

Protecting, Maintaining and Improving the Health of All Minnesotans

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.

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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

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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 Moorhead Rehabilitation & Healthcare Center August 18, 2020 Page 4 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

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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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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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

DEPART	IMENT OF HEALTH	AND HUMAN SERVICES			1	FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	Сом	E SURVEY PLETED
		245052	B. WING				C
	PROVIDER OR SUPPLIER	245052			TREET ADDRESS, CITY, STATE, ZIP CODE	077	31/2020
					810 SECOND AVENUE NORTH		
	-	N & HEALTHCARE CENTER			IOORHEAD, MN 56560		
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F 000	INITIAL COMMEN	ſS	F 0	00			
	was completed at y complaint investiga NOT to be in comp	1/20, an abbreviated survey our facility to conduct a tion. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.					
	to resident health a on 7/28/20, when th discharged R8 from homeless. On 7/28 administrator, and i (DON) were notified	d in an immediate jeopardy (IJ) nd safety. An IJ at F622 began he facility involuntarily in the facility and rendering him /20, at 3:53 p.m. the nterim director of nursing d of the IJ situation. The facility diacy on 7/31/20 at 12:38 p.m.					
	Complaint H50521 [°] F622.	19C was substantiated at					
	Additionally, the foll be substantiated: H5052125C at F55	lowing complaint was found to 0.					
	The following comp substantiated with r H5052120C H5052122C	plaints were found to be no deficiencies cited:					
	Additionally, the foll to be unsubstantiat H5052117C H5052118C H5052121C H5052123C H5052124C	lowing complaints were found ed:					
		f correction (POC) will serve f compliance upon the					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						08/28/2020

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

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	Department's acce enrolled in ePOC, y at the bottom of the form. Your electron be used as verifica receipt of an accep on-site revisit of yo validate that substa	ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance. Upon table electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with					
F 550 SS=D	Resident Rights/Ex		F 55	50		9/2/20	
	self-determination, access to persons	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
	with respect and di resident in a mann promotes maintena her quality of life, re	cility must treat each resident gnity and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's acility must protect and of the resident.					
	access to quality ca severity of condition must establish and practices regarding provision of service	facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source.					
	§483.10(b) Exercis The resident has th	e of Rights. ne right to exercise his or her					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 09/15/2020 / APPROVED). 0938-0391
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F 550	or resident of the Un §483.10(b)(1) The f resident can exercise interference, coerci- from the facility. §483.10(b)(2) The r free of interference, reprisal from the fac- rights and to be sup exercise of his or he subpart. This REQUIREMEN by: Based on interview facility failed to prov- manner for 1 of 1 re- interactions while as Finding include: R3's quarterly Minin 5/30/20, indicated F included renal insuf depression. The ME cognition and was in transfer, dressing, t hygiene. R3's care plan revise was at risk for active care needs due to co impaired balance. F was independent wi mobility, transfers, or	of the facility and as a citizen nited States. acility must ensure that the se his or her rights without on, discrimination, or reprisal resident has the right to be coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this IT is not met as evidenced r, and document review, the ride services in a respectful esidents (R3) during staff	F	550	 F- 550 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. 2. All residents have a right to dignity in the facility and have the potential to be affected. 3. An all staff in-service was conducted 	

Facility ID: 00938

If continuation sheet Page 3 of 31

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
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		N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
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F 550	required clear explachoices for interver indicated R3 had re explain all procedu the resident time to Review of 3's Moor Healthcare Concer Form, indicated on stated to nursing as embarrassed by oc (OTA). R3 indicated entrance of his roo by and she noticed was not his. R3 indi off him without say was very embarrass rough. NA-A told R apologized to R3. T adult report was su On 7/22/20 at 1:29 sitting in his wheeld room looking arour off of him that was thought someone h did not know it was not explain what sh t-shirt off of him. R2 embarrassed beca present in the hallw took the t-shirt off of closet and told him felt humiliated but h	anation of situation and htion. Further, the care plan efusals, and directed staff to res before starting and allow o adjust to changes. Thead Rehabilitation and n and Problem Resolution 6/22/20 at 11:45 a.m. R3 ssistant (NA)-A he was ccupational therapist assistant d he was in the doorway m, when the OTA was walking R3 was wearing a t-shirt that licated OTA yanked the t-shirt ing anything. R3 indicated he sed and at times she can be 3 she would pass it along and The form indicated a vulnerable bmitted. p.m. R3 indicated he was chair in the doorway of his nd, when OTA pulled a t-shirt not his. R3 indicated he had given him the t-shirt and not his. R3 indicated OTA did ne was doing and just took the	F 55	 Rights and Dignity along with on how to utilize the language interpreter assistance and we number is located within the administrative staff will contil conduct Ambassador rounds regularly with the residents to concerns including respect/or Resident Council meeting or over all Resident Rights with on Dignity and Respect. An all Laundry Staff will be held review clothing labeling and routines. An audit has been deversion of Ambaa Rounds with managers to idareas of dignity/respect and laundry to ensure resident of delivered to the right resident will be completed weekly tim then monthly to ensure compresults of the audits will be recommendations. The audit completed by the Administrational designee. Compliance: September 2, 2 	e line for here this facility. The nue to s to meet o discuss any lignity. n 8/14/20 went an emphasis neeting with 8/28/20 to distribution eloped to ssador entify any audits on othing t. The audit es 2 months bliance. The eported to the t will be tor or her	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
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Or wa an co tak hir on rer or shi do an wit a r Or me rep ou hir toli the inco we aft se toli nu Or (D the inco Th the Or Shi do an wit a r Or Shi do an wit a r Or Shi do an V Or Shi do an V Shi toli Shi Shi Shi Shi Shi Shi Shi Shi Shi Sh	alking by R3's roc nother resident t-s build look at the tag king the t-shirt off m another t-shirt of m another t-shirt of the start of the r m another the time of m another the time of the tim the hallway, we m and did not say the incident becaus a did not know what dicated R3 told he ent back in his roc ter the incident be ent back in his roc ter the incident be and the nurse m 7/22/20 at 9:45 at ON) indicated she e incident, did not cident and could m m and could r m and another the time of 7/22/20 at 10:41	p.m. OTA indicated she was om and noticed he had hirt on and asked R3 if she g. OTA indicated R3 started in the hallway and she got out of his closet and he put it ITA indicated she could not esidents were in the hallway ed she felt R3 understood what ay to him and what she was d she did not speak Spanish interpreter to communicate of the incident and felt it was	F 5	550				

Facility ID: 00938

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	the R3 and OTA. The felt rushed and was OTA and this was up indicated she would residents with response cares. She indicate assumptions and in have been avoided Review of facility por Resident reviewed	blicy titled, Dignity Of The on 4/12/18, indicated all				
	environment that m	arge Requirements	F 622			9/2/20
	remain in the facility discharge the resid (A) The transfer or resident's welfare a cannot be met in th (B) The transfer or because the reside sufficiently so the re- services provided b (C) The safety of in endangered due to status of the reside (D) The health of in otherwise be endar	ity requirements- permit each resident to y, and not transfer or ent from the facility unless- discharge is necessary for the ind the resident's needs e facility; discharge is appropriate nt's health has improved esident no longer needs the by the facility; dividuals in the facility is the clinical or behavioral nt; idividuals in the facility would				

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
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F 622	appropriate notice, under Medicare or I Nonpayment applie submit the necessa payment or after the Medicare or Medica resident refuses to resident who becon admission to a facil resident only allowa or (F) The facility ceas (ii) The facility ceas (ii) The facility may resident while the a § 431.230 of this ch exercises his or her discharge notice fro 431.220(a)(3) of this discharge or transfe or safety of the resi facility. The facility that failure to transf §483.15(c)(2) Docu When the facility tra- resident under any in paragraphs (c)(1) section, the facility tra- resident under and communicated to the institution or provide (i) Documentation in must include: (A) The basis for th (i) of this section. (B) In the case of para	to pay for (or to have paid Medicaid) a stay at the facility. si fi the resident does not ary paperwork for third party e third party, including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid; set to operate. not transfer or discharge the uppeal is pending, pursuant to napter, when a resident r right to appeal a transfer or om the facility pursuant to § s chapter, unless the failure to er would endanger the health dent or other individuals in the must document the danger fer or discharge would pose. umentation. ansfers or discharges a of the circumstances specified)(i)(A) through (F) of this must ensure that the transfer umented in the resident's appropriate information is ne receiving health care	F 62	22			

If continuation sheet Page 7 of 31

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		. 0938-039 E SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:		NG	· · ·	IPLETED	
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F 622	Continued From pa	ige 7	F 62	22			
		mpts to meet the resident					
	needs, and the service available at the receiving						
	facility to meet the i	need(s). tion required by paragraph (c)					
	(2)(i) of this section	must be made by-					
		physician when transfer or					
	(A) or (B) of this se	sary under paragraph (c) (1)					
		en transfer or discharge is					
	necessary under pa	aragraph (c)(1)(i)(C) or (D) of					
	this section.	vided to the receiving provider					
		vided to the receiving provider imum of the following:					
	(A) Contact informa	ation of the practitioner					
		care of the resident.					
	contact information	sentative information including					
	(C) Advance Direct						
		uctions or precautions for					
	ongoing care, as ap (E) Comprehensive						
		sary information, including a					
	copy of the residen	t's discharge summary,					
		3.21(c)(2) as applicable, and tation, as applicable, to ensure					
	a safe and effective						
		NT is not met as evidenced					
	by:	·		F 600			
		v and document review the w 1 of 1 residents (R8) who		F- 622			
	had insulin depende	ent Diabetes Mellitus reviewed		1. R8 is no longer a resid			
		harge to remain in the facility		facility. The Moorhead Cou			
		ppeal was pending. This esulted in an immediate		caseworker and the Moorhe Dakota police departments			
		on when R8 was discharged		contacted on 7/30/20 to con			
	from the facility to a	a hotel for a two week stay and		check for R8. Per MD orde			
		munity services secured for hotel stay, subsequently		considered for readmission after having been seen in th			

