

Revised October 28, 2020 to add the signature

Electronically delivered October 8, 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 August 18, 2020, we notified you a remedy was imposed. On September 22, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 2, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 2, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 18, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 2, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 2, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, 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



Electronically delivered October 8, 2020

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Feel free to contact me if you have questions.

Sincerely,

Signature block here



Electronically delivered

October 8, 2020

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

Re: Reinspection Results

Event ID: 2TUO12

Dear Administrator:

On September 22, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 22, 2020. At this time these correction orders were found corrected.

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



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.

Moorhead Rehabilitation & Healthcare Center August 18, 2020 Page 2

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

Moorhead Rehabilitation & Healthcare Center August 18, 2020 Page 3

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

Moorhead Rehabilitation & Healthcare Center August 18, 2020 Page 5

initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Moorhead Rehabilitation & Healthcare Center August 18, 2020 Page 6

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

PRINTED: 09/15/2020 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING				31/ 2020
NAME OF F	PROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 017	3172020
MOORH	EAD REHABILITATION	N & HEALTHCARE CENTER			10 SECOND AVENUE NORTH DORHEAD, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS 1/20, an abbreviated survey	F 0	000			
	was completed at y complaint investiga NOT to be in complete.	trour 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 the discharged R8 from homeless. On 7/28/ administrator, and in (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 H505211 F622.	19C was substantiated at					
	Additionally, the foll be substantiated: H5052125C at F55	lowing complaint was found to					
		plaints were found to be no deficiencies cited:					
	Additionally, the foll to be unsubstantiate H5052117C H5052118C H5052121C H5052123C H5052124C	lowing complaints were found ed:					
		f correction (POC) will serve of compliance upon the					
ABORATOR)	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically 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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	СОМ	E SURVEY IPLETED
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F 000 F 550 SS=D	enrolled in ePOC, y at the bottom of the form. Your electron be used as verifical receipt of an accep on-site revisit of you validate that substate regulations has been your verification. Resident Rights/Ex	otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. Upon table electronic POC, an our facility may be conducted to ential compliance with the en attained in accordance with ercise of Rights	F 000			9/2/20
	self-determination, access to persons outside the facility, this section. §483.10(a)(1) A fact with respect and digresident in a manner promotes maintenather quality of life, reindividuality. The fapromote the rights of \$483.10(a)(2) The faccess to quality caseverity of condition must establish and practices regarding provision of service residents regardles.	right to a dignified existence, and communication with and and services inside and including those specified in willity 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 cility must protect and of the resident. Facility must provide equal are regardless of diagnosis, and, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all sof payment source.				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 550	rights as a reside or resident of the §483.10(b)(1) The resident can exerinterference, coeffrom the facility. §483.10(b)(2) The free of interference reprisal from the rights and to be sexercise of his or subpart. This REQUIREM by: Based on intervice facility failed to promanner for 1 of 1 interactions while Finding include: R3's quarterly Min 5/30/20, indicated included renal insidepression. The cognition and was transfer, dressing hygiene. R3's care plan rewas at risk for accare needs due to impaired balance was independent mobility, transfers Further, the care	nt of the facility and as a citizen	F 5	F- 550 1. R3 clothing was inspect properly labeled and placed and any unlabeled or imprositems were removed. R3 or reviewed and no adjustmen needed. R3 via interpreter feeling safe in the facility. A residents with communicat were reviewed and care plaupdated as needed. Reside interviewed and there were dignity, respect or mistreativoiced. 2. All residents have a right the facility and have the positive affected. 3. An all staff in-service with a review the policie.	d in his room operly placed care plan ints were reported All other ion barriers ans were ents were ents were ent no reports of ment were ght to dignity in tential to be was conducted	

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F 550	required clear exp choices for interve indicated R3 had a explain all procede the resident time to Review of 3's Moo Healthcare Conce Form, indicated or stated to nursing a embarrassed by o (OTA). R3 indicate entrance of his roo by and she notice was not his. R3 in off him without say was very embarra rough. NA-A told F apologized to R3. adult report was s On 7/22/20 at 1:29 sitting in his whee room looking arou off of him that was thought someone did not know it wa not explain what s t-shirt off of him. F embarrassed beca present in the hall took the t-shirt off closet and told him felt humiliated but indicated OTA too scared him at the R3 indicated it hap	lanation of situation and ention. Further, the care plan refusals, and directed staff to ures before starting and allow of adjust to changes. The ad Rehabilitation and refusals and Problem Resolution of 6/22/20 at 11:45 a.m. R3 assistant (NA)-A he was accupational therapist assistant ed he was in the doorway of my when the OTA was walking draw as wearing a t-shirt that dicated OTA yanked the t-shirt ying anything. R3 indicated he ssed and at times she can be R3 she would pass it along and The form indicated a vulnerable	F 5	Rights and Dignity along won how to utilize the langual interpreter assistance and number is located within the administrative staff will conconduct Ambassador rounderegularly with the residents concerns including respect Resident Council meeting of over all Resident Rights with on Dignity and Respect. A all Laundry Staff will be held review clothing labeling and routines. 4. An audit has been demonitor completion of Ambase Rounds with managers to it areas of dignity/respect and laundry to ensure resident delivered to the right reside will be completed weekly to the monthly to ensure corresults of the audits will be QAPI committee for future recommendations. The audit completed by the Administrates designee. Compliance: September 2,	age line for where this e facility. The stinue to ds to meet to discuss any didgnity. On 8/14/20 went the an emphasis meeting with d 8/28/20 to d distribution veloped to passador dentify any dentify	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		ON & HEALTHCARE CENTER		28	B10 SECOND AVENUE NORTH IOORHEAD, MN 56560		
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F 550	On 7/22/20 at 4:55 walking by R3's roanother resident tould look at the tataking the t-shirt on in the hallway remember if other or not. OTA indicashe was trying to shoing. OTA indicatand did not use ar with R3 at the time a miscommunication of 7/22/20 at 9:35 memory was intactive.	5 p.m. OTA indicated she was com and noticed he had eshirt on and asked R3 if she ag. OTA indicated R3 started ff in the hallway and she got to out of his closet and he put it OTA indicated she could not residents were in the hallway ted she felt R3 understood what say to him and what she was seed she did not speak Spanish interpreter to communicate to of the incident and felt it was on.	F 5	550			
	out in the hallway, him and did not sat told her he was enthe incident because he did not know windicated R3 told hwent back in his roafter the incident because him. NA-A in told him she would nurse and the nurse and the nurse the incident, did not incident and could The DON indicated the residents with	e next day that he was sitting when OTA took a t-shirt off of my anything. NA-A indicated R3 inbarrassed and humiliated after use it caught him off guard and hat she was doing. NA-A mer he put on another t-shirt, from and stayed in his room because other residents had dicated she apologized to R3, if report the incident to the use had filed a grievance. To a.m., director of nursing the was not here at the time of the thoo anything about the not speak to what happened. If a.m. administrator indicated took R3's t-shirt off of him					

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	without talking to his she felt there was a the R3 and OTA. The felt rushed and was OTA and this was used indicated she would residents with responders. She indicated assumptions and inhave been avoided. Review of facility properties of the felt	im. The administrator indicated a misunderstanding between he administrator indicated R3 is not able to understand the un-dignified. The administrator dexpect staff to treat the ect and dignity while providing ed staff cannot make indicated this situation could lead to a manner and in an inaintains and enhances each indicated in a manner and in an inaintains and enhances each indicated in full recognition of lity. For and discharge-lity requirements a permit each resident to be and not transfer or lent from the facility unlessing the facility; discharge is appropriate entity health has improved esident no longer needs the boy the facility; dividuals in the facility would ent; individuals in the facility would individuals in the facility would entity individuals in the facility would inclividuals in the facility would individuals in the facilit	F 62			9/2/20

