle) daily in the morning for Diabetes Mellitus.

Review of R8's Medication Administration Record (MAR) dated 6/1/20, to 6/29/20, revealed the following:

-blood glucose checks ordered four times a day and was last checked on 6/29/20, at 8:00 a.m. with the results of 197

-blood glucose results ranged from 66-463

- R8 did not have his blood glucose checked 39 times due to various reasons ranging from R8's refusal or absence from the facility.

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- R8 received Glypizide 5 mg. (milligrams) daily and last received it on 6/29/20, at 8:00 a.m.

- R8 received Lantus SoloStar Solution Pen-injector insulin 10 units subcutaneously daily in the morning for Diabetes Mellitus and last received on 6/29/20, at 8:00 a.m.

R8's Notice of Discharge dated 2/24/20, identified R8's health had improved sufficiently and R8 no longer needed the services of the facility and R8 would be discharged to another facility on 3/24/20.

R8's Continuance Order related to involuntary discharge and transfer dated 3/30/20, was provided to the facility on 3/30/20. The order identified a hearing had been scheduled for 4/7/20, to determine if the facility could lawfully discharge R8.

R8's second Continuance Order related to involuntary discharge transfer dated 5/5/20, was provided to the facility on 5/8/20. The order identified another continuance of the matter in order to prepare for an appropriate transfer to another facility. The order identified if the parties had not resolved the matter by 8/5/20, the matter would be placed back on the judge's docket for hearing.

R8's Release of Responsibility for Discharge against Medical Advice (AMA) form with illegible date, identified by the director of nursing as 6/29/20, signed by the resident indicated R8 had been informed of the risks and consequences of leaving the facility AMA.

R8's Transfer/ Discharge notice dated 6/30/20, identified the facility discharged R8 on 6/29/20,

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| 21925 | Continued From page 17<br>due to AMA discharge.<br><br>Review of R8's Social Services Care Conference Summary form dated 6/2/20, revealed R8's mood/behaviors showed improvement and indicated recommendations for discharge had been made on several occasions.<br><br>Review of R8's Social Services Discharge Summary form dated 6/29/20, signed on 6/30/20, by the interim DON, revealed R8 discharged AMA, required ongoing assistance with ADL's, medication administration and blood sugar monitoring. The form indicated the former LSW continued to work on community resources to assist R8 with obtaining housing.<br><br>On 7/21/20, at 10:15 a.m. LPN-B stated she reported to work on 6/29/20, and had been informed by other facility staff the administrator and DON had R8 sign the AMA form and discharged R8 from the facility. LPN-B was informed R8 had been brought to a local hotel to stay for a couple of weeks. LPN-B stated she had worked the previous weekend and R8 had exhibited no behaviors and expressed excitement over the potential to be fitted for a prosthesis and the goal of obtaining housing.<br><br>On 7/21/20, at 2:00 p.m. via telephone interview family member (FM) stated he received a telephone call from R8 a day or two after his discharge from the facility and stated he had been "kicked out" of the facility. R8 said he had a two week hotel stay and did not say where he would be staying after the hotel stay. FM stated he did not know where R8 currently was living or if he had housing.<br><br>On 7/21/20, at 3:06 p.m. former RN-A stated she | 21925 | | |

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had worked in the facility until approximatley the past couple of weeks prior. She stated she was aware R8 had behaviors in the past of leaving against facility policy and confirmed he had no behaviors since the facility met with him and informed him if he did not follow the rules he would be discharged. Former RN-A stated on 6/29/20, the administrator, interim DON and MDS Coordinator informed her R8 had left the facility on an unapproved leave over the weekend. Former RN-A reviewed R8's electronic health record (EHR) and confirmed the documentation lacked any leaves or behaviors for R8 occurring over the weekend. Former RN-A contacted staff over the telephone who had worked the previous weekend and confirmed R8 had not left the facility over the previous weekend and in fact it was another resident who did. Former RN-A entered R8's room where the administrator was packing R8's belongings and informed her R8 did not break the rules. Former RN-A stated she also notified interim DON R8 did not break the rules and R8 was still discharged. Former RN-A informed the interim DON R8 was on insulin, had not been administering his own insulin and interim DON stated R8 should be fine and should know what he was doing. Former RN-A stated the facility had set up a two week hotel stay for R8 and did not know where he went to after that. Former RN-A stated R8 did not initiate the discharge and had planned on being discharged in the future, when housing had been secured for him.

On 7/21/20, at 3:50 p.m. during a telephone interview with the Motel 6 front desk staff (FDS) she indicated R8 had stayed at the hotel for a couple of weeks and had left the hotel. The FDS stated a man who she thought was his son picked him up and she was not certain where he went to

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from there.