Facility ID: 00938

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		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ´			(X3) DATE SURVEY COMPLETED		
		245052	B. WING			C 07/31/2020		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		01/2020	
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 622	Continued From pa	ge 8	F6	622				
		20/00 at 1:00 a va what the			appropriate for readmission to the	facility.		
	facility discharged F hotel for a two week in place after the tw 3:53 p.m. the admin nursing (DON) were The facility implement IJ was removed on the facility made att majority of the staff appropriate dischar The noncompliance and severity level D potential for more the immediate jeopardy Findings include: R8's quarterly Minin 4/7/20, identified R8 had diagnoses while left below the knee high blood pressure	29/20, at 1:00 p.m. when the R8 from the facility to a local k stay with no secured housing to week stay. On 7/28/20, at histrator and interim director of e notified of the IJ situation. ented corrective action and the 7/31/20, at 12:38 p.m., when tempts to locate R8 and the had been re-educated and ge procedures were in place. e remained at the lower scope 0, iolated, no actual harm with han minimal harm that is not to mum Data Set (MDS) dated 8 was cognitively intact and ch included Diabetes Mellitus, amputation, viral hepatitis and e. The MDS identified R8 did independent with most activities			 All residents in the facility with discharge anticipated back into the community have the potential to be affected. 7.29.20 the IDT and Licensed Nursing Staff were in-serviced on p Resident Transfer/Discharge, Leav Against Medical Advice and Leave Absence. No policy changes were warranted. IDT team was in-serviced discharge planning to begin at adm and include: resident social suppor educational needs, any clinical sup that will be needed with the goal of ensuring a safe discharge for the residents to a community of their cl All discharges since survey exit we reviewed by the IDT team and are complete. 	oolicies re of ed on iission t, port hoice.		
	of daily living (ADL' toileting, grooming MDS identified R8 I seven days of insul day assessment re R8's admission Can dated 1/18/20, iden admitted to the faci below the knee am with most ADL's. Th to make his needs consistent carbohyd	living (ADL's) which included transfers, , grooming and bathing tasks. Further, th entified R8 had no behaviors and receive ays of insulin injections during the seven essment reference period. Mission Care Area Assessment (CAA) (18/20, identified R8 had recently been d to the facility after surgery for a left he knee amputation and was independer st ADL's. The CAA indicated R8 was able his needs known and was on a ent carbohydrate controlled diet for his s. The CAA indicated R8 had little interest			4. An audit has been developed monitor the date of anticipated disc IDT meeting related to discharge to confirm discharge address, necess equipment (DME) required, medica transportation, community services physician notification with orders an reason for discharge. The audit wi completed daily x 10 days, weekly weeks then monthly. The results of audits will be reported to the QAPI committee for future recommendat The audit will be completed by the Administrator or her designee.	charge, b ary ations, s, nd II be x 4 f the		

Facility ID: 00938

		AND HUMAN SERVICES				FORM	09/15/2020 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	COM	E SURVEY PLETED
		245052	B. WING				C 31/2020
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	Continued From pa	age 9	F 6	22			
	or pleasures in doi	ng things and the facility had Ith services upon admission.	10		Compliance: September 2, 2020		
	Assessment form of	f Administration of Medication dated 6/17/20, revealed it was R8 to self administer					
	independent with m mobility, transfers a identified R8 had D insulin, blood gluco monitored for signs hyperglycemia (hig hypoglycemia (low indicated R8 interm the building without identified R8 did no medications and in	ised 7/14/20, identified R8 was nost ADL's including: bed and eating. The care plan biabetes Mellitus, received se checks and was to be and symptoms for h blood sugar) and blood sugar). The care plan hittently refused cares and left t notifying staff. The care plan ot self administer his own dicated social services would a necessary for a community					
	Review of R8's pro 6/30/20, revealed t	gress notes from 2/24/20, to he following:					
	R8 with a 30 day no health improving su service from the fa	y, the administrator provided otice of discharge due to his ufficiently, no longer in need of cility and indicated R8 would leadowlane Board and Care					
	administrator met v send documentatio ombudsman for lor former LSW along	ensed social worker (LSW) and with R8 to obtain consent to on requested by the regional ng term care (ROLTC) and with R8 contacted Lakes and Action to follow-up on					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245052	B. WING _				C 31/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH		N & HEALTHCARE CENTER		28	310 SECOND AVENUE NORTH		
		a nearmoare center		Μ	OORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	financial/housing as	-	F 62	22			
	Former registered r	nurse (RN)-A contacted) regarding R8's leave.					
	- 3/12/20, Clay cour LSW to report R8's	nty report completed by former leave.					
	contacts listed on fi brother stated he has in two weeks. Moor notified too. Later th LSW received a phy and Prairie Commu indicating R8 showe p.m. requesting ass stated R8 appeared	Ils made by facility staff of le with voice mails left. R8's ad not seen or heard from R8 head police department (PD) nat day at 3:41 p.m., former one call from staff from Lakes nity Action Partnership ed up at their office at 2:30 sistance with housing and a very ill looking and was o get information from.					
	to emergency room	ed to the facility and was sent (ER) for evaluation and ion and was returned to the					
	transfer to Meadow	SW met with R8 to discuss lane and R8 declined the ons presented to R8.					
	completing MNCho	SW assisted R8 with ices assessment (application lay County Public Health over					
	Clay County Public	SW received message from Health R8 was accepted for R8 was informed and stated my face."					

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		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	1 · ·				IPLETED
							С
		245052	B. WING			07/	31/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HEALTHCARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETION DATE
F 622	Continued From pa	ge 11	F 6	622			
	- 1/9/20 former 1 91	W stated she received phone					
	call from Opportuni						
		certified to provide relocation					
		to individuals with limited s to re-establish themselves					
	within the communi	ty) and they accepted R8 to					
	assist with relocation	on services.					
		een by nurse practitioner (NP) pisodes and A1C (the A1C					
	test is a blood test t	hat provides information about					
		lood glucose over the past ed to be 9.5. Provider ordered					
	an increase in insul						
		betes Association [ADA] uggested the following targets					
		ant adults with diabetes. A1C					
		on age and health. Also, ent glycemic goals may be					
	appropriate for eac	h individual: A1C: Less than					
	5	be reported as eAG: Less fore a meal (preprandial					
	plasma glucose): 8	0-130 mg/dL. 1-2 hours after					
		eal (postprandial plasma					
	glucose): Less than	180 mg/dL)					
	- 5/5/20, R8 comple social security disal	eted phone application for bility.					
	- 5/20/20, seen by N	NP for evaluation of					
	hyperglycemia and	indicated suboptimal control					
		pliance and inability to to improper timing of blood					
		. Orders obtained to repeat					
	A1C tomorrow and	to continue with Lantus insulin					
		of insulin used to treat wice daily and once daily					

Facility ID: 00938

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM	APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245052	B. WING				C 31/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD REHABILITATION	N & HEALTHCARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	Continued From pa Glipizide (an oral m Diabetes Mellitus). - 5/22/20, A1C resu notified with no new - 6/4/20, seen by NI with foor ulcer and n but continued eleva glucose monitoring. depressive disorder reported increasing declined medication A1C in one month, twice a day and cor - 6/10/20, NP chang daily and to check A - 6/17/20, staff note room and R8 had s lethargic. On call M notified. NP examin meds on hold and h emergency medical was sent to the ER brother notified. R8 being evaluated wit dehydration and alco - 6/19/20, staff atter blood to check A1C - 6/20/20, R8 left the returned to the facil	ge 12 edication used to treat Its came back at 8.8, NP orders obtained. P, type 2 Diabetes Mellitus noted blood glucose improved tions related to timing of blood Diagnosis of major r, recurrent, mild and R8 depression, however, he as at that time. Plan to repeat continue with Lantus insulin at that time. Plan to repeat continue with Glipizide daily. ged insulin from twice daily to A1C next week. d an empty vodka bottle in lurred speech and appeared D notified and interim DON red R8 and placed diabetic nanded over care to I services (EMS) staff. R8 for evaluation and R8's returned to the facility after h a new diagnosis of	F 6				
	- 6/21/20, at 2:10 a.	m. R8 was noted to be ing area outside his					

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM	09/15/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	245052	B. WING			C 31/2020
NAME OF PROVIDER OR SUPPLI	R		STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHEAD REHABILITAT	ION & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
 possession of th and had no order handle it accordination - 6/23/20, former DON and ROLT to discuss behave against medical notified if he left advice or went of designated times the facility. Discu goal to obtain how relocation service rules and expect - 6/29/20, late er met with R8 to d have since the 6 administrator, in ROLTC. Administ behaviors after h result would be if facility for failing agreement." R8 stated he did nov repeated the "viot the previous were immediate disch pack his own thi his own belongin with packing up to pack up anyth been opened an wrapped around administrator an approached nurs 	Staff suspected R8 had e keys. At 7:57 a.m. MD notified rs and indicated the facility ng to facility protocols. LSW, administrator, interim C (via the telephone) met with R8 ioral concerns, leaving the facility advice and safety issues. R8 was the facility against medical utside to smoke outside of his e he would be discharged from ssion continued regarding R8's using and continue working with es. R8 verbally agreed to follow				