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	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 622	appropriate notice, under Medicare or Nonpayment applie submit the necessipayment or after the Medicare or Medicare or Medicare or Medicare ident refuses to resident who beconsided admission to a facing resident only allow or (F) The facility ceal (ii) The facility may resident while the align 431.230 of this continuous exercises his or hed discharge notice for 431.220(a)(3) of the discharge or transfor safety of the resident under any in paragraphs (c)(1) section, the facility or discharge is downward in paragraphs (c)(1) section, the facility or discharge is downward in paragraphs (c)(1) section, the facility or discharge is downward in provide (i) Documentation must include: (A) The basis for the case of paragraphs (c) (i) of this section. (B) In the case of paragraphs (c) (ii) In the case of paragraphs (c) (iii) In the case of paragraphs (c) (iiii) In the case of paragraphs (c) (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	Medicaid) a stay at the facility. See if the resident does not any paperwork for third party see third party, including aid, denies the claim and the pay for his or her stay. For a mes eligible for Medicaid after lity, the facility may charge a able charges under Medicaid; sees to operate. In not transfer or discharge the appeal is pending, pursuant to hapter, when a resident or right to appeal a transfer or om the facility pursuant to § is chapter, unless the failure to fer would endanger the health ident or other individuals in the remust document the danger fer or discharge would pose. Jumentation. Jumentation. Jumentation (F) of this must ensure that the transfer cumented in the resident's dappropriate information is the receiving health care	F6	522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		C 07/31/2020	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	1 01/01/2020	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	D BE COMPLÉTION	N
F 622	needs, and the ser facility to meet the (ii) The documenta (2)(i) of this section (A) The resident's produced discharge is neces (A) or (B) of this sec (B) A physician who necessary under pathis section. (iii) Information promust include a min (A) Contact information promust include a min (C) Advance Direct (D) All special instrongoing care, as a (E) Comprehensive (F) All other necessory of the resident consistent with §48 any other documer a safe and effective This REQUIREMED by: Based on interview facility failed to allohad insulin dependent for appropriate discount of the facility to a no housing or comment (II) situating the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III) and the facility to a no housing or comment (III).	impts to meet the resident vice available at the receiving need(s). Ition required by paragraph (c) in must be made byothysician when transfer or sary under paragraph (c) (1) action; and en transfer or discharge is aragraph (c)(1)(i)(C) or (D) of vided to the receiving provider imum of the following: ation of the practitioner care of the resident. Sentative information including active information including active information, including active information including acti	F 62	F- 622 1. R8 is no longer a resident at facility. The Moorhead County caseworker and the Moorhead an Dakota police departments were contacted on 7/30/20 to conduct a check for R8. Per MD order, R8 were considered for readmission to the after having been seen in the emeroom and is medically safe and	d North a well will be facility	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
					I	С
		245052	B. WING _			31/2020
NAME OF F	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP C	CODE	
MOORHE	EAD REHABILITATION	ON & HEALTHCARE CENTER		2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
	CLIMMADY C	TATEMENT OF DEFICIENCIES			DDECTION	0.650
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 622	Continued From p	nage 8	F 62	22		
1 022	Continued From p	bage 0	F 02		. 4 - 41 - 4 : 1:4 .	
	The 11 heaven and	3/00/00 -4 4:00 + +		appropriate for readmission	i to the facility.	
		6/29/20, at 1:00 p.m. when the		2 All residents in the fee	:11:45	
		d R8 from the facility to a local sek stay with no secured housing		All residents in the fac discharge anticipated back		
		two week stay. On 7/28/20, at		community have the potent		
		ninistrator and interim director of		affected.	iai to be	
		ere notified of the IJ situation.		anotica.		
		mented corrective action and the				
		on 7/31/20, at 12:38 p.m., when		3. 7.29.20 the IDT and Li	icensed	
	the facility made a	attempts to locate R8 and the		Nursing Staff were in-service	ed on policies	
		aff had been re-educated and		Resident Transfer/Discharg		
		arge procedures were in place.		Against Medical Advice and		
		ce remained at the lower scope		Absence. No policy change		
		D, iolated, no actual harm with		warranted. IDT team was in		
		than minimal harm that is not		discharge planning to begin		
	immediate jeopar	dy.		and include: resident social educational needs, any clin		
	Findings include:			that will be needed with the		
	i ilidiliga ilicidac.			ensuring a safe discharge f		
	R8's quarterly Mir	nimum Data Set (MDS) dated		residents to a community of		
		R8 was cognitively intact and		All discharges since survey		
		nich included Diabetes Mellitus,		reviewed by the IDT team a		
	left below the kne	e amputation, viral hepatitis and		complete.		
		re. The MDS identified R8 did				
		independent with most activities				
		L's) which included transfers,		4. An audit has been dev		
		g and bathing tasks. Further, the		monitor the date of anticipa		
		3 had no behaviors and received		IDT meeting related to disc		
		ulin injections during the seven		confirm discharge address,		
	day assessment i	elerence penou.		equipment (DME) required, transportation, community s		
	R8's admission C	are Area Assessment (CAA)		physician notification with o		
		entified R8 had recently been		reason for discharge. The		
		cility after surgery for a left		completed daily x 10 days,		
		mputation and was independent		weeks then monthly. The r		
		The CAA indicated R8 was able		audits will be reported to the		
		s known and was on a		committee for future recom		
		ydrate controlled diet for his		The audit will be completed		
	diabetes. The CA	A indicated R8 had little interest		Administrator or her design	ee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245052	B. WING				C 31/2020
NAME OF I	PROVIDER OR SUPPLIER	२	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
MOORHI	EAD REHABILITATIO	ON & HEALTHCARE CENTER			810 SECOND AVENUE NORTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 622	offered mental he Review of R8's Se Assessment form not appropriate fo medications. R8's care plan, re independent with mobility, transfers identified R8 had insulin, blood gluc monitored for sign hyperglycemia (hi- hypoglycemia (lov indicated R8 inter- the building withor identified R8 did n medications and i coordinate service discharge. Review of R8's pr 6/30/20, revealed - 2/24/20, late ent R8 with a 30 day i	alth services upon admission. Elf Administration of Medication dated 6/17/20, revealed it was r R8 to self administer Vised 7/14/20, identified R8 was most ADL's including: bed and eating. The care plan Diabetes Mellitus, received cose checks and was to be as and symptoms for gh blood sugar) and v blood sugar). The care plan mittently refused cares and left ut notifying staff. The care plan not self administer his own indicated social services would be necessary for a community	F 6	522	Compliance: September 2, 2020		
	be discharged to I home in Benson 3/9/20, former lid	acility and indicated R8 would Meadowlane Board and Care censed social worker (LSW) and with R8 to obtain consent to					
	send documentati ombudsman for lo former LSW along	on requested by the regional ong term care (ROLTC) and g with R8 contacted Lakes and y Action to follow-up on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245052	B. WING				31/2020
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 SECOND AVENUE NORTH MOORHEAD, MN 56560	1 011	01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	Former registered is medical doctor (ME - 3/12/20, Clay could LSW to report R8's - 3/13/20, phone can contacts listed on fibrother stated he hin two weeks. Moornotified too. Later the LSW received a phand Prairie Communicating R8 show p.m. requesting assistated R8 appeared extremely difficult to - 3/14/20- R8 return to emergency room refused the evaluate facility.	e facility without notifying staff. nurse (RN)-A contacted) regarding R8's leave. nty report completed by former	F 6	622	,		
	completing MNCho	SW assisted R8 with ices assessment (application Clay County Public Health over					
	Clay County Public	SW received message from Health R8 was accepted for . R8 was informed and stated my face."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245052	B. WING			1	31/2020
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		2810	EET ADDRESS, CITY, STATE, ZIP CODE D SECOND AVENUE NORTH ORHEAD, MN 56560	1 077	0172020
(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	call from Opportuni Services (company services (company service corrdination income, and abilitie within the communiassist with relocation - 4/21/20, R8 was sofor hyperglycemia etest is a blood test average levels of bithree months) note an increase in insulfut (The American Diaguidelines 1/1/20, sofor most nonpregnatargets differ based more or less stringe appropriate for eactime 7%. A1C may also than 154 mg/dL Beplasma glucose): 8 beginning of the meglucose): Less than - 5/5/20, R8 comples social security disalfut - 5/20/20, seen by I hyperglycemia and due to diet noncom titrate insulin due to glucose monitoring A1C tomorrow and (a long acting form	W stated she received phone ty Community certified to provide relocation in to individuals with limited its to re-establish themselves ity) and they accepted R8 to on services. Item by nurse practitioner (NP) episodes and A1C (the A1C that provides information about lood glucose over the past ed to be 9.5. Provider ordered in. 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) Interest the received phone application for individual and the state of the provides in the state of the past and	F6	22			