On 7/22/20, at 11:55 a.m. during an telephone interview with the ROLTC, she indicated she had been involved with R1's discharge planning meetings with the facility. She confirmed she had assisted R8 to file a first and second appeal to his notice of discharge provided on 2/24/20. R8 stated he was happy the facility was required to keep him during the appeal process and stated he voiced he had hope for the first time in his life. ROLTC indicated R8 had been actively working on relocation services with a relocation specialist to obtain housing.

ROLTC indicated she had received a telephone call from the administrator on 6/22/20, who stated R8 had recently left the facility for a funeral and the facility questioned if he had followed the facility's COVID 19 precautions while he was at the funeral. The administrator stated because of the possible breach in COVID 19 precautions, the facility felt he needed to be discharged from the facility AMA. At that time, ROLTC contacted R8 via telephone and reviewed the facility concerns. R8 stated he wanted to leave the facility, but because there was a plan in place for long term housing after discharge, he did not want to jeopardize that plan. He stated he would follow the facility rules and not leave the facility.

ROLTC stated also that day the facility held a meeting with R8 and facility staff and reviewed the facility rules regarding resident leave of absences from the facility. R8 again stated he would follow the rules and did not want to jeopardize his long term housing plans. R8 stated "it is black and white" and " I will follow the rules." ROLTC stated she had contacted the interim DON and LSW on 6/26/20, and was told that R8

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was doing much better, had struggled with quarantine but was redirectable.

ROLTC stated on 7/6/20, she had been made aware R8 had been discharged from the facility and she began calling and emailing the administrator on 7/6/20, 7/7/20, and did not receive a call back from the administrator until 7/8/20.
ROLTC stated she had been told by the administrator that R8 had informed them he was leaving the facility AMA on 6/29/20. The administrator stated because there were no openings at the homeless shelter, he went to a local hotel. ROLTC stated she had asked the administrator to clarify how this was an AMA discharge when the facility had packed up his belongings, and drove him to a hotel in another state in the midst of a discharge appeal. She stated the administrator was unable to explain R8's discharge and offered no further information. ROLTC informed the administrator she needed a copy of the AMA form and indicated she would be forwarding it to an appeal judge.

On 7/22/20, at 12:41 p.m. LPN-A stated on 6/29/20, when he arrived at the facility that morning there had been nothing reported to him about plans to discharge R8. LPN-A stated he was informed later in the morning by the former LSW R8 was being discharged and to give R8 his medications. LPN-A stated R8 appeared agitated,angry and was cursing after learning he was being discharged. LPN-A stated he talked to R8 and he did not know why he was being discharged. LPN-A offered medication education to R8 and he refused. LPN-A stated he was told the facility provided lodging and transportation for R8 to a local hotel. LPN-A stated R8 received routine insulin and confirmed R8 did not

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| 21925 | Continued From page 21<br>administer his own insulin.<br><br>On 7/22/20, at 1:37 p.m. interim DON stated the facility and ROLTC met with R8 on 6/23/20, to inform him if the behaviors of leaving the facility, smoking outside of designated times and alcohol intoxication continued he would be discharged from the facility. Interim DON stated R8 agreed to follow the rules of the facility. Interim DON stated on 6/29/20, the facility was made aware of R8 not following the facility rules over the weekend, she and former LSW met with R8 to discuss his behaviors and reminded R8 the facility had talked to him prior to this time of immediate discharge if behaviors continued. R8 responded by saying he did not care and he wanted to leave the facility and did not provide any other verbal communication about the behaviors. Interim DON stated the option of R8 going to a local homeless shelter was discussed and again R8 stated he did not care. The facility contacted the local homeless shelter and there were no beds available and only had chairs open. Interim DON stated the facility was not comfortable with that option and paid for a two week hotel stay for R8. R8 contacted a female friend to pick him up and she was at the facility when R8 left the facility. Interim DON confirmed there were no behaviors of R8 leaving the facility, smoking outside of designated times or alcohol intoxication in the progress notes documented since the meeting on 6/23/20. Interim DON stated she was unsure, but either she or the administrator had R8 sign the AMA paperwork and she could not recall which one. Interim DON stated she had not been informed of R8 being on insulin and stated R8 must have been able to administer it since he went on leaves prior to the 6/29/20, discharge. Interim DON stated R8 was given his medications and refused the education offered by LPN-A. | 21925 | | |