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY PLETED
		245052	B. WING				C 31/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		01/2020
				2	810 SECOND AVENUE NORTH		
MOORHI		N & HEALTHCARE CENTER		Ν	MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	put his hands in the administrator advise that and the police of administrator hands continued to argue extra staff were call R8 up and waiting f discharge to the Mo AMA paperwork and a hotel then to a sh packed up and he w Motel 6. - 6/29/20, at 12:57 p interdisciplinary tea regarding noted bel the weekend. R8 w and very dismissive former LSW and into opportunity to elabor but R8 remained no language. "R8 was meeting regarding of behaviors towards as R8 stated understat to shelter was discu go AMA to the Mote be cognitively intact medications and pet transport. Female fr at the time of the All - 6/29/20, at 15:09 p	air and cursed at them. The ed R8 one more attempt like would be contacted. The ed R8 the red bag and R8 and become aggressive and led in to assist. While packing for transport, R8 opted to otel 6 in Fargo, ND, signed the d stated he would "rather go to elter." R8's final items were was taken by transport to p.m. interim DON indicated the m (IDT) team spoke with R8 haviors which occurred over as noted to be non responsive e during the meeting. The terim DON offered R8 the prate on behaviors in question on verbal only using his body reminded about previous IDT consequences related to poor staff and other residents"and nding. "Immediate discharge ussed with R8 but R8 opted to el 6 in Fargo." R8 was noted to t and R8 left the facility with ersonal belongings via facility riend was noted to be present MA. y, at 12:59 p.m. former LSW tion agency and Clay County a discharge.	F	522			
		R8 discharged AMA from the					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/15/2020 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			PLETED
		245052	B. WING				C 31/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD REHABILITATION	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID			ID				(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI> TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
F 622	Continued From pa	ge 15	F 6	22			
	- 6/30/20, at 9:23 a.	m. Recapitulation of stay					
	note, interim DON i	ndicated R8 required ongoing					
		e, medication administration onitoring. Former LSW					
		n community resources to					
	assist R8 with hous	ing.					
		m. (greater than 1 day after ndicated R8 refused education					
	on medication admi	inistration times and R8 stated					
		be told how and when to take 8 was educated on the risks					
	and benefits of the						
	The progress notes	lacked documentation of					
	behaviors exhibited	by R8 from 6/22/20, to					
	6/29/20, day of disc administrator indica	ited R8 had violated the verbal					
	agreement from the	e previous week.					
		NP progress notes from revealed the following:					
	- 5/14/20- telemedi	cine nursing home visit, NP					
	identified R8 had ur	ncontrolled type 2 Diabetes					
		lycemia and last A1C was 9.4. insulin and Glipizide and					
	blood glucose moni times a day.	toring was ordered for four					
		cine nursing home visit, MD					
	indicated R8 had un type 2. Plan to cont	ncontrolled Diabetes Mellitus inue present care.					
		ndicated R8 had alcohol					
		lood alcohol level of .212 and . R8 was kept in the ER for an					
		time and given intravenous					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATI	0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		245052	B. WING				31/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD REHABILITATION	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	indicated R8's A1C had uncontrolled Di changes were made Review of R8's labo to 6/29/20, revealed - 2/28/20, R8's A1C - 4/21/20, R8's A1C - 5/22/20, R8's A1C No further A1C labs after 5/22/20. Review of R8's uns identified by facility included Lantus So Insulin 10 units (a u administration 100 of subcutaneously (tis and muscle) daily in Mellitus. Review of R8's Med (MAR) dated 6/1/20 following: -blood glucose chee and was last check with the results of 1	back to the facility. back to the facility. cine nursing home visit, MD was 8.8 on 5/22/20 and R8 abetes Mellitus and no e. oratory test A1C, from 2/28/20, d the following: was 6.9. was 9.5. was 8.8. s were found in R8's record igned Physician Orders, as R8's current orders, loStar Solution Pen-injector nit of measurement in insulin units per milliliter [ml]) sue layer between the skin of the morning for Diabetes dication Administration Record 0, to 6/29/20, revealed the cks ordered four times a day ed on 6/29/20, at 8:00 a.m.	F 6	522	DEFICIENCY)		
		s blood glucose checked 39					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
						(C
	PROVIDER OR SUPPLIER	245052	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	07/:	31/2020
					10 SECOND AVENUE NORTH		
MOORHE	EAD REHABILITATION	N & HEALTHCARE CENTER		Ν	MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 622	times due to various	s reasons ranging from R8's	F 6	22			
	refusal or absence	from the facility.					
		zide 5 mg. (milligrams) daily on 6/29/20, at 8:00 a.m.					
	Pen-injector insulin	is SoloStar Solution 10 units subcutaneously daily Diabetes Mellitus and last D, at 8:00 a.m.					
	R8's health had imp longer needed the s	harge dated 2/24/20, identified proved sufficiently and R8 no services of the facility and R8 d to another facility on					
	discharge and trans provided to the facil identified a hearing	Order related to involuntary sfer dated 3/30/20, was lity on 3/30/20. The order had been scheduled for e if the facility could lawfully					
	involuntary discharg provided to the facil identified another co order to prepare for another facility. The had not resolved the	uance Order related to ge transfer dated 5/5/20, was lity on 5/8/20. The order ontinuance of the matter in an appropriate transfer to order identified if the parties e matter by 8/5/20, the matter ck on the judge's docket for					
	against Medical Adv date, identified by th 6/29/20, signed by th	sponsibility for Discharge vice (AMA) form with illegible ne director of nursing as the resident indicated R8 had re risks and consequences of					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245052	B. WING				C 31/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHE	EAD REHABILITATION	N & HEALTHCARE CENTER			2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 622	Continued From pa leaving the facility A R8's Transfer/ Disclidentified the facility due to AMA dischar Review of R8's Soc Summary form date mood/behaviors she indicated recomme been made on seve Review of R8's Soc Summary form date by the interim DON AMA, required ongo medication adminis monitoring. The for continued to work of assist R8 with obtai On 7/21/20, at 10:1 reported to work on informed by other fa and DON had R8 si discharged R8 from informed R8 had be stay for a couple of worked the previous exhibited no behavio over the potential to the goal of obtaining On 7/21/20, at 2:00 family member (FM	ge 18 MA. harge notice dated 6/30/20, discharged R8 on 6/29/20, ge. ial Services Care Conference ed 6/2/20, revealed R8's owed improvement and indations for discharge had eral occasions. ial Services Discharge ed 6/29/20, signed on 6/30/20, revealed R8 discharged bing assistance with ADL's, tration and blood sugar m indicated the former LSW in community resources to ning housing. 5 a.m. LPN-B stated she 6/29/20, and had been acility staff the administrator ign the AMA form and in the facility. LPN-B was been brought to a local hotel to weeks. LPN-B stated she had is weekend and R8 had ors and expressed excitement o be fitted for a prosthesis and g housing. p.m. via telephone interview) stated he received a	F 6		DEFICIENCY)	RIATE	DATE
	discharge from the been "kicked out" o	R8 a day or two after his facility and stated he had f the facility. R8 said he had a y and did not say where he					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245052	B. WING				C 31/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	would be staying af he did not know wh if he had housing. On 7/21/20, at 3:06 had worked in the f past couple of weel aware R8 had beha against facility polic behaviors since the informed him if he of would be discharge 6/29/20, the admini Coordinator informed on an unapproved I Former RN-A review record (EHR) and of lacked any leaves of over the weekend. over the telephone weekend and confit facility over the prev was another reside entered R8's room packing R8's belom not break the rules. notified interim DOI and R8 was still dis informed the interim not been administe interim DON stated know what he was facility had set up a and did not know w Former RN-A stated discharge and had	ge 19 ter the hotel stay. FM stated ere R8 currently was living or p.m. former RN-A stated she acility until approximatley the sprior. She stated she was hviors in the past of leaving y and confirmed he had no facility met with him and did not follow the rules he d. Former RN-A stated on strator, interim DON and MDS ed her R8 had left the facility eave over the weekend. wed R8's electronic health confirmed the documentation or behaviors for R8 occurring Former RN-A contacted staff who had worked the previous rmed R8 had not left the vious weekend and in fact it in who did. Former RN-A where the administrator was gings and informed her R8 did Former RN-A stated she also N R8 did not break the rules charged. Former RN-A n DON R8 was on insulin, had ring his own insulin and R8 should be fine and should doing. Former RN-A stated the two week hotel stay for R8 here he went to after that. d R8 did not initiate the planned on being discharged housing had been secured for	F	522			

Facility ID: 00938

If continuation sheet Page 20 of 31

		AND HUMAN SERVICES			FC	TED: 09/15/2020 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´	IPLE CONSTRUCTION) DATE SURVEY COMPLETED
		245052	B. WING			C 07/31/2020
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP	CODE	
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION E DATE
F 622	On 7/21/20, at 3:50 interview with the M she indicated R8 ha couple of weeks an stated a man who s him up and she was from there. On 7/22/20, at 11:5 interview with the R been involved with meetings with the fa assisted R8 to file a notice of discharge stated he was happ keep him during the he voiced he had h ROLTC indicated R on relocation servic to obtain housing. ROLTC indicated sl call from the admin R8 had recently left the facility question facility's COVID 19 the funeral. The add the possible breach facility felt he needef facility AMA. At that via telephone and r R8 stated he wanter because there was housing after discha- jeopardize that plan the facility rules and ROLTC stated also	age 20 p.m. during a telephone lotel 6 front desk staff (FDS) ad stayed at the hotel for a id had left the hotel. The FDS she thought was his son picked is not certain where he went to 5 a.m. during an telephone COLTC, she indicated she had R1's discharge planning acility. She confirmed she had a first and second appeal to his provided on 2/24/20. R8 by the facility was required to a appeal process and stated ope for the first time in his life. 8 had been actively working ces with a relocation specialist he had received a telephone istrator on 6/22/20, who stated the facility for a funeral and ed if he had followed the precautions while he was at ministrator stated because of h in COVID 19 precautions, the ed to be discharged from the time, ROLTC contacted R8 eviewed the facility, but a plan in place for long term arge, he did not want to h. He stated he would follow d not leave the facility.	F 62	22		

Facility ID: 00938

If continuation sheet Page 21 of 31

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245052	B. WING				C 31/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	the facility rules reg absences from the would follow the rule jeopardize his long "it is black and white ROLTC stated she DON and LSW on 6 was doing much be quarantine but was ROLTC stated on 7 aware R8 had been and she began calli administrator on 7/6 receive a call back 7/8/20. ROLTC stated she administrator that R leaving the facility A administrator stated openings at the hor local hotel. ROLTC administrator to claid discharge when the belongings, and dro state in the midst of stated the administr R8's discharge and ROLTC informed th copy of the AMA for forwarding it to an a On 7/22/20, at 12:4 6/29/20, when he at morning there had I about plans to disch was informed later LSW R8 was being	arding resident leave of facility. R8 again stated he es and did not want to term housing plans. R8 stated e" and " I will follow the rules." had contacted the interim 6/26/20, and was told that R8 tter, had struggled with redirectable. /6/20, she had been made discharged from the facility ng and emailing the 6/20, 7/7/20, and did not from the administrator until had been told by the 88 had informed them he was MA on 6/29/20. The d because there were no neless shelter, he went to a stated she had asked the rify how this was an AMA e facility had packed up his ove him to a hotel in another f a discharge appeal. She rator was unable to explain offered no further information. the administrator she needed a rm and indicated she would be	F 6	522			