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	` '	E SURVEY PLETED
		245052	B. WING			l	C
NAME OF PROVIDER OF	R SUPPLIER	243032	D. WIING		TREET ADDRESS, CITY, STATE, ZIP CODE	07/	31/2020
					810 SECOND AVENUE NORTH		
MOORHEAD REHAL	BILITATIO	N & HEALTHCARE CENTER			MOORHEAD, MN 56560		
PREFIX (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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
- 5/22/20, notified w - 6/4/20, s with foor obtaining plucose in depressive reported in declined in A1C in on twice a data - 6/10/20, daily and - 6/17/20, room and lethargic. notified. Notified in meds on emergence was sent brother in being evaluated by the control of the con	(an oral manual	lits came back at 8.8, NP orders obtained. P, type 2 Diabetes Mellitus noted blood glucose improved ations 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 atinue with Glipizide daily. In ged insulin from twice daily to A1C next week. In and placed diabetic handed over care to a services (EMS) staff. R8 for evaluation and R8's returned to the facility after the anew diagnosis of cohol intoxication. In the plant of the plant of the plant of the services of the plant of the facility after the anew diagnosis of cohol intoxication. In the plant of the plant of the plant of the services of the plant of the pla	F6	522			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION			E SURVEY PLETED
		245052	B. WING				31/ 2020
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	CODE	, 077	5172020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 622	possession of the kand had no orders handle it according - 6/23/20, former LS DON and ROLTC (to discuss behavior against medical admotified if he left the advice or went outs designated times he the facility. Discuss goal to obtain hous relocation services rules and expectation services and expectation services and expectation services. The facility for failing to agreement. The facility for failing to agreement. The facility for failing to agreement. The facility for failing to agreement would be immediated the "violation the previous week I immediate discharge pack his own things his own belongings with packing up bel to pack up anything been opened and a wrapped around it wadministrator and papproached nursing	aff suspected R8 had eys. At 7:57 a.m. MD notified and indicated the facility to facility protocols. SW, administrator, interim via the telephone) met with R8 ral concerns, leaving the facility vice and safety issues. R8 was a facility against medical ide to smoke outside of his e would be discharged from ion continued regarding R8's ing and continue working with R8 verbally agreed to follow ons. Tat 12:51 p.m. administrator russ behaviors he continued to 1/20, meeting with m DON, former LSW and tor informed R8 "since he had rs and over the weekend the nediate discharge from the	F 6	522			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245052	B. WING_		I	C / 31/2020
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		10112020
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 622	put his hands in the administrator advist that and the police administrator hand continued to argue extra staff were cal R8 up and waiting discharge to the MAMA paperwork and a hotel then to a ship packed up and he Motel 6. - 6/29/20, at 12:57 interdisciplinary tear regarding noted be the weekend. R8 wand very dismissive former LSW and in opportunity to elabout R8 remained no language. "R8 was meeting regarding behaviors towards R8 stated understate to shelter was disc go AMA to the Mote be cognitively intace medications and petransport. Female of at the time of the A-6/29/20, late entransport. Female of at the time of the A-6/29/20, at 15:09	e air and cursed at them. The red R8 one more attempt like would be contacted. The ed R8 the red bag and R8 and become aggressive and lled in to assist. While packing for transport, R8 opted to otel 6 in Fargo, ND, signed the red stated he would "rather go to relter." R8's final items were was taken by transport to p.m. interim DON indicated the red (IDT) team spoke with R8 red haviors which occurred over reas noted to be non responsive to a during the meeting. The reterim DON offered R8 the reason behaviors in question on verbal only using his body reminded about previous IDT consequences related to poor staff and other residents" and red inding. "Immediate discharge ussed with R8 but R8 opted to red 6 in Fargo." R8 was noted to ret and R8 left the facility with resonal belongings via facility friend was noted to be present MA. Ty, at 12:59 p.m. former LSW retion agency and Clay County A discharge. P.m. licensed practical nurse R8 discharged AMA from the	F 62	22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245052	B. WING_		07	C // 31/2020
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		70 112020
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 622	- 6/30/20, at 9:23 a note, interim DON assist with ADL car and blood sugar m continued to work assist R8 with house - 6/30/20, at 2:20 p discharge) LPN-A is on medication adm "he did not need to his medications." Fand benefits of the The progress notes behaviors exhibited 6/29/20, day of disc administrator indicates agreement from the Review of MD and 5/14/20, to 6/24/20 - 5/14/20 - telemedidentified R8 had us Mellitus with hypers R8 received Lantus blood glucose montimes a day. - 5/27/20, telemedicated R8 had us type 2. Plan to con - 6/17/20, ER visit in the continues and services	a.m. Recapitulation of stay indicated R8 required ongoing re, medication administration onitoring. Former LSW on community resources to sing. a.m. (greater than 1 day after ndicated R8 refused education ninistration times and R8 stated be told how and when to take R8 was educated on the risks decision. Is lacked documentation of the by R8 from 6/22/20, to charge although the lated R8 had violated the verbal e previous week. NP progress notes from revealed the following: Ilicine nursing home visit, NP ncontrolled type 2 Diabetes glycemia and last A1C was 9.4. In insulin and Glipizide and laterial intoring was ordered for four cine nursing home visit, MD ncontrolled Diabetes Mellitus tinue present care.	F 62	22		
	intoxication with a low blood pressure	blood alcohol level of .212 and . R8 was kept in the ER for an time and given intravenous				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245052	B. WING			1	C 31/2020
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SECOND AVENUE NORTH OORHEAD, MN 56560	1 077	01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 622	indicated R8's A1C had uncontrolled Dichards were mad 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 No further A1C laborater 5/22/20. Review of R8's unsidentified by facility included Lantus So Insulin 10 units (a undinistration 100 subcutaneously (tis and muscle) daily in Mellitus. Review of R8's Med (MAR) dated 6/1/20 following: -blood glucose checand was last check with the results of 1	back to the facility. cine nursing home visit, MD was 8.8 on 5/22/20 and R8 iabetes Mellitus and no e. cratory test A1C, from 2/28/20, d the following: c was 6.9. c was 9.5. c was 8.8. s were found in R8's record igned Physician Orders, as R8's current orders, loStar Solution Pen-injector unit of measurement in insulin units per milliliter [ml]) sue layer between the skin in 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	22			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245052	B. WING _		07	C / 31/2020	
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 622	- R8 received Glypiand last received it - R8 received Lanter Pen-injector insuling in the morning for Directived on 6/29/20 R8's Notice of Discer R8's health had implemented the would be discharge 3/24/20. R8's Continuance of discharge and transprovided to the facilitied a hearing 4/7/20, to determine discharge R8. R8's second Continuance R8's second Continuance R8.	is reasons ranging from R8's from the facility. izide 5 mg. (milligrams) daily on 6/29/20, at 8:00 a.m. us SoloStar Solution 10 units subcutaneously daily Diabetes Mellitus and last	F 62				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING			C 7/31/2020
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CX (EACH CORRECTIVE ACTIVE ACTIVE ACTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 622	leaving the facility R8's Transfer/ Disidentified the facil due to AMA disch Review of R8's So Summary form da mood/behaviors s indicated recomm been made on se Review of R8's So Summary form da by the interim DO AMA, required on medication admin monitoring. The fo continued to work assist R8 with obt On 7/21/20, at 10 reported to work o informed by other and DON had R8 discharged R8 fro informed R8 had stay for a couple o worked the previous exhibited no beha over the potential the goal of obtain On 7/21/20, at 2:0 family member (F telephone call fro discharge from th been "kicked out"	charge notice dated 6/30/20, ity discharged R8 on 6/29/20, arge. Decial Services Care Conference ated 6/2/20, revealed R8's showed improvement and rendations for discharge had veral occasions. Decial Services Discharge had veral occasions. Decial Services Discharge ated 6/29/20, signed on 6/30/20, N, revealed R8 discharged going assistance with ADL's, istration and blood sugar form indicated the former LSW on community resources to aining housing. 15 a.m. LPN-B stated she on 6/29/20, and had been facility staff the administrator sign the AMA form and form the facility. LPN-B was been brought to a local hotel to of weeks. LPN-B stated she had out wiors and expressed excitement to be fitted for a prosthesis and	F6	522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245052	B. WING				C 31/2020
	PROVIDER OR SUPPLIER	N & HEALTHCARE CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE B10 SECOND AVENUE NORTH IOORHEAD, MN 56560	1 017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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 APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	would be staying a he did not know whif he had housing. On 7/21/20, at 3:00 had worked in the past couple of wee aware R8 had behagainst facility polic behaviors since the informed him if he would be discharge 6/29/20, the admin Coordinator informon an unapproved Former RN-A revierecord (EHR) and lacked any leaves over the weekend. over the telephone weekend and configatility over the prewas another reside entered R8's room packing R8's below not break the rules notified interim DO and R8 was still disinformed the interin not been administed interim DON stated know what he was facility had set up a and did not know we Former RN-A stated discharge and had	fter the hotel stay. FM stated here R8 currently was living or 50 p.m. former RN-A stated she facility until approximatley the liks prior. She stated she was aviors in the past of leaving by and confirmed he had no e facility met with him and did not follow the rules he led. Former RN-A stated on istrator, interim DON and MDS ed her R8 had left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend. It was a left the facility leave over the weekend and in fact it left who leave the administrator was a legings and informed her R8 did in the facility leave over the weekend and in fact it left who leave the also on R8 was on insulin, had be leave the leave the weekend and in fact it leave the leave the weekend and in fact it leave the l	F6	322			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING			C 07/31/2020	
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		
F 622	On 7/21/20, at 3:5 interview with the she indicated R8 is couple of weeks a stated a man who him up and she with from there. On 7/22/20, at 11: interview with the been involved with meetings with the assisted R8 to file notice of dischargistated he was hapkeep him during the voiced he had ROLTC indicated on relocation servito obtain housing. ROLTC indicated call from the admir R8 had recently lethe facility question facility's COVID 18 the funeral. The acting the possible bread facility felt he need facility AMA. At the via telephone and R8 stated he want because there was housing after discipled pardize that platter facility rules are ROLTC stated als	age 20 0 p.m. during a telephone Motel 6 front desk staff (FDS) had stayed at the hotel for a ind had left the hotel. The FDS she thought was his son picked as not certain where he went to 55 a.m. during an telephone ROLTC, she indicated she had a R1's discharge planning facility. She confirmed she had a first and second appeal to his e provided on 2/24/20. R8 by the facility was required to ne appeal process and stated hope for the first time in his life. R8 had been actively working ices with a relocation specialist she had received a telephone nistrator on 6/22/20, who stated fft the facility for a funeral and ned if he had followed the precautions while he was at dministrator stated because of the in COVID 19 precautions, the ded to be discharged from the at time, ROLTC contacted R8 reviewed the facility concerns ted to leave the facility, but s a plan in place for long term harge, he did not want to an. He stated he would follow and not leave the facility held a not facility staff and reviewed	F 6	722			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
		245052	B. WING			C 07/31/2020
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER	,	STREET ADDRESS, CITY, STATE, Z 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIAT	
F 622	absences from the would follow their jeopardize his lone. "it is black and with ROLTC stated shoon and LSW or was doing much be quarantine but was doing much be quarantine but was administrator on a receive a call bace 7/8/20. ROLTC stated she administrator that leaving the facility administrator state openings at the hold hotel. ROLTC administrator to compare when the belongings, and state in the midst stated the administrator to compare when the belongings, and state in the midst stated the administrator to compare when the belongings, and state in the midst stated the administrator to compare when the belongings, and state in the midst stated the administrator to compare when the discharge are ROLTC informed copy of the AMA forwarding it to an about plans to discharge late LSW R8 was being the received and the state of the	egarding resident leave of e facility. R8 again stated he ules and did not want to g term housing plans. R8 stated hite" and "I will follow the rules." e had contacted the interim of 6/26/20, and was told that R8 better, had struggled with as redirectable. 7/6/20, she had been made en discharged from the facility alling and emailing the 7/6/20, 7/7/20, and did not k from the administrator until the had been told by the R8 had informed them he was a AMA on 6/29/20. The ed because there were no omeless shelter, he went to a C stated she had asked the larify how this was an AMA are facility had packed up his lrove him to a hotel in another of a discharge appeal. She strator was unable to explain and offered no further information. the administrator she needed a orm and indicated she would be	F6	522		