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| 21925 | Continued From page 22<br><br>Interim DON stated the administrator met with R8 in his room after her and former LSW left R8's room.<br><br>On 7/22/20, at 2:29 p.m. MDS Coordinator (MDSC) stated she took call over the weekend prior to 6/29/20, and stated she had received a telephone call about R8 going outside unsupervised. MDSC stated she could not recall the specifics of the call and indicated she did not document it anywhere.<br><br>On 7/22/20, at 3:03 p.m. the administrator stated R8 was provided with a notice of discharge on 2/24/20, to Meadowlane nursing home in Benson. The ROLTC contacted the administrator sometime after the notice was given and stated R8 did not have an interest in going to Meadowlane and the first appeal had been filed on 3/30/20, followed by a second notice filed on 5/8/20. The administrator stated a hearing never happened due to COVID-19 restrictions and confirmed R8 was currently in the midst of a second appeal when he was discharged on 6/29/20. The administrator stated on 6/23/20, a meeting was held with R8, the facility and ROLTC to discuss concerns with behaviors of leaving the facility for days at a time, going out his window to the courtyard to smoke and lighting up substances in his room. The administrator stated R8 had agreed to follow the rules through conversations with ROLTC.<br><br>Administrator stated on 6/29/20, they were informed of R8's behaviors exhibited over the weekend and could not recall the details of the behaviors. Administrator stated interim DON and former LSW went in to R8's room to discuss behaviors and she was told R8 cursed at them and stated he was done with the facility. | 21925 | | |

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Administrator stated she entered R8's room and R8 was in the restroom at the time. When he came back out the administrator attempted to talk to R8 and he declined to discuss the situation further. R8 informed the administrator he would pack his own belongings and would leave the facility. Administrator stated she and NA-B assisted with packing R8's belongings and placed on a cart provided by the facility. Administrator stated while assisting with removing R8's belongings from the dresser, she noted a green leafy substance tied up in a red cloth and R8 informed her it was sage. R8 stated he was leaving repeatedly while the administrator and NA-B continued to pack R8's belongings. Administrator stated former LSW contacted a local shelter and no beds were available and the facility agreed to pay for a two week stay at a local hotel. R8 stated it was better than going to the local shelter and agreed. Administrator stated R8's girlfriend arrived and had wanted to transport R8 and the administrator offered facility transportation and R8 accepted that offer of transportation. Administrator stated LPN-A gave R8 a bag of medications and indicated she was not aware R8 had been on insulin. Administrator stated she was not sure who provided R8 with the AMA form to sign.

On 7/22/20, at 4:04 p.m. maintenance supervisor (MS) stated he was asked by the administrator and interim DON to transport R8 to the Motel 6 in Fargo ND on 6/29/20. MS stated he stood by in R8's room while facility staff packed his belongings and the administrator approached him in R8's room and asked MS to bring R8's belongings out to the facility van. R8's girlfriend was present and took some of his belongings to her vehicle. MS transported R8 to the Motel 6 hotel in Fargo ND and stated the only thing R8

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asked was why was he going to Fargo when he only had ties in Moorhead. MS stated he had repaired R8's window in the past due to R8 going out his window, and stated there had been no further repairs needed at the time of R8's discharge.

On 7/27/20, at 12:05 p.m. during telephone interview former LSW stated she had been working in the facility until the previous week. She stated she was aware R8 had been actively pursuing relocation assistance to obtain housing, was awaiting results of approval for disability and there were no plans to discharge him prior to 6/29/20. Former LSW confirmed R8 had been in the middle of a discharge appeal and had been informed the facility could not discharge R8 during the appeal process. Former LSW stated she was informed in the IDT meeting on 6/29/20, R8 had exhibited behaviors of taking the key from the nurses station to the activities room and leaving the facility to smoke over the weekend and the interim DON stated R8 needed to be discharged. Former LSW confirmed R8's EHR had lacked documentation of any behaviors R8 exhibited over the previous weekend. Former LSW indicated interim DON stated she had talked to regional clinical consultant (RCC) and the chief operating officer (COO) of the facility about R8's behavioral concerns and the need to discharge R8 from the facility and they responded the facility "would just take the tag." Interim DON and former LSW went to R8's room where R8 was sleeping in his bed with blankets covering his head and interim DON asked R8 about the smoking behaviors reported over the weekend. Interim DON reminded R8 of the 6/23/20, meeting where it was discussed he would be discharged if he exhibited further behaviors and R8 did not respond. Interim DON stated to R8 he needed to

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leave, informed him to get his belongings together and stated the facility was discharging R8 from the facility. R8 did not respond as he was still sleeping.

Former LSW stated she had contacted two local homeless shelters and was told there were no openings for beds and she reported this to the interim DON and expressed not feeling comfortable with the plan. Former LSW stated the facility paid for a two week stay at the Motel 6 hotel in Fargo ND. Former LSW stated the administrator and a NA packed up R8's belongings while R8 was seated in his wheelchair facing the door and was not talking. Former LSW stated the administrator and interim DON had R8 sign the AMA form. Former LSW stated MS drove R8 via facility transportation to the hotel and a female acquaintance of R8 arrived at the facility too. Former LSW stated on 6/30/20, she found out the behaviors reported about R8 were actually exhibited by another resident residing in the facility. Former LSW stated the interim DON, administrator and herself wrote the discharge note in R8's EHR on that same day. Former LSW stated she was informed by the administrator she received a telephone call a couple of weeks later from staff at the Motel 6 in Fargo ND to request an additional two weeks stay for R8 or R8 would be homeless and the facility denied the request. Former LSW stated she was aware the activities director (AD) received a phone call the previous week from R8, who indicated he was homeless and living under a bridge.