If continuation sheet Page 22 of 31

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG		C
		245052	B. WING _		07	//31/2020
NAME OF F	PROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
MOORH	EAD REHABILITATIO	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 622	Continued From pa	age 22	F 62	22		
	was being discharg R8 and he did not H discharged. LPN-A to R8 and he refuse the facility provided R8 to a local hotel. routine insulin and administer his own On 7/22/20, at 1:37 facility and ROLTC inform him if the be smoking outside of intoxication continue from the facility. Int follow the rules of t on 6/29/20, the faci following the facility and former LSW m behaviors and rem to him prior to this to behaviors continue did not care and he and did not provide communication abo stated the option of shelter was discuss not care. The facility available and only fistated the facility w	' p.m. interim DON stated the met with R8 on 6/23/20, to chaviors of leaving the facility, designated times and alcohol led he would be discharged erim DON stated R8 agreed to he facility. Interim DON stated ility was made aware of R8 not rules over the weekend, she let with R8 to discuss his inded R8 the facility had talked time of immediate discharge if d. R8 responded by saying he e wanted to leave the facility				
	R8 contacted a fem she was at the facil Interim DON confir of R8 leaving the fac designated times o	hale friend to pick him up and lity when R8 left the facility. med there were no behaviors acility, smoking outside of r alcohol intoxication in the cumented since the meeting on				

If continuation sheet Page 23 of 31

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 09/15/2020 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			CON	E SURVEY IPLETED C
		245052	B. WING				31/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	•
MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	6/23/20. Interim DC either she or the ac AMA paperwork an one. Interim DON si informed of R8 bein must have been ab went on leaves price Interim DON stated and refused the ed Interim DON stated in his room after he room. On 7/22/20, at 2:29 (MDSC) stated she prior to 6/29/20, an telephone call about unsupervised. MDS the specifics of the document it anywh On 7/22/20, at 3:03 R8 was provided w 2/24/20, to Meadow The ROLTC contact sometime after the R8 did not have an Meadowlane and th on 3/30/20, followe 5/8/20. The administ happened due to C confirmed R8 was second appeal whe 6/29/20. The administ happened due to C confirmed R8 was second appeal whe 6/29/20. The administ happened due to C	DN stated she was unsure, but dministrator had R8 sign the id she could not recall which stated she had not been ing on insulin and stated R8 ble to administer it since he or to the 6/29/20, discharge. d R8 was given his medications ucation offered by LPN-A. d the administrator met with R8 er and former LSW left R8's D p.m. MDS Coordinator e took call over the weekend d stated she had received a ut R8 going outside SC stated she could not recall call and indicated she did not ere. B p.m. the administrator stated ith a notice of discharge on vlane nursing home in Benson. cted the administrator notice was given and stated	F 6	522			

If continuation sheet Page 24 of 31

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED		
		245052	B. WING _			C 07/31/2020		
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
MOORHEAD REHABILITATION & HEALTHCARE CENTER					310 SECOND AVENUE NORTH IOORHEAD, 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	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 622	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 62	22				

If continuation sheet Page 25 of 31

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			NG) co	COMPLETED C 07/31/2020	
		B. WING		07		
			STREET ADDRESS, CITY, STATE, ZIP COI		10112020	
MOORHI	EAD REHABILITATIO	N & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 622	Continued From pa	age 25	F 62	22		
	(MS) stated he was and interim DON to Fargo ND on 6/29/2 R8's room while fac belongings and the in R8's room and a belongings out to th was present and to her vehicle. MS tra hotel in Fargo ND a asked was why wa only had ties in Mo repaired R8's wind out his window, and further repairs need discharge.	4 p.m. maintenance supervisor s asked by the administrator o transport R8 to the Motel 6 in 20. MS stated he stood by in cility staff packed his e administrator approached him isked MS to bring R8's he facility van. R8's girlfriend ook some of his belongings to nsported R8 to the Motel 6 and stated the only thing R8 s he going to Fargo when he orhead. MS stated he had ow in the past due to R8 going d stated there had been no ded at the time of R8's				
	interview former LS working in the facil stated she was awa pursuing relocation was awaiting result there were no plan 6/29/20. Former LS the middle of a disc informed the facility during the appeal p she was informed in R8 had exhibited b the nurses station leaving the facility t	05 p.m. during telephone SW stated she had been ity until the previous week. She are R8 had been actively assistance to obtain housing, ts of approval for disability and s to discharge him prior to SW confirmed R8 had been in charge appeal and had been y could not discharge R8 process. Former LSW stated in the IDT meeting on 6/29/20, ehaviors of taking the key from to the activities room and to smoke over the weekend				
	discharged. Forme had lacked docume exhibited over the LSW indicated inte	N stated R8 needed to be r LSW confirmed R8's EHR entation of any behaviors R8 previous weekend. Former rim DON stated she had talked consultant (RCC) and the chief				

If continuation sheet Page 26 of 31

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY		
		A. BUILDIN	со	COMPLETED				
		B. WING		07	C // 31/2020			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO				
MOORHEAD REHABILITATION & HEALTHCARE CENTER				2810 SECOND AVENUE NORTH MOORHEAD, MN 56560				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 622	Continued From pa	nge 26	F 62	2				
	behavioral concern R8 from the facility "would just take the LSW went to R8's r in his bed with blan interim DON asked behaviors reported DON reminded R8 it was discussed he exhibited further be respond. Interim DO leave, informed him together and stated	COO) of the facility about R8's s and the need to discharge and they responded the facility e tag." Interim DON and former room where R8 was sleeping kets covering his head and R8 about the smoking over the weekend. Interim of the 6/23/20, meeting where e would be discharged if he shaviors and R8 did not ON stated to R8 he needed to n to get his belongings the facility was discharging . R8 did not respond as he was						
	homeless shelters a openings for beds a interim DON and ex- comfortable with the the facility paid for a hotel in Fargo ND. administrator and a belongings while Ra facing the door and stated the administ sign the AMA form. R8 via facility transp female acquaintance too. Former LSW s out the behaviors re exhibited by another	d she had contacted two local and was told there were no and she reported this to the xpressed not feeling e plan. Former LSW stated a two week stay at the Motel 6 Former LSW stated the a NA packed up R8's 8 was seated in his wheelchair I was not talking. Former LSW rator and interim DON had R8 Former LSW stated MS drove portation to the hotel and a ce of R8 arrived at the facility tated on 6/30/20, she found eported about R8 were actually er resident residing in the W stated the interim DON,						

Facility ID: 00938

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		AND HUMAN SERVICES				FORM	: 09/15/2020 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C
		245052	B. WING			07	/31/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHEAD REHABILITATION & HEALTHCARE CENTER					810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	from staff at the Mo an additional two w be homeless and th Former LSW stated director (AD) receiv week from R8, who and living under a b On 7/28/20, at 11:0 the administrator at to take R8 out for a was being discharg word about it and in to go. R8 informed disability and housin LSW and they had live. AD stated R8 of over the weekend th happen. R8 stated he did not follow the he would be dischar facility via the facilit 7/21/20, AD stated from R8 and he stat drugs and needed to R8 if he was hungy food and asked him food and brought it wheelchair under a On 7/28/20, at 11:1 6/29/20, the administra R8's belongings, R8 administrator inform On 7/28/20, at 11:1	tel 6 in Fargo ND to request eeks stay for R8 or R8 would ne facility denied the request. d she was aware the activities red a phone call the previous n indicated he was homeless	F 6	22			

If continuation sheet Page 28 of 31

		AND HUMAN SERVICES			FOF	ED: 09/15/2020 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) [DATE SURVEY OMPLETED C	
245052		B. WING _		07/31/2020		
NAME OF	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, 2		
MOORHEAD REHABILITATION & HEALTHCARE CENTER				2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	245052 E F PROVIDER OR SUPPLIER E HEAD REHABILITATION & HEALTHCARE CENTER E SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E		F 62	22		

If continuation sheet Page 29 of 31

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/15/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245052		B. WING			C 07/31/2020		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHEAD REHABILITATION & HEALTHCARE CENTER					810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	since his last known room in Fargo, ND. Review of facility po Against Medical Ad an AMA discharge of leave the facility. Th and administrator w impending AMA dist the resident to discu- policy stated the fac durable medical eq or provide the resid The IJ that began of 7/31/20, when the f Moorhead, MN PD attempt to locate Ra developed a plan to to the facility if R8 of The facility provided members about the discharge policy an facility provided edu AMA procedure and The noncompliance and severity level D Governor Tim Walz Order(EO) 20-14, s identified beginning and continuing for t emergency, all resid	en transferred to the Fargo PD in residence had been a hotel blicy titled Resident Leave vice revised 5/15/20, identified when a resident chooses to be policy indicated the LSW vould be notified of any charges and would meet with uss risks and benefits. The cility was not to assist with uipment (DME), transportation ent with any medications. In 7/28/20, was removed on acility contacted the and the Fargo, ND PD to 8. Additionally, the facility o accept R8 back as a resident lecided he wanted to return. d education to the IDT e AMA procedure, transfer d leave of absence policy. The ucation to licensed staff on the d the leave of absence policy.	F	522			
	termination is due to endangering the sa	nergency, except where the o the tenant seriously fety of other residents. The cting evictions was a vital tool					

Facility ID: 00938

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		AND HUMAN SERVICES				FORM	09/15/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245052	B. WING	i			31/2020
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HEALTHCARE CENTER			810 SECOND AVENUE NORTH NOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	to keep Minnesotar the community spre- and nationwide. The household facing er from the Attorney G happening. Governor Tim Walz signed 7/13/20, ide	Ige 30 hs in their homes to mitigate ead of COVID-19 in Minnesota e EO indicated any person or viction would have assistance deneral to prevent this from 2's Emergency EO 20-78, ntified the COVID-19 ency was extended through	F	622			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00938



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 <u>only a suggestion</u> 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

Moorhead Rehabilitation & Healthcare Center August 18, 2020 Page 2

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

Minneso	ta Department of He	alth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	-n. I`	,	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00938	В	3. WING		07/3	; 1/2020
	PROVIDER OR SUPPLIER	ST		ESS CITY S	TATE, ZIP CODE		
		28		ND AVENUI			
MOORHI	EAD REHABILITATION	N & HEALTHCARI M	OORHEAD	D, MN 5656	60		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2	2 000			
	****ATTE	NTION*****					
	NH LICENSING CORRECTION ORDER						
	144A.10, this correct pursuant to a surve found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru	nether a violation has be	eued , it is ed plation nce e of een				
	comply with any of lack of compliance. re-inspection with a result in the assess	the items will be conside Lack of compliance up ny item of multi-part rule ment of a fine even if th uring the initial inspectio	ered oon e will e item				
	that may result from orders provided tha the Department with	hearing on any assessn n non-compliance with the t a written request is mathin hin 15 days of receipt of ant for non-compliance.	hese ade to				
	Department's staff	/20, surveyors of this visited the above provid tion and the following	er for a				
	The following comp substantiated:	laints were found to be					
Vinnesota D	epartment of Health						
	ically Signed	ER/SUPPLIER REPRESENTAT	IVES SIGNAI	IUKE	TITLE		(X6) DATE 08/28/20