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		07	C // 31/2020	
	PROVIDER OR SUPPLIE	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE	
F 622	agitated, angry an was being dischar R8 and he did no discharged. LPN-to R8 and he refuthe facility provide R8 to a local hoter routine insulin an administer his own On 7/22/20, at 1:3 facility and ROLT inform him if the Ismoking outside intoxication conting from the facility. I follow the rules of on 6/29/20, the fat following the facility and former LSW behaviors and reto him prior to this behaviors continudid not care and I and did not provide communication a stated the option shelter was discurred to him prior to the she was at the facility option and paid for R8 contacted a fashe was at the facility option and paid for R8 leaving the designated times	d was cursing after learning he rged. LPN-A stated he talked to t know why he was being A offered medication education sed. LPN-A stated he was told ed lodging and transportation for I. LPN-A stated R8 received d confirmed R8 did not	F6	522			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		I \ /	(X3) DATE SURVEY COMPLETED	
		245052	B. WING		07	C / 31/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		131/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	6/23/20. Interim D either she or the a AMA paperwork at one. Interim DON informed of R8 be must have been a went on leaves pri Interim DON state and refused the ed Interim DON state in his room after h room. On 7/22/20, at 2:2 (MDSC) stated sh prior to 6/29/20, at telephone call abounsupervised. MD the specifics of the document it anywho on 7/22/20, to Meado The ROLTC containsometime after the R8 did not have at Meadowlane and to n 3/30/20, followe 5/8/20. The admin happened due to confirmed R8 was second appeal who 6/29/20. The admin meeting was held to discuss concert facility for days at the courtyard to state on the courtyard to state on the courtyard to state on the courtyard to state of the courtyard to state on the courty and the courtyard to state on the courty and the courty are courty and courty are courty and courty are courty and courty are courty and	ON stated she was unsure, but dministrator had R8 sign the nd 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 ducation offered by LPN-A. d the administrator met with R8 er and former LSW left R8's	F 63	22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		I	C / 31/2020	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 622	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F6	322			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		I' '	(X3) DATE SURVEY COMPLETED	
		245052	B. WING _		07	C / 31/2020	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	On 7/22/20, at 4:0 (MS) stated he wa and interim DON to Fargo ND on 6/29 R8's room while fabelongings and their R8's room and abelongings out to was present and to her vehicle. MS transition to the was present and to her vehicle. MS transition in Fargo ND asked was why was only had ties in Morepaired R8's windout his window, and further repairs need ischarge. On 7/27/20, at 12: interview former L working in the facilist stated she was away pursuing relocation was awaiting result there were no plansited was awaiting result the middle of a disinformed the facilist during the appeal she was informed R8 had exhibited to the nurses station leaving the facility and the interim Dodischarged. Former had lacked docume exhibited over the LSW indicated interior in the state of the state of the LSW indicated interior in the state of the s	age 25 4 p.m. maintenance supervisor is asked by the administrator transport R8 to the Motel 6 in 1/20. MS stated he stood by in acility staff packed his ele administrator approached him asked MS to bring R8's che facility van. R8's girlfriend book some of his belongings to ansported R8 to the Motel 6 and stated the only thing R8 as he going to Fargo when he borhead. MS stated he had show in the past due to R8 going and stated there had been not be dear the time of R8's 05 p.m. during telephone SW stated she had been litty until the previous week. She ware R8 had been actively in assistance to obtain housing, at the discharge him prior to SW confirmed R8 had been in charge appeal and had been in charge appeal and had been by could not discharge R8 process. Former LSW stated in the IDT meeting on 6/29/20, behaviors of taking the key from to the activities room and to smoke over the weekend DN stated R8 needed to be ear LSW confirmed R8's EHR tentation of any behaviors R8 previous weekend. Former erim DON stated she had talked consultant (RCC) and the chief	F 62	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING		07	C / 31/2020	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 622	operating officer behavioral conce R8 from the facili "would just take t LSW went to R8' in his bed with blainterim DON asked behaviors reported DON reminded Rit was discussed exhibited further respond. Interim leave, informed have, informed have, informed have, informed have together and state R8 from the facili still sleeping. Former LSW states homeless shelter openings for bed interim DON and comfortable with the facility paid for hotel in Fargo ND administrator and belongings while facing the door a stated the administing the AMA form	page 26 (COO) of the facility about R8's rns and the need to discharge ty and they responded the facility he tag." Interim DON and former is room where R8 was sleeping ankets covering his head and red R8 about the smoking and over the weekend. Interim red over the weekend. Interim red over the weekend. Interim red over the weekend if he behaviors and R8 did not DON stated to R8 he needed to red the facility was discharging red sand was told there were no sand she reported this to the expressed not feeling the plan. Former LSW stated red a NA packed up R8's R8 was seated in his wheelchair and was not talking. Former LSW strator and interim DON had R8 m. Former LSW stated MS drove resportation to the hotel and a	F 6	,			
	too. Former LSW out the behaviors exhibited by anot facility. Former LS administrator and note in R8's EHR stated she was in	rice of R8 arrived at the facility stated on 6/30/20, she found reported about R8 were actually her resident residing in the SW stated the interim DON, I herself wrote the discharge on that same day. Former LSW formed by the administrator she one call a couple of weeks later					