On 7/28/20, at 11:05 a.m. AD stated on 6/29/20, the administrator approached her and asked her to take R8 out for a cigarette. R8 informed AD he was being discharged by the facility, said a curse word about it and indicated he had nowhere else

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to go. R8 informed AD he had been working on disability and housing assistance with former LSW and they had been trying to find a place to live. AD stated R8 did not say what he had done over the weekend to cause the discharge to happen. R8 stated the interim DON had told him he did not follow the facility rules and as a result he would be discharged. AD stated R8 left the facility via the facility van driven by MS. On 7/21/20, AD stated she received a phone call from R8 and he stated he was homeless, back on drugs and needed to borrow money. AD informed R8 if he was hungry she would buy him some food and asked him where he was. AD bought food and brought it to R8 who was in his wheelchair under a bridge in Moorhead, MN.

On 7/28/20, at 11:13 a.m. NA-B stated on 6/29/20, the administrator asked her to assist her with packing up R8's belongings. NA-B stated while the administrator and herself packed up R8's belongings, R8 was upset, swearing and the administrator informed R8 to stop that behavior.

On 7/28/20, at 11:16 a.m. health unit coordinator (HUC) stated on 6/29/20, she heard discussion regarding R8's discharge and about an hour later R8 wheeled himself to the front desk and the administrator met him there. HUC stated R8 asked the administrator where he was going and identified he was homeless and had nowhere to go. Administrator told R8 the facility had paid for a two week stay at a hotel. R8 asked the administrator where he would go after that and the administrator replied he was on a waiting list and HUC was not sure what that meant. R8 asked for a third time where he was going after his two weeks were up and there was no response from the administrator. HUC stated she felt R8 "did not have a clue" he was being

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discharged and was cussing and swearing at the administrator and he told her she just discharged him. HUC stated the administrator had R8 sign the AMA form and at first R8 would not sign the form and then he said " forget it" and signed the form. HUC stated a couple of weeks later she received a phone call from the Motel 6 staff asking about an extension to keep R8's room and she forwarded the call to the administrator. HUC stated R8 did call up to the facility one day and asked to speak to AD. R8 informed HUC he was homeless, had no money and was thinking about going back on drugs again. HUC stated she had transferred the call to the AD.

On 7/31/20, at 10:09 a.m. the Fargo PD intake specialist (FPDIS) stated the facility had filed a report on 7/30/20, requesting a well check be completed on R8. The FPDIS stated at that time R8 had not been located by the PD.

On 7/31/20, at 10:46 a.m. the Moorhead PD dispatch (MPDD) stated the facility had filed a report on 7/30/20, requesting a well check be completed on R8. The MPDD stated the information had been transferred to the Fargo PD since his last known residence had been a hotel room in Fargo, ND.

Review of facility policy titled Resident Leave Against Medical Advice revised 5/15/20, identified an AMA discharge when a resident chooses to leave the facility. The policy indicated the LSW and administrator would be notified of any impending AMA discharges and would meet with the resident to discuss risks and benefits. The policy stated the facility was not to assist with durable medical equipment (DME), transportation or provide the resident with any medications.

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The IJ that began on 7/28/20, was removed on 7/31/20, when the facility contacted the Moorhead, MN PD and the Fargo, ND PD to attempt to locate R8. Additionally, the facility developed a plan to accept R8 back as a resident to the facility if R8 decided he wanted to return. The facility provided education to the IDT members about the AMA procedure, transfer discharge policy and leave of absence policy. The facility provided education to licensed staff on the AMA procedure and the leave of absence policy. The noncompliance remained at the lower scope and severity level D.

Governor Tim Walz's Emergency Executive Order(EO) 20-14, signed March 23, 2020, identified beginning no later than March 24, 2020 and continuing for the duration of the peacetime emergency, all residential landlords must cease terminating residential leases during the pendency of the emergency, except where the termination is due to the tenant seriously endangering the safety of other residents. The EO identified restricting evictions was a vital tool to keep Minnesotans in their homes to mitigate the community spread of COVID-19 in Minnesota and nationwide. The EO indicated any person or household facing eviction would have assistance from the Attorney General to prevent this from happening.

Governor Tim Walz's Emergency EO 20-78, signed 7/13/20, identified the COVID-19 Peacetime Emergency was extended through 8/12/20.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and

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