6899

If continuation sheet 1 of 30

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	B. WING			C 31/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MOORH	EAD REHABILITATION	N & HEALTHCARL	COND AVENUE EAD, MN 5656			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	H5052120C with no H5052122C with no	ensing order issued at 1925. b licensing order issued. b licensing order issued. b ensing order issued at 1805.				
	In addition, the follo to be unsubstantiat H5052117C H5052118C H5052121C H5052123C H5052124C	wing complaints were found ed:				
	the State Licensing federal software. Ta assigned to Minness Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." For	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and rrection.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a Department of Hea you electronically. is necessary for Sta	in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf licensing orders are				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00938	B. WING		07/31/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
IOORHI	EAD REHABILITATION	V & HEALTHCARL	OND AVENU		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET E DATE
2 000	Continued From pa	ge 2	2 000		
	State licensure proc completion date, the	indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health.			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF			
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		9/2/20
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a			
	by: Based on interview facility failed to prov	ent is not met as evidenced , and document review, the vide services in a respectful esidents (R3) during staff ssisting with cares.		 F- 550 1. R3 clothing was inspected to be properly labeled and placed in his roon and any unlabeled or improperly placed items were removed. R3 care plan 	
	R3's quarterly Minir 5/30/20, indicated F included renal insuf depression. The MI	num Data Set (MDS) dated R3 had diagnoses which ficiency, diabetes and DS indicated R3 had intact ndependent with bed mobility,		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.	

6899

2TUO11

If continuation sheet 3 of 30

(EACH DEFICIENC) REGULATORY OR L Continued From pa transfer, dressing, 1 hygiene.	N & HEALTHCARI 2810 SEC MOORHEA TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. Building B. Wing	STATE, ZIP CODE JE NORTH 560 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	N BE	ETED
AD REHABILITATION SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa transfer, dressing, 1 hygiene.	N & HEALTHCARI N & HEALTHCARI TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 3	DRESS, CITY, OND AVENI AD, MN 565 ID PREFIX TAG	JE NORTH 560 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	07/31	(X5)
AD REHABILITATION SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa transfer, dressing, 1 hygiene.	N & HEALTHCARI 2810 SEC MOORHEA TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	OND AVENU AD, MN 565 ID PREFIX TAG	JE NORTH 560 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa transfer, dressing, 1 hygiene.	M& HEALTHCARI MOORHEA TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 3	AD, MN 565 ID PREFIX TAG	560 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	
(EACH DEFICIENC) REGULATORY OR L Continued From pa transfer, dressing, 1 hygiene.	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	
(EACH DEFICIENC) REGULATORY OR L Continued From pa transfer, dressing, 1 hygiene.	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	
transfer, dressing, t hygiene.	-	21805			
hygiene.	toilet use and personal	21005			
	sed on 6/17/20, indicated R3 ities of daily living (ADL's) self		 All residents have a right to dig the facility and have the potential to affected. 		
care needs due to o impaired balance. F was independent w mobility, transfers, Further, the care pl required considerat required clear expla choices for interver indicated R3 had re explain all procedur the resident time to Review of 3's Moor Healthcare Concer Form, indicated on stated to nursing as embarrassed by oc (OTA). R3 indicated entrance of his roon by and she noticed was not his. R3 ind off him without sayi was very embarras rough. NA-A told R3 apologized to R3. T	disease process, amputee and R3's care plan indicated R3 ith bathing/showering, bed dressing, eating and toilet use. an indicated R3 was hispanic, tions with communication and anation of situation and ntion. Further, the care plan efusals, and directed staff to res before starting and allow adjust to changes. head Rehabilitation and n and Problem Resolution 6/22/20 at 11:45 a.m. R3 sistant (NA)-A he was coupational therapist assistant d he was in the doorway m, when the OTA was walking R3 was wearing a t-shirt that icated OTA yanked the t-shirt ng anything. R3 indicated he sed and at times she can be 3 she would pass it along and The form indicated a vulnerable		monitor completion of Ambassador Rounds with managers to identify a areas of dignity/respect and audits laundry to ensure resident clothing delivered to the right resident. The will be completed weekly times 2 m	sident ction or is . The et ss any 20 went phasis with all b tion to ny on	
sitting in his wheeld room looking aroun off of him that was	hair in the doorway of his nd, when OTA pulled a t-shirt not his. R3 indicated he nad given him the t-shirt and not his. R3 indicated OTA did		QAPI committee for future recommendations. The audit will be	•	
e ((ebwowraa Csro	mbarrassed by oc DTA). R3 indicated ntrance of his roor y and she noticed vas not his. R3 ind ff him without sayi vas very embarras bugh. NA-A told R3 pologized to R3. T dult report was su 0n 7/22/20 at 1:29 itting in his wheeld boom looking arour ff of him that was nought someone h id not know it was	mbarrassed by occupational therapist assistant OTA). R3 indicated he was in the doorway ntrance of his room, when the OTA was walking y and she noticed R3 was wearing a t-shirt that vas not his. R3 indicated OTA yanked the t-shirt ff him without saying anything. R3 indicated he vas very embarrassed and at times she can be ough. NA-A told R3 she would pass it along and pologized to R3. The form indicated a vulnerable dult report was submitted.	mbarrassed by occupational therapist assistant OTA). R3 indicated he was in the doorway ntrance of his room, when the OTA was walking y and she noticed R3 was wearing a t-shirt that vas not his. R3 indicated OTA yanked the t-shirt ff him without saying anything. R3 indicated he vas very embarrassed and at times she can be ough. NA-A told R3 she would pass it along and pologized to R3. The form indicated a vulnerable dult report was submitted.	 mbarrassed by occupational therapist assistant DTA). R3 indicated he was in the doorway ntrance of his room, when the OTA was walking y and she noticed R3 was wearing a t-shirt that ras not his. R3 indicated OTA yanked the t-shirt ff him without saying anything. R3 indicated he ras very embarrassed and at times she can be ough. NA-A told R3 she would pass it along and pologized to R3. The form indicated a vulnerable dult report was submitted. On 7/22/20 at 1:29 p.m. R3 indicated he was itting in his wheelchair in the doorway of his pom looking around, when OTA pulled a t-shirt ff of him that was not his. R3 indicated he mought someone had given him the t-shirt and id not know it was not his. R3 indicated OTA did routines. an audit has been developed to monitor completion of Ambassador Rounds with managers to identify a areas of dignity/respect and audits laundry to ensure resident clothing delivered to the right resident. The will be completed weekly times 2 m then monthly to ensure compliance results of the audits will be reported QAPI committee for future recommendations. The audit will be completed by the Administrator or h designee. 	 mbarrassed by occupational therapist assistant DTA). R3 indicated he was in the doorway intrance of his room, when the OTA was walking y and she noticed R3 was wearing a t-shirt that ras not his. R3 indicated OTA yanked the t-shirt ff him without saying anything. R3 indicated he ras very embarrassed and at times she can be bough. NA-A told R3 she would pass it along and pologized to R3. The form indicated a vulnerable dult report was submitted. On 7/22/20 at 1:29 p.m. R3 indicated he was itting in his wheelchair in the doorway of his boom looking around, when OTA pulled a t-shirt ff of him that was not his. R3 indicated he hought someone had given him the t-shirt and id not know it was not his. R3 indicated OTA did routines. 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.

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	СОМ (E SURVEY PLETED C
		00938	B. WING	B. WING		31/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
MOORH	EAD REHABILITATION	N & HEALTHCARL	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	embarrassed becau present in the hallw took the t-shirt off o closet and told him felt humiliated but h indicated OTA took scared him at the tii R3 indicated it happ even have a chance On 7/22/20 at 4:55 walking by R3's roc another resident t-s could look at the tag taking the t-shirt off him another t-shirt off him another t-shirt off him another t-shirt off him another t-shirt off on in the hallway. O remember if other r or not. OTA indicate she was trying to sa doing. OTA indicate and did not use an with R3 at the time a miscommunicatio On 7/22/20 at 9:35 memory was intact reported to her the out in the hallway, w him and did not say told her he was emil the incident becaus he did not know wh indicated R3 told he went back in his roc after the incident becaus	use there were other residents ay. R3 indicated after OTA f him, she got a shirt out of his to put it on. R3 indicated he was not hurt or abused. R3 the shirt off so quick, it kind of me and caught him off guard. bened so quick he did not e to fight for the t-shirt. p.m. OTA indicated she was on and noticed he had hirt on and asked R3 if she g. OTA indicated R3 started in the hallway and she got but of his closet and he put it OTA indicated she could not esidents were in the hallway ed she felt R3 understood what ay to him and what she was interpreter to communicate of the incident and felt it was	t			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED C
		00938	B. WING			31/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
MOORH	EAD REHABILITATION	& HEALTHCAR	OND AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21805	(DON) indicated she the incident, did not incident and could r The DON indicated the residents with re On 7/22/20 at 10:41 she thought OTA to without talking to his she felt there was a the R3 and OTA. Th felt rushed and was OTA and this was u indicated she would residents with respe- cares. She indicated assumptions and in have been avoided. Review of facility por Resident reviewed of resident will be trea environment that m resident's dignity ar his or her individual SUGGESTED MET The administrator, of designee could dev care by the interdiso residents dignity is for could update policies staff on these change ensure resident(s) of could be completed could be reviewed by	a.m., director of nursing e was not here at the time of know anything about the not speak to what happened. she would expect staff to treat espect and dignity. I a.m. administrator indicated ok R3's t-shirt off of him m. The administrator indicated misunderstanding between he administrator indicated R3 not able to understand the n-dignified. The administrator I expect staff to treat the ect and dignity while providing d staff cannot make dicated this situation could blicy titled, Dignity Of The on 4/12/18, indicated all ted in a manner and in an aintains and enhances each id respect in full recognition of ity. HOD OF CORRECTION: director of nursing (DON), or elop and implement a plan of ciplinary team to ensure being maintained. The facility es and procedures, educate ges, and audit periodically to dignity are maintained. Audits , and results of these audits by the quality assessment and vement (QAPI) committee to				