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

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	E SURVEY PLETED
		245052	B. WING				C 31/2020
	NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEALTHCARE CENTER			281	REET ADDRESS, CITY, STATE, ZIP CODE 10 SECOND AVENUE NORTH DORHEAD, MN 56560	1 077	0112020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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	from staff at the Mo an additional two who homeless and the Former LSW stated director (AD) received week from R8, who and living under a liv	otel 6 in Fargo ND to request eeks stay for R8 or R8 would ne facility denied the request. d she was aware the activities yed a phone call the previous o indicated he was homeless	F6	22			

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

	OVIDER/SUPPLIER/CLIA	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245052		B. WING		С	
NAME OF PROVIDER OR CURRUER	245052	b. WING		07/31/2	2020	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION & HEA	LTHCARE CENTER		STREET ADDRESS, CITY, STATE, Z 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560	IF CODE		
(X4) ID SUMMARY STATEMENT C PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTI	PRECEDED BY FULL	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) DMPLETION DATE	
regarding R8's discharge at R8 wheeled himself to the f administrator met him there asked the administrator whidentified he was homeless go. Administrator told R8 th a two week stay at a hotel. administrator where he wouthe administrator replied he and HUC was not sure what asked for a third time where his two weeks were up and response from the administrator and he told he him. HUC stated the administrator and he told he him. HUC stated the administrator and at first R form and then he said "forg form. HUC stated a couple received a phone call from asking about an extension is she forwarded the call to the stated R8 did call up to the asked to speak to AD. R8 in homeless, had no money a going back on drugs again. transferred the call to the A On 7/31/20, at 10:09 a.m. the specialist (FPDIS) stated the report on 7/30/20, requesting completed on R8. The FPD R8 had not been located by On 7/31/20, at 10:46 a.m. the dispatch (MPDD) stated the report on 7/30/20, requesting the port of 7/30/20 and 10:46 a.m. the	front desk and the e. HUC stated R8 ere he was going and and had nowhere to be facility had paid for R8 asked the ald go after that and e was on a waiting list at that meant. R8 e he was going after there was no trator. HUC stated she he was being g and swearing at the er she just discharged istrator had R8 sign 8 would not sign the get it" and signed the of weeks later she the Motel 6 staff to keep R8's room and e administrator. HUC facility one day and aformed HUC he was nd was thinking about HUC stated she had D. The Fargo PD intake he facility had filed a hig a well check be be stated at that time of the Moorhead PD er facility had filed a hig a facility had filed a high a facility had filed a facility had fi		522			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245052	B. WING				C 31/2020
	PROVIDER OR SUPPLIEI	ON & HEALTHCARE CENTER		2810	EET ADDRESS, CITY, STATE, ZIP CODE D SECOND AVENUE NORTH ORHEAD, MN 56560	1 011	0112020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 622	since his last known room in Fargo, NI Review of facility Against Medical A an AMA discharge leave the facility, and administrator impending AMA discharge leave the facility and administrator impending AMA discharge medical error provide the resident to dispolicy stated the findurable medical error provide the resident to locate developed a plan to the facility if R8 The facility provided error acceptable and severity level Governor Tim Wa Order(EO) 20-14, identified beginning and continuing for emergency, all residential residential error in the facility provided error acceptable and severity level Governor Tim Wa Order(EO) 20-14, identified beginning and continuing for emergency, all residential residential error in the facility provided error acceptable acc	een transferred to the Fargo PD wn residence had been a hotel D. policy titled Resident Leave divice revised 5/15/20, identified when a resident chooses to The policy indicated the LSW would be notified of any ischarges and would meet with class risks and benefits. The acility was not to assist with equipment (DME), transportation ident with any medications. on 7/28/20, was removed on a facility contacted the D and the Fargo, ND PD to R8. Additionally, the facility to accept R8 back as a resident of decided he wanted to return. The AMA procedure, transfer and leave of absence policy. The ducation to licensed staff on the not the leave of absence policy. The remained at the lower scope	F6	522			
	endangering the s	to the tenant seriously safety of other residents. The					