Minnesc	ota Department of He	alth		FO	RM APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		00938	B. WING		C)7/31/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
MOORH	EAD REHABILITATION	N & HEAI THCARI	OND AVENU AD, MN 565		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE
21805	Continued From pa	ge 6	21805		
	TIME PERIOD FOF (14) days.	R CORRECTION: Fourteen			
21925	MN St. Statute 144 Residents of HC Fa	.651 Subd. 29 Patients & ac.Bill of Rights	21925		9/2/20
	shall not be arbitrar Residents must be proposed discharge justification no later discharge from the transfer to another notice shall include the proposed action telephone number of ombudsman pursua Act, section 307(a)(of this right, may ch notice period ends. shortened in situation control, such as a co review, the accomment residents, a change treatment program, resident's welfare, of prohibited by the pu- paying for the resid the medical record. reasonable effort to without disrupting re- by: Based on interview facility failed to allow had insulin depende for appropriate disc	ers and discharges. Residents ily transferred or discharged. notified, in writing, of the e or transfer and its than 30 days before facility and seven days before room within the facility. This the resident's right to contest h, with the address and of the area nursing home ant to the Older Americans (12). The resident, informed hoose to relocate before the The notice period may be ons outside the facility's letermination by utilization nodation of newly-admitted e in the resident's medical or the resident's own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a o accommodate new residents oom assignments. ent is not met as evidenced and document review the w 1 of 1 residents (R8) who ent Diabetes Mellitus reviewed tharge to remain in the facility ppeal was pending. This		F- 622 1. R8 is no longer a resident at the facility. The Moorhead County caseworker and the Moorhead and Nor	th

Minnesc	ota Department of He	alth			FORM APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00938	B. WING		C 07/31/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
MOODU		2810 SEC		UE NORTH	
WOORN	EAD REHABILITATION	MOORHE	AD, MN 56	560	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
21925	Continued From pa	ige 7	21925		
	jeopardy (IJ) situati from the facility to a no housing or comr after the two week rendering him home The IJ began on 6/2 facility discharged F hotel for a two weel in place after the tw 3:53 p.m. the admin nursing (DON) were	29/20, at 1:00 p.m. when the R8 from the facility to a local k stay with no secured housing vo week stay. On 7/28/20, at histrator and interim director of e notified of the IJ situation.		Dakota police departments were contacted on 7/30/20 to conduct a check for R8. Per MD order, R8 w considered for readmission to the after having been seen in the eme room and is medically safe and appropriate for readmission to the 2. All residents in the facility with discharge anticipated back into the community have the potential to be affected.	vill be facility rgency facility. n a e
	IJ was removed on the facility made att majority of the staff appropriate dischar The noncompliance and severity level D potential for more th immediate jeopardy Findings include:			3. 7.29.20 the IDT and Licensed Nursing Staff were in-serviced on Transfer/Discharge, Leave Agains Medical Advice and Leave of Abse Discharge planning for all admitted residents will be conducted with th of ensuring a safe discharge for th resident to a community of their ch All discharges since survey exit we reviewed by the IDT team and are complete.	policies t ence. d e goal e e noice. ere
	4/7/20, identified R8 had diagnoses which left below the knee high blood pressure not walk and was in of daily living (ADL' toileting, grooming MDS identified R8 I seven days of insul day assessment ref R8's admission Can dated 1/18/20, iden	num Data Set (MDS) dated 8 was cognitively intact and ch included Diabetes Mellitus, amputation, viral hepatitis and e. The MDS identified R8 did idependent with most activities s) which included transfers, and bathing tasks. Further, the had no behaviors and received in injections during the seven ference period. The Area Assessment (CAA) tified R8 had recently been lity after surgery for a left		4. An audit has been developed monitor the date of anticipated dis IDT meeting related to discharge t confirm discharge address, neces equipment (DME) required, medic transportation, community services physician notification with orders a reason for discharge. The audit w completed daily x 10 days, weekly weeks then monthly. The results of audits will be reported to the QAPI committee for future recommenda The audit will be completed by the	charge, o sary ations, s, ind ill be x 4 of the tions.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		00938	B. WING		07/31/2020	
AME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OORHEA		N & HEALTHCARL	OND AVENU AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLE	
21925	Continued From pa	ge 8	21925			
v tr c c c c c c c c c c c c c c c c c c	vith most ADL's. The consistent carbohyd iabetes. The CAA or pleasures in doir offered mental heal Review of R8's Self Assessment form d not appropriate for nedications. R8's care plan, revi ndependent with m nobility, transfers a dentified R8 had D nsulin, blood gluco nonitored for signs hyperglycemia (high hypoglycemia (low hadicated R8 interm he building without dentified R8 did no nedications and ind	putation and was independent the CAA indicated R8 was able known and was on a drate controlled diet for his indicated R8 had little interest ing things and the facility had th services upon admission. Administration of Medication lated 6/17/20, revealed it was R8 to self administer sed 7/14/20, identified R8 was tost ADL's including: bed and eating. The care plan iabetes Mellitus, received se checks and was to be and symptoms for in blood sugar) and blood sugar). The care plan ittently refused cares and left notifying staff. The care plan t self administer his own dicated social services would a necessary for a community		Administrator or her designee. Compliance: September 2, 2020		
	Review of R8's prog 5/30/20, revealed th	gress notes from 2/24/20, to ne following:				
F h s b	R8 with a 30 day no nealth improving su service from the fac	r, the administrator provided otice of discharge due to his ifficiently, no longer in need of cility and indicated R8 would eadowlane Board and Care				
		ensed social worker (LSW) and vith R8 to obtain consent to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	-	
IOORHI	EAD REHABILITATION	N & HEALTHCAR	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21925	Continued From pa	ge 9	21925			
	ombudsman for lon former LSW along Prairie Community financial/housing as - 3/11/20, R8 left the Former registered r medical doctor (MD - 3/12/20, Clay cour LSW to report R8's - 3/13/20, phone ca contacts listed on fi brother stated he has in two weeks. Moor notified too. Later th LSW received a ph and Prairie Commu- indicating R8 show p.m. requesting ass stated R8 appeared extremely difficult to	e facility without notifying staff. nurse (RN)-A contacted)) regarding R8's leave. nty report completed by forme	r			
	to emergency room	ion and was returned to the				
	transfer to Meadow	SW met with R8 to discuss lane and R8 declined the ons presented to R8.				
	completing MNCho	SW assisted R8 with ices assessment (application clay County Public Health over				
	- 3/25/20, former LS	SW received message from				

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00938	B. WING		C 07/31/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	•	
		2810 SEC	COND AVENU			
MOORH	EAD REHABILITATION	MOORHE	EAD, MN 5656	60		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21925	Continued From pa	ge 10	21925			
	Clay County Public Health R8 was accepted for relocation services. R8 was informed and stated "you put a smile on my face."					
	call from Opportuni Services(company service corrdination income, and abilitie	certified to provide relocation to individuals with limited s to re-establish themselves ty) and they accepted R8 to				
	for hyperglycemia e test is a blood test t average levels of bl	een by nurse practitioner (NP) pisodes and A1C (the A1C hat provides information about ood glucose over the past ed to be 9.5. Provider ordered in.				
	guidelines 1/1/20, s for most nonpregna targets differ based more or less stringe appropriate for each 7%. A1C may also than 154 mg/dL Be plasma glucose): 80	betes Association [ADA] uggested the following targets ant adults with diabetes. A1C on age and health. Also, ent glycemic goals may be h individual: A1C: Less than be reported as eAG: Less fore a meal (preprandial 0-130 mg/dL. 1-2 hours after eal (postprandial plasma in 180 mg/dL)				
	- 5/5/20, R8 comple social security disal	eted phone application for bility.				
inneast- D	due to diet noncom titrate insulin due to glucose monitoring.	NP for evaluation of indicated suboptimal control pliance and inability to to improper timing of blood . Orders obtained to repeat to continue with Lantus insulin				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00938	B. WING		07/31/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORHE	EAD REHABILITATIO	N & HEAI THCARI	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21925	Continued From pa	age 11	21925			
 (Diabetes Mellitus)	n of insulin used to treat twice daily and once daily nedication used to treat				
	- 5/22/20, A1C resunctified with no new	ults came back at 8.8, NP v orders obtained.				
	with foor ulcer and but continued eleva glucose monitoring depressive disorder reported increasing declined medication A1C in one month,	P, type 2 Diabetes Mellitus noted blood glucose improved ations related to timing of blood Diagnosis of major r, recurrent, mild and R8 g depression, however, he ns at that time. Plan to repeat continue with Lantus insulin ntinue with Glipizide daily.				
	- 6/10/20, NP chan daily and to check a	ged insulin from twice daily to A1C next week.				
	room and R8 had s lethargic. On call M notified. NP examine meds on hold and b emergency medication was sent to the ER brother notified. R8	ed an empty vodka bottle in slurred speech and appeared ID notified and interim DON ned R8 and placed diabetic handed over care to al services (EMS) staff. R8 for evaluation and R8's 8 returned to the facility after th a new diagnosis of cohol intoxication.				
		mpted times three to draw C and were unsuccessful.				
	returned to the faci	ne facility at 4:26 p.m. and lity at 6:58 p.m. with alcohol in aff removed the alcohol.				
	- 6/21/20, at 2:10 a	.m. R8 was noted to be				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00938	B. WING	B. WING		C 31/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MOORHE	EAD REHABILITATION	N & HFAI THCARI	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21925	Continued From pa	•	21925			
	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.					
			/			
	met with R8 to disc have since the 6/22 administrator, interi ROLTC. Administra behaviors after hou result would be imm facility for failing to agreement." R8 no stated he did not ur repeated the "violat the previous week hi immediate discharg pack his own things his own belongings with packing up bel to pack up anything been opened and a	m DON, former LSW and tor informed R8 "since he had irs and over the weekend the nediate discharge from the	t			
	administrator and p approached nursing	laced into a bag. R8 g assistant (NA)-B and the juickly pushed the drawer shut	,			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED C	
		00938	B. WING			31/2020
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOORH	EAD REHABILITATION	N& HEALTHCAR	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21925	Continued From pa	ge 13	21925			
	administrator advise that and the police of administrator hande continued to argue extra staff were call R8 up and waiting f discharge to the Mo AMA paperwork and a hotel then to a sho packed up and he w Motel 6.	air and cursed at them. The ed R8 one more attempt like would be contacted. The ed R8 the red bag and R8 and become aggressive and ed in to assist. While packing or transport, R8 opted to otel 6 in Fargo, ND, signed the d stated he would "rather go to elter." R8's final items were vas taken by transport to				
	interdisciplinary tea regarding noted bel the weekend. R8 w and very dismissive former LSW and int opportunity to elabor but R8 remained no language. "R8 was meeting regarding of behaviors towards of R8 stated understan to shelter was discu go AMA to the Mote be cognitively intact medications and pe	b.m. interim DON indicated the m (IDT) team spoke with R8 haviors which occurred over as noted to be non responsive e during the meeting. The terim DON offered R8 the orate on behaviors in question on verbal only using his body reminded about previous IDT consequences related to poor staff and other residents" and nding. "Immediate discharge ussed with R8 but R8 opted to el 6 in Fargo." R8 was noted to and R8 left the facility with orsonal belongings via facility riend was noted to be present MA.				
	notified R8's relocation relocation relocation relation relatio relation relation re	o.m. licensed practical nurse 88 discharged AMA from the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00938	B. WING			31/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
NOORHI	EAD REHABILITATION	N & HEALTHCARL	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
	note, interim DON i assist with ADL card and blood sugar mo continued to work o assist R8 with hous - 6/30/20, at 2:20 p. discharge) LPN-A ir	m. Recapitulation of stay ndicated R8 required ongoing e, medication administration onitoring. Former LSW on community resources to sing. 				
	his medications." R and benefits of the The progress notes behaviors exhibited 6/29/20, day of disc	lacked documentation of by R8 from 6/22/20, to harge although the ated R8 had violated the verbal				
	5/14/20, to 6/24/20, - 5/14/20- telemedi identified R8 had ur Mellitus with hyperg R8 received Lantus	NP progress notes from revealed the following: icine nursing home visit, NP ncontrolled type 2 Diabetes glycemia and last A1C was 9.4 insulin and Glipizide and itoring was ordered for four				
	indicated R8 had ur type 2. Plan to cont - 6/17/20, ER visit in intoxication with a b low blood pressure.	ndicated R8 had alcohol blood alcohol level of .212 and . R8 was kept in the ER for an time and given intravenous				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00938	B. WING			C 07/31/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
MOORH	EAD REHABILITATION	N & HFAI THCARI	COND AVENUE EAD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21925	 - 6/24/20, telemedic indicated R8's A1C had uncontrolled Di changes were made Review of R8's labor to 6/29/20, revealed - 2/28/20, R8's A1C - 4/21/20, R8's A1C - 5/22/20, R8's A1C - 5/22/20, R8's A1C No further A1C labs after 5/22/20. Review of R8's uns identified by facility included Lantus So Insulin 10 units (a u administration 100 subcutaneously (tis and muscle) daily in Mellitus. Review of R8's Med (MAR) dated 6/1/20 following: -blood glucose check with the results of 1 -blood glucose resultion -blood glucose resultion - R8 did not have hit 	cine nursing home visit, MD was 8.8 on 5/22/20 and R8 abetes Mellitus and no e. oratory test A1C, from 2/28/20, d the following: was 6.9. was 9.5. was 8.8. s were found in R8's record igned Physician Orders, as R8's current orders, loStar Solution Pen-injector nit of measurement in insulin units per milliliter [mI]) sue layer between the skin of the morning for Diabetes dication Administration Record 0, to 6/29/20, revealed the cks ordered four times a day ed on 6/29/20, at 8:00 a.m.		DEFICIENC	, , , , , , , , , , , , , , , , , , ,		

TATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00938	B. WING	B. WING		C 07/31/2020	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IOORHI	EAD REHABILITATION	N & HEALTHCAR	COND AVENUE EAD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
21925	Continued From pa	ge 16	21925				
	- R8 received Glypizide 5 mg. (milligrams) daily and last received it on 6/29/20, at 8:00 a.m.						
	Pen-injector insulin	us SoloStar Solution 10 units subcutaneously daily Diabetes Mellitus and last D, at 8:00 a.m.					
	R8's health had imp longer needed the s	harge dated 2/24/20, identified proved sufficiently and R8 no services of the facility and R8 ed to another facility on					
	discharge and trans provided to the faci identified a hearing	Order related to involuntary sfer dated 3/30/20, was lity on 3/30/20. The order had been scheduled for e if the facility could lawfully					
	involuntary discharg provided to the faci identified another c order to prepare for another facility. The had not resolved th	nuance Order related to ge transfer dated 5/5/20, was lity on 5/8/20. The order ontinuance of the matter in r an appropriate transfer to order identified if the parties e matter by 8/5/20, the matter took on the judge's docket for					
	against Medical Ad date, identified by the 6/29/20, signed by	esponsibility for Discharge vice (AMA) form with illegible he director of nursing as the resident indicated R8 had he risks and consequences of MA.					
		harge notice dated 6/30/20, / discharged R8 on 6/29/20,					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00938	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 07/31/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	•	
MOORHI			OND AVENUE AD, MN 5656	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21925	Continued From pa	ge 17	21925			
	due to AMA dischar	ge.				
	Summary form date mood/behaviors sho indicated recomme been made on seve					
	Summary form date by the interim DON AMA, required ongo medication adminis monitoring. The form	ial Services Discharge ed 6/29/20, signed on 6/30/20, , revealed R8 discharged bing assistance with ADL's, tration and blood sugar m indicated the former LSW on community resources to ning housing.				
	reported to work on informed by other fa and DON had R8 si discharged R8 from informed R8 had be stay for a couple of worked the previous exhibited no behavi	5 a.m. LPN-B stated she 6/29/20, and had been acility staff the administrator ign the AMA form and the facility. LPN-B was een brought to a local hotel to weeks. LPN-B stated she had s weekend and R8 had ors and expressed excitement b be fitted for a prosthesis and g housing.				
	On 7/21/20, at 2:00 family member (FM telephone call from discharge from the been "kicked out" o two week hotel stay would be staying af	p.m. via telephone interview l) stated he received a R8 a day or two after his facility and stated he had f the facility. R8 said he had a and did not say where he ter the hotel stay. FM stated ere R8 currently was living or				

	NT OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED C 31/2020
VAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IOORH	EAD REHABILITATION	N & HFAI THCARI	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21925	had worked in the f past couple of weel aware R8 had beha against facility polic behaviors since the informed him if he of would be discharge 6/29/20, the admini Coordinator informed on an unapproved I Former RN-A review record (EHR) and of lacked any leaves of over the weekend. over the telephone weekend and confin facility over the pre- was another reside entered R8's room packing R8's below not break the rules. notified interim DOI and R8 was still dis informed the interin not been administe interim DON stated know what he was facility had set up a and did not know w Former RN-A stated discharge and had in the future, when him. On 7/21/20, at 3:50 interview with the M she indicated R8 ha couple of weeks an	acility until approximatley the ks prior. She stated she was aviors in the past of leaving ey and confirmed he had no a facility met with him and did not follow the rules he ed. Former RN-A stated on strator, interim DON and MDS ed her R8 had left the facility eave over the weekend. wed R8's electronic health confirmed the documentation or behaviors for R8 occurring Former RN-A contacted staff who had worked the previous rmed R8 had not left the vious weekend and in fact it nt who did. Former RN-A where the administrator was gings and informed her R8 did. Former RN-A stated she also N R8 did not break the rules charged. Former RN-A n DON R8 was on insulin, had ring his own insulin and R8 should be fine and should doing. Former RN-A stated the two week hotel stay for R8 here he went to after that. d R8 did not initiate the planned on being discharged housing had been secured for				