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

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245052	B. WING		07	C // 31/2020	
	PROVIDER OR SUPPLIER	ON & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2810 SECOND AVENUE NORTH MOORHEAD, MN 56560		70112020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	the community sprand nationwide. The household facing of from the Attorney (happening. Governor Tim Walsigned 7/13/20, ide	age 30 Ins in their homes to mitigate read of COVID-19 in Minnesota the EO indicated any person or eviction would have assistance General to prevent this from Z's Emergency EO 20-78, entified the COVID-19 pency was extended through	F6	22			



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

(X6) DATE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		С	
		00938	B. WING		07/31/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HEAI THCARI	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	ETE
2 000	Initial Comments		2 000			
	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.					
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff	/20, surveyors of this visited the above provider for a tion and the following				
	The following comp substantiated:	laints were found to be				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 08/28/20

TITLE

STATE FORM 6899 2TUO11 If continuation sheet 1 of 30

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			A. BOILDING.				C
		00938		B. WING		l l	31/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOORH	EAD REHABILITATIO	N & HEALTHCARI		OND AVENU AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 000	H5052120C with not H5052122C with not H5052125C with lice In addition, the follow to be unsubstantiated H5052117C H5052118C H5052121C H5052124C Minnesota Department the State Licensing federal software. To assigned to Minnesota Department of Heaville and the Correction order the findings which a statute after the state as evidence by." For are the Suggested Time period for Correction of State lice the Minnesota Dep Informational Bullet http://www.health.sobul.htm The State delineated on the and Department of Heaville and the state of the Minnesota Dep Informational Bullet http://www.health.sobul.htm The State delineated on the and Department of Heaville and the state of the Minnesota Dep Informational Bullet http://www.health.sobul.htm The State delineated on the and Department of Heaville Adelineated on the Adelineated	pensing order issued to licensing the licensing order is licensing orders are in violation of the licensure orders consist article of licensing orders are licensing orders	umenting using en les for ber D Prefix oliance is efficiencies" ortion of includes state is not met is findings in and ectronic tent with the profinfo/infied mitted to correction	2 000	DEFICIENCY)		

Minnesota Department of Health

STATE FORM 2TUO11 If continuation sheet 2 of 30

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
MOORHI	EAD REHABILITATION	N & HFAI THCARI	OND AVENU AD, MN 565				
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2 000	Continued From pa	ge 2	2 000				
	State licensure processing 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	Residents of HC Fa Subd. 5. Courteouresidents have the courtesy and respe	ac.Bill of Rights us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a	21805			9/2/20	
	by: Based on interview facility failed to prov manner for 1 of 1 re interactions while a Finding include: R3's quarterly Minir 5/30/20, indicated F included renal insut depression. The MI	ent is not met as evidenced , and document review, the vide services in a respectful esidents (R3) during staff ssisting with cares. mum Data Set (MDS) dated R3 had diagnoses which ficiency, diabetes and DS indicated R3 had intact ndependent with bed mobility,		F- 550 1. R3 clothing was inspected to be properly labeled and placed in his and any unlabeled or improperly pitems were removed. R3 care plareviewed and no adjustments were needed. R3 via interpreter reporte feeling safe in the facility. All other residents with communication barrowere reviewed and care plans were updated as needed.	room laced n e ed r riers		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		PLE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBE	A. BUILDIN	IG:	COIVIF	LETED
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			I		1 01.70	
NAME OF F	PROVIDER OR SUPPLIER	ST	REET ADDRESS, CIT	Y, STATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HEALTHCARL 28	10 SECOND AVE	NUE NORTH		
MOOKIN	LAD KENADIENANOI	MO	OORHEAD, MN 5	6560		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
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21805	Continued From pa	ige 3	21805			
	transfer dressing t	toilet use and personal				
	hygiene.	tonot doo and percenai		2. All residents have a right to o	lianity in	
	riygiono.			the facility and have the potential		
	R3's care plan revis	sed on 6/17/20, indicated	IR3	affected.	.0 .00	
		rities of daily living (ADL's		anotica.		
		disease process, ampute				
		R3's care plan indicated		3. An all staff in-service was co	nducted	
	•	rith bathing/showering, b		8/6/20 to review the policies on Re		
		dressing, eating and toile		Rights and Dignity along with instr		
		an indicated R3 was his		on how to utilize the language line		
		tions with communication		interpreter assistance and where		
		anation of situation and		number is located within the facilit		
		ntion. Further, the care pl	an	administrative staff will continue to	•	
		efusals, and directed staf		conduct Ambassador rounds to m	eet	
	explain all procedui	res before starting and a	llow	regularly with the residents to disc	uss any	
	the resident time to	adjust to changes.		concerns including respect/dignity	'.	
				Resident Council meeting on 8/14	/20 went	
	Review of 3's Moor	head Rehabilitation and		over all Resident Rights with an e	mphasis	
	Healthcare Concern	n and Problem Resolutio	n	on Dignity and Respect. A meetin	g with all	
	Form, indicated on	6/22/20 at 11:45 a.m. R3	3	Laundry Staff will be held 8/28/20	to	
		ssistant (NA)-A he was		review clothing labeling and distrib	oution	
		cupational therapist assi	stant	routines.		
		d he was in the doorway				
		m, when the OTA was wa	0	4. An audit has been developed		
		R3 was wearing a t-shirt		monitor completion of Ambassado		
		icated OTA yanked the t-		Rounds with managers to identify		
		ng anything. R3 indicate		areas of dignity/respect and audits		
		sed and at times she car		laundry to ensure resident clothing		
		3 she would pass it along		delivered to the right resident. The		
		he form indicated a vuln	erable	will be completed weekly times 2		
	adult report was su	bmitted.		then monthly to ensure compliance		
	0. 7/00/00 1.4.00	DO '- 1' (11		results of the audits will be reported	ea to the	
		p.m. R3 indicated he wa		QAPI committee for future		
		chair in the doorway of hi		recommendations. The audit will k		
		id, when OTA pulled a t-s	snirt	completed by the Administrator or	ner	
		not his. R3 indicated he		designee.		
		ad given him the t-shirt		0		
		not his. R3 indicated O7		Compliance: September 2, 2020		
		e was doing and just too	k the			
	t-shirt off of him. R3	3 indicated he was				

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MOORHEAD REHABILITAT	ION & HEAI THCARI	COND AVENU EAD, MN 565				
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
present in the hat took the t-shirt or closet and told hat felt humiliated be indicated OTA to scared him at the R3 indicated it has even have a character of the even had been here out in the hallware out in	cause there were other residents allway. R3 indicated after OTA ff of him, she got a shirt out of his im to put it on. R3 indicated he at he was not hurt or abused. R3 look the shirt off so quick, it kind one time and caught him off guard. appened so quick he did not appened so quick he did not appened so quick he had the transpersion of the had the transpersion of the had the transpersion of the had appened so got in the hallway and she got into out of his closet and he put it he his closet and he pu	f t				

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		00938	B. WING		l l	31/2020	
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21805	On 7/22/20 at 9:45 (DON) indicated shithe incident, did no incident and could a The DON indicated the residents with a could be residents with a could be the residents with a could be resident without talking to his she felt there was a the R3 and OTA. The felt rushed and was OTA and this was a could cated she would residents with respicares. She indicated assumptions and in have been avoided. Review of facility por Resident reviewed resident will be treaten vironment that may resident's dignity and his or her individua. SUGGESTED MET The administrator, designee could devicare by the interdisting residents dignity is could update policies staff on these channels are resident(s) could be completed could be reviewed.	a.m., director of nursing le was not here at the time of t know anything about the not speak to what happened. I she would expect staff to tre espect and dignity. I a.m. administrator indicated look R3's t-shirt off of him m. The administrator indicated a misunderstanding between the administrator indicated R3 is not able to understand the lin-dignified. The administrator did expect staff to treat the ect and dignity while providing did staff cannot make indicated this situation could blicy titled, Dignity Of The on 4/12/18, indicated all lated in a manner and in an latintains and enhances each and respect in full recognition of lity. THOD OF CORRECTION: director of nursing (DON), or relop 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 d, and results of these audits by the quality assessment an vement (QAPI) committee to	d f				

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MOORHI	EAD REHABILITATION	N & HFAI THCARI	OND AVENU AD, MN 565		
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21805	Continued From pa	ge 6	21805		
	TIME PERIOD FOR CORRECTION: Fourteen (14) days.				
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.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 combudsman pursua Act, section 307(a)(of this right, may chnotice period ends. shortened in situatic control, such as a creview, the accommersidents, a change treatment program, resident's welfare, oprohibited by the pupaying for the resid the medical record.	than 30 days before facility and seven days before room within the facility. This the resident's right to contest and to the area nursing home and to the Older Americans (12). The resident, informed alloose to relocate before the The notice period may be consoutside the facility's determination by utilization modation of newly-admitted in 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 accommodate new residents			
	by: Based on interview facility failed to allow had insulin depende for appropriate disc	and document review the w 1 of 1 residents (R8) who ent Diabetes Mellitus reviewed harge 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 I	

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NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
МООРЫ	EAD REHABILITATION	2810 SEC	OND AVENU	JE NORTH	
WOOKIII	LAD KEHABIEHAHOI	MOORHE	AD, MN 565	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETE
21925	Continued From pa	ge 7	21925		
	deficient practice regiopardy (IJ) situation the facility to a no housing or commafter the two week I rendering him home. The IJ began on 6/2 facility discharged Fhotel for a two weel in place after the two 3:53 p.m. the adminursing (DON) were the facility implementation of the facility made att majority of the staff appropriate dischart The noncompliance and severity level Depotential for more the immediate jeopardy.	esulted in an immediate on when R8 was discharged a hotel for a two week stay and munity services secured for hotel stay, subsequently eless. 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 seempts to locate R8 and the had been re-educated and ge procedures were in place. It is remained at the lower scope 10, iolated, no actual harm with the nan minimal harm that is not 1/2.		Dakota police departments were contacted on 7/30/20 to conduct a check for R8. Per MD order, R8 were considered for readmission to the after having been seen in the emeroom 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. 3. 7.29.20 the IDT and Licensed Nursing Staff were in-serviced on Transfer/Discharge, Leave Agains Medical Advice and Leave of Abserbischarge planning for all admitted residents will be conducted with the of ensuring a safe discharge for the resident to a community of their chall discharges since survey exit we reviewed by the IDT team and are complete.	vill be facility rgency facility. n a e e d policies t ence. d e goal 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's	num 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 s) which included transfers,		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	charge, o sary ations,
	MDS identified R8 Is seven days of insul day assessment reference R8's admission Cardated 1/18/20, iden	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		transportation, community service physician notification with orders a reason for discharge. The audit w completed daily x 10 days, weekly weeks then monthly. The results audits will be reported to the QAPI committee for future recommenda The audit will be completed by the	ind ill be x 4 of the tions.

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21925	Continued From pa	ige 8	21925			
	with most ADL's. The tomake his needs consistent carbohydiabetes. The CAA or pleasures in doir offered mental head Review of R8's Self Assessment form on appropriate for medications. R8's care plan, reviindependent with mobility, transfers a identified R8 had D			Administrator or her designee. Compliance: September 2, 2020		
	indicated R8 interm the building without identified R8 did no medications and incoordinate services discharge. Review of R8's proc 6/30/20, revealed the 2/24/20, late entry R8 with a 30 day not health improving suservice from the fact be discharged to M home in Benson.	blood sugar). The care plan nittently refused cares and left to notifying staff. The care plan of self administer his own dicated social services would a necessary for a community gress notes from 2/24/20, to the following: If the administrator provided office of discharge due to his sufficiently, no longer in need of cility and indicated R8 would leadowlane Board and Care ensed social worker (LSW) and with R8 to obtain consent to				

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21925	ombudsman for lor former LSW along Prairie Community financial/housing as - 3/11/20, R8 left th Former registered is medical doctor (ME - 3/12/20, Clay coul LSW to report R8's - 3/13/20, phone cannotified too. Later the later than two weeks. Moor notified too. Later the LSW received a phand Prairie Communicating R8 show p.m. requesting assisted R8 appeared extremely difficult to - 3/14/20- R8 return to emergency room refused the evaluate facility.	on requested by the regional ag term care (ROLTC) and with R8 contacted Lakes and Action to follow-up on ssistance. e facility without notifying staff. nurse (RN)-A contacted D) regarding R8's leave. Inty report completed by former aleave. alls made by facility staff of ille with voice mails left. R8's ad not seen or heard from R8 rhead police department (PD) that day at 3:41 p.m., former none call from staff from Lakes unity Action Partnership ed up at their office at 2:30 sistance with housing and divery ill looking and was to get information from. The dothe facility and was sent in (ER) for evaluation and tion and was returned to the facility R8 to discuss	21925			
	transfer. Other opti - 3/19/20, former LS completing MNCho for disability) with C the phone.	value and R8 declined the ons presented to R8. SW assisted R8 with sices assessment (application Clay County Public Health over SW received message from				

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21925	Clay County Public relocation services. "you put a smile on - 4/9/20, former LSV call from Opportuni Services (company service corrdination income, and abilitie within the communi assist with relocation - 4/21/20, R8 was sofor hyperglycemia et est is a blood test that average levels of blood test is a blood test that average levels of blood test is a blood test that average levels of blood test is a blood test in increase in insuluation (The American Diaguidelines 1/1/20, sofor most nonpregnation targets differ based more or less strings appropriate for each 7%. A1C may also than 154 mg/dL Belplasma glucose): 8 beginning of the meglucose): Less than - 5/5/20, R8 comples social security disalined to diet noncom titrate insulin due to glucose monitoring.	Health R8 was accel R8 was informed an my face." W stated she receive ty Community certified to provide re to individuals with lines to re-establish then ty) and they accepted on services. Heen by nurse practition tepisodes and A1C (the that provides informat lood glucose over the tepisodes and A1C (the that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides informat lood glucose over the tepisodes and halt. He that provides	d stated d phone elocation mited nselves d R8 to oner (NP) e A1C tion about e past ordered DA] ng targets es. A1C Also, ay be ss than Less dial urs after ma n for	21925			