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVE COMPLETED C	
		00938	B. WING	B. WING		31/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HEALTHCARL	COND AVENUI EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21925	Continued From pa	ge 19	21925			
	from there.					
	interview with the R been involved with meetings with the fa assisted R8 to file a notice of discharge stated he was happ keep him during the he voiced he had he ROLTC indicated R	5 a.m. during an telephone OLTC, she indicated she had R1's discharge planning acility. She confirmed she had a first and second appeal to his provided on 2/24/20. R8 by the facility was required to a appeal process and stated ope for the first time in his life. 8 had been actively working ses with a relocation specialist				
	call from the admin R8 had recently left the facility question facility's COVID 19 the funeral. The add the possible breach facility felt he neede facility AMA. At that via telephone and r R8 stated he wante because there was housing after discha- jeopardize that plan	he had received a telephone istrator on 6/22/20, who stated the facility for a funeral and ed if he had followed the precautions while he was at ministrator stated because of a in COVID 19 precautions, the ed to be discharged from the time, ROLTC contacted R8 eviewed the facility concerns. ed to leave the facility, but a plan in place for long term arge, he did not want to a. He stated he would follow d not leave the facility.				
	meeting with R8 an the facility rules reg absences from the would follow the rul jeopardize his long "it is black and whit ROLTC stated she	that day the facility held a d facility staff and reviewed arding resident leave of facility. R8 again stated he es and did not want to term housing plans. R8 stated e" and " I will follow the rules." had contacted the interim 6/26/20, and was told that R8				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED
	00938		B. WING			31/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MOORH	EAD REHABILITATIO	N & HFAI THCAR	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21925	Continued From pa	ige 20	21925			
	was doing much better, had struggled with quarantine but was redirectable.					
	aware R8 had beer and she began call administrator on 7/6 receive a call back 7/8/20. ROLTC stated she administrator that F leaving the facility A administrator stated openings at the hor local hotel. ROLTC administrator to cla discharge when the belongings, and dro state in the midst o stated the administ R8's discharge and ROLTC informed th copy of the AMA for forwarding it to an a					
	6/29/20, when he a morning there had about plans to discl was informed later LSW R8 was being medications. LPN-/ agitated,angry and was being discharg	1 p.m. LPN-A stated on rrived at the facility that been nothing reported to him harge R8. LPN-A stated he in the morning by the former discharged and to give R8 his A stated R8 appeared was cursing after learning he led. LPN-A stated he talked to				
	discharged. LPN-A to R8 and he refuse the facility provided R8 to a local hotel.	know why he was being offered medication education ed. LPN-A stated he was told lodging and transportation for LPN-A stated R8 received confirmed R8 did not				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00938	B. WING		07/3	31/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MOORH	EAD REHABILITATION	N & HFAI THCARI	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21925	Continued From pa	ge 21	21925			
	administer his own insulin.					
	facility and ROLTC inform him if the be smoking outside of intoxication continu from the facility. Inte follow the rules of th on 6/29/20, the faci following the facility and former LSW m behaviors and remi to him prior to this t behaviors continued did not care and he and did not provide communication abores stated the option of shelter was discuss not care. The facilit homeless shelter and available and only first stated the facility wo option and paid for R8 contacted a ferm she was at the facil Interim DON confirm of R8 leaving the fac designated times of progress notes doc 6/23/20. Interim DC either she or the ad AMA paperwork and one. Interim DON s informed of R8 beir	p.m. interim DON stated the met with R8 on 6/23/20, to haviors of leaving the facility, designated times and alcohol ed he would be discharged erim DON stated R8 agreed to he facility. Interim DON stated lity was made aware of R8 not rules over the weekend, she et with R8 to discuss his nded R8 the facility had talked ime of immediate discharge if d. R8 responded by saying he wanted to leave the facility any other verbal but the behaviors. Interim DON R8 going to a local homeless sed and again R8 stated he did y contacted the local nd there were no beds had chairs open. Interim DON as not comfortable with that a two week hotel stay for R8. hale friend to pick him up and ity when R8 left the facility. med there were no behaviors socility, smoking outside of r alcohol intoxication in the umented since the meeting on N stated she was unsure, but liministrator had R8 sign the d she could not recall which totated she had not been ng on insulin and stated R8 le to administer it since he	4			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/31/2020	
		00938	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HEALTHCARL	COND AVENUE EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21925	Continued From pa	ge 22	21925			
	Interim DON stated the administrator met with R8 in his room after her and former LSW left R8's room.					
	(MDSC) stated she prior to 6/29/20, and telephone call abou unsupervised. MDS	SC stated she could not recall call and indicated she did not				
	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.					
	informed of R8's be weekend and could behaviors. Administ former LSW went in behaviors and she	d on 6/29/20, they were shaviors exhibited over the I not recall the details of the trator stated interim DON and In to R8's room to discuss was told R8 cursed at them done with the facility.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C			
		00938	B. WING	G		07/31/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
MOORH	EAD REHABILITATION	N & HEALTHCAR	OND AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21925	Continued From pa	ge 23	21925				
	R8 was in the restruction of the restruction. A state of the restruction of the restruction. The restruction of the restruction of the restruction of the restruction of the restruction. The restruction of the restruction o	d she entered R8's room and bom at the time. When he administrator attempted to talk ed to discuss the situation d the administrator he would gings and would leave the bor stated she and NA-B ng R8's belongings and placed by the facility. Administrator ng with removing R8's e dresser, she noted a green d up in a red cloth and R8 sage. R8 stated he was while the administrator and back R8's belongings. d former LSW contacted a b beds were available and the by for a two week stay at a ed it was better than going to d agreed. Administrator stated ed and had wanted to e administrator offered facility R8 accepted that offer of binistrator stated LPN-A gave titons and indicated she was been on insulin. Administrator sure who provided R8 with the p.m. maintenance supervisor asked by the administrator transport R8 to the Motel 6 in 20. MS stated he stood by in cility staff packed his administrator approached him sked MS to bring R8's he facility van. R8's girlfriend ok some of his belongings to asported R8 to the Motel 6 and stated the only thing R8					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00938	B. WING		07/31/202	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MOORHE	EAD REHABILITATION	N & HFAI THCARI	COND AVENUE EAD, MN 5656			
				PROVIDER'S PLAN OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21925	Continued From pa	ge 24	21925			
	only had ties in Moo repaired R8's windo out his window, and	s he going to Fargo when he orhead. MS stated he had ow in the past due to R8 going d stated there had been no ded at the time of R8's				
	interview former LS working in the facili stated she was awa pursuing relocation was awaiting result there were no plans 6/29/20. Former LS the middle of a disc informed the facility during the appeal p she was informed in R8 had exhibited be the nurses station t leaving the facility to and the interim DO discharged. Former had lacked docume exhibited over the p LSW indicated inter to regional clinical of operating officer (C behavioral concern R8 from the facility "would just take the LSW went to R8's r	5 p.m. during telephone W stated she had been ty until the previous week. She are R8 had been actively assistance to obtain housing, s of approval for disability and s to discharge him prior to W confirmed R8 had been in could not discharge R8 rocess. Former LSW stated in the IDT meeting on 6/29/20, ehaviors of taking the key from o the activities room and o smoke over the weekend N stated R8 needed to be r LSW confirmed R8's EHR entation of any behaviors R8 previous weekend. Former rim DON stated she had talked consultant (RCC) and the chief OO) of the facility about R8's s and the need to discharge and they responded the facility a tag." Interim DON and former room where R8 was sleeping kets covering his head and				
	behaviors reported DON reminded R8 it was discussed he	R8 about the smoking over the weekend. Interim of the 6/23/20, meeting where would be discharged if he haviors and R8 did not				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00938	B. WING			C 31/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		2810 SEC	OND AVENUE			
		MOORHE	AD, MN 5656	60		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21925	Continued From pa	ge 25	21925			
	together and stated	to get his belongings the facility was discharging R8 did not respond as he was				
	homeless shelters a openings for beds a interim DON and ex- comfortable with the the facility paid for a hotel in Fargo ND. I administrator and a belongings while R8 facing the door and stated the administr sign the AMA form. R8 via facility transp female acquaintance too. Former LSW si out the behaviors re exhibited by anothe facility. Former LSV administrator and h note in R8's EHR of stated she was info received a telephon from staff at the Mo an additional two we be homeless and th Former LSW stated director (AD) receiv week from R8, who and living under a b	e plan. Former LSW stated a two week stay at the Motel 6 Former LSW stated the NA packed up R8's 8 was seated in his wheelchair was not talking. Former LSW rator and interim DON had R8 Former LSW stated MS drove portation to the hotel and a se of R8 arrived at the facility tated on 6/30/20, she found eported about R8 were actually r resident residing in the V stated the interim DON, erself wrote the discharge in that same day. Former LSW rmed by the administrator she is call a couple of weeks later tel 6 in Fargo ND to request eeks stay for R8 or R8 would he facility denied the request. I she was aware the activities ed a phone call the previous indicated he was homeless				
	the administrator ap to take R8 out for a was being discharg	pproached her and asked her cigarette. R8 informed AD he ed by the facility, said a curse idicated he had nowhere else				

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		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C			
		00938	B. WING			07/31/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
MOORHEAD REHABILITATION & HEALTHCARI 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21925	Continued From pa	ige 26	21925				
	disability and housi LSW and they had live. AD stated R8 of over the weekend the happen. R8 stated he did not follow the he would be dischar facility via the facilit 7/21/20, AD stated from R8 and he sta drugs and needed from R8 and brought if wheelchair under a On 7/28/20, at 11:1 (HUC) stated on 6/2 regarding R8's disc R8 wheeled himsel administrator met hasked the administr identified he was he go. Administrator to a two week stay at administrator where the administrator re- and HUC was not st asked for a third tim his two weeks were	AD he had been working on ng assistance with former been trying to find a place to did not say what he had done o cause the discharge to the interim DON had told him e facility rules and as a result rged. AD stated R8 left the ty van driven by MS. On she received a phone call ted he was homeless, back or to borrow money. AD informed y she would buy him some n where he was. AD bought t to R8 who was in his bridge in Moorhead, MN. 3 a.m. NA-B stated on strator asked her to assist her 's belongings. NA-B stated ator and herself packed up 8 was upset, swearing and the ned R8 to stop that behavior. 6 a.m. health unit coordinator 29/20, she heard discussion tharge and about an hour later f to the front desk and the him there. HUC stated R8 rator where he was going and omeless and had nowhere to old R8 the facility had paid for a hotel. R8 asked the e he would go after that and eplied he was on a waiting list sure what that meant. R8 ne where he was going after e up and there was no administrator. HUC stated she					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, SI			51/2020
		2810 SE				
MOORH		MOORH	EAD, MN 5656	60		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21925	Continued From pa	age 27	21925			
	administrator and h him. HUC stated th the AMA form and a form and then he s form. HUC stated a received a phone of asking about an ex- she forwarded the of stated R8 did call u asked to speak to A homeless, had no r going back on drug transferred the call On 7/31/20, at 10:0 specialist (FPDIS) report on 7/30/20, r completed on R8. R8 had not been lo On 7/31/20, at 10:4 dispatch (MPDD) s report on 7/30/20, r completed on R8. information had be since his last know room in Fargo, ND. Review of facility po Against Medical Ad an AMA discharge leave the facility. Th and administrator v impending AMA disc the resident to disc policy stated the facility.	 9 a.m. the Fargo PD intake stated the facility had filed a requesting a well check be The FPDIS stated at that time reated by the PD. 6 a.m. the Moorhead PD tated the facility had filed a requesting a well check be The MPDD stated the en transferred to the Fargo PE n residence had been a hotel 				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION		E SURVEY PLETED	
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:				
		00938	B. WING			C 31/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	EAD REHABILITATIO			ENORTH			
		MOORH	EAD, MN 5656	60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21925	Continued From pa	age 28	21925				
	7/31/20, when the f Moorhead, MN PD attempt to locate R developed a plan to to the facility if R8 of The facility provide members about the discharge policy an facility provided edu AMA procedure and The noncompliance and severity level D		•				
	Order(EO) 20-14, sidentified beginning and continuing for the emergency, all resist terminating resident pendency of the en- termination is due the endangering the sa EO identified restrict to keep Minnesotar the community spre- and nationwide. The household facing effrom the Attorney G happening.	z's Emergency Executive signed March 23, 2020, g no later than March 24, 2020 the duration of the peacetime idential landlords must cease nitial leases during the nergency, except where the to the tenant seriously afety of other residents. The cting evictions was a vital tool ns in their homes to mitigate ead of COVID-19 in Minnesota ie EO indicated any person or viction would have assistance General to prevent this from					
	signed 7/13/20, ide Peacetime Emerge 8/12/20.	z's Emergency EO 20-78, ntified the COVID-19 ency was extended through					
	administrator, direc	THOD OF CORRECTION: The ctor of nursing (DON), or iew and/or develop policy and	•				

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	B. WING	60	COMPLETED C 07/31/2020
AME OF PROVIDER OR SUPPLIER STREET ADD IOORHEAD REHABILITATION & HEALTHCARI (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	DRESS, CITY, S OND AVENU AD, MN 565 ID	E NORTH 60	
SUMMARY STATEMENT OF DEFICIENCIES 2810 SECO MOORHEA (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES	OND AVENU Ad, MN 565 ID	E NORTH 60	
SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	AD, MN 565	60	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID		
	TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
21925 Continued From page 29	21925		
procedures that provide guidance on proper and safe discharges from the facility to include against medical advice (AMA) discharges. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days			