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21925	(a long acting form Diabetes Mellitus) to Glipizide (an oral melipizide (an oral melipizide). - 5/22/20, A1C resultation of the second in th	of insulin used to treat wice daily and once daily redication used to treat alts came back at 8.8, NP orders obtained. P, type 2 Diabetes Mellitus noted blood glucose improved ations 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 atinue with Glipizide daily. Ged insulin from twice daily to A1C next week. Ad an empty vodka bottle in lurred speech and appeared D notified and interim DON and R8 and placed diabetic nanded over care to I services (EMS) staff. R8 for evaluation and R8's returned to the facility after the a new diagnosis of	21925			

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		2		OND AVENU			
MOORH	EAD REHABILITATIOI	N & HFAI THCARI		AD, MN 565			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		PREFIX TAG	(EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
21925	5 Continued From page 12			21925			
2.020	outside in the smok designated time. St possession of the k and had no orders handle it according - 6/23/20, former LS DON and ROLTC (to discuss behavior against medical ad- notified if he left the advice or went outs designated times h- the facility. Discuss goal to obtain hous	sing area outside his caff suspected R8 had seys. At 7:57 a.m. MD nand indicated the facility to facility protocols. SW, administrator, intervia the telephone) met vial concerns, leaving the vice and safety issues. It facility against medical side to smoke outside of e would be discharged in continued regarding and continue working R8 verbally agreed to facility agreed t	rim with R8 e facility R8 was I f his from g R8's ng with	2.1020			
	- 6/29/20, late entry met with R8 to disc have since the 6/22 administrator, interi ROLTC. Administrate behaviors after hour esult would be immediately for failing to agreement." R8 not stated he did not ur repeated the "violate the previous week immediate discharg pack his own things his own belongings with packing up bel to pack up anything been opened and a wrapped around it wadministrator and papproached nursing	v at 12:51 p.m. administ uss behaviors he continual 2/20, meeting with m DON, former LSW a ator informed R8 "since irs and over the weeker nediate discharge from	nued to nd he had nd the then or made ould to pack o assist attempt had ed tie				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00938	B. WING		07/3	1/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOORHI	EAD REHABILITATIO	N & HFAI THCARI	OND AVENU			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	AD, MN 565	PROVIDER'S PLAN OF CORRECTION	- N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21925	Continued From pa	ge 13	21925			
		e air and cursed at them. The				
		ed R8 one more attempt like would be contacted. The				
	administrator hande	ed R8 the red bag and R8				
		and become aggressive and led in to assist. While packing				
	R8 up and waiting f	or transport, R8 opted to				
		otel 6 in Fargo, ND, signed the d stated he would "rather go to				
a hotel then to a shelter." R8's final items were						
	packed up and he was taken by transport to Motel 6.					
	interdisciplinary tea regarding noted be	p.m. interim DON indicated the m (IDT) team spoke with R8 haviors which occurred over				
	and very dismissive	as noted to be non responsive during the meeting. The terim DON offered R8 the				
	but R8 remained no	orate on behaviors in question on verbal only using his body				
	meeting regarding	reminded about previous IDT consequences related to poor staff and other residents"and				
	R8 stated understa	nding. "Immediate discharge ussed with R8 but R8 opted to				
		el 6 in Fargo." R8 was noted to tand R8 left the facility with				
		ersonal belongings via facility				
	transport. Female f at the time of the Al	riend was noted to be present MA.				
		y, at 12:59 p.m. former LSW tion agency and Clay County discharge.				
		p.m. licensed practical nurse R8 discharged AMA from the ately 1:00 p.m.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			3) DATE SURVEY COMPLETED	
	00938	B. WING		07/3) 1/2020	
NAME OF PROVIDER OR SUPPLIER MOORHEAD REHABILITATION 6	& HEALTHCARI 2810 SEC	ORESS, CITY, S OND AVENU AD, MN 565		,		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
note, interim DON indassist with ADL care, and blood sugar mon continued to work on assist R8 with housin - 6/30/20, at 2:20 p.m discharge) LPN-A indon medication admining the did not need to be his medications." R8 and benefits of the description of the desc	dicated R8 required ongoing medication administration nitoring. Former LSW community resources to ng. n. (greater than 1 day after dicated R8 refused education istration times and R8 stated e told how and when to take was educated on the risks ecision. acked documentation of by R8 from 6/22/20, to arge although the ed R8 had violated the verbal previous week. P progress notes from evealed the following: ine nursing home visit, NP controlled type 2 Diabetes ycemia and last A1C was 9.4. Insulin and Glipizide and oring was ordered for four the nursing home visit, MD controlled Diabetes Mellitus are present care. dicated R8 had alcohol cod alcohol level of .212 and R8 was kept in the ER for an me and given intravenous	21925				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00938	B. WING		07/3	; 1/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOORHI	EAD REHABILITATION	N & HFAI THCARI	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21925	Continued From pa	ge 15	21925			
	indicated R8's A1C	cine nursing home visit, MD was 8.8 on 5/22/20 and R8 iabetes Mellitus and no e.				
	Review of R8's laborate 6/29/20, revealed	oratory test A1C, from 2/28/20, d the following:				
	- 2/28/20, R8's A1C	was 6.9.				
	- 4/21/20, R8's A1C	was 9.5.				
	- 5/22/20, R8's A1C	was 8.8.				
	No further A1C labs after 5/22/20.	s were found in R8's record				
	Review of R8's unsigned Physician Orders, identified by facility as R8's current orders, included Lantus SoloStar Solution Pen-injector Insulin 10 units (a unit of measurement in insulin administration 100 units per milliliter [ml]) subcutaneously (tissue layer between the skin and muscle) daily in the morning for Diabetes Mellitus.					
		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. 97				
	-blood glucose resu	ılts ranged from 66-463				
		is blood glucose checked 39 s reasons ranging from R8's from the facility.				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BUILDING.			c
		00938		B. WING		l l	31/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOORH	EAD REHABILITATIOI	N & HEALTHCARI		OND AVENU AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21925	Continued From page 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 subcutaneo Diabetes Mellitus and D, at 8:00 a.m.					
	R8's health had implement longer needed the	harge dated 2/24/20, proved sufficiently an services of the facility ed to another facility o	d R8 no / and R8				
	R8's Continuance Order related to involuntary discharge and transfer dated 3/30/20, was provided to the facility on 3/30/20. The order identified a hearing had been scheduled for 4/7/20, to determine if the facility could lawfully discharge R8.						
	involuntary dischard provided to the faci identified another corder to prepare for another facility. The had not resolved th	nuance Order related ge transfer dated 5/5/ lity on 5/8/20. The order continuance of the mar r an appropriate trans e order identified if the lie matter by 8/5/20, the ack on the judge's doc	/20, was der atter in ofer to e parties ne matter				
	against Medical Addate, identified by the 6/29/20, signed by	esponsibility for Disch vice (AMA) form with he director of nursing the resident indicated ne risks and consequa MA.	illegible as R8 had				
		harge notice dated 6, y discharged R8 on 6					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00938		B. WING		I	C 31/2020
	PROVIDER OR SUPPLIER	N & HEALTHCARI	2810 SEC	DRESS, CITY, S OND AVENU AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY I SC IDENTIFYING INFORMA'	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21925	Summary form date mood/behaviors she indicated recomme been made on seven Review of R8's Soc Summary form date by the interim DON AMA, required ongo medication adminismonitoring. The form continued to work of assist R8 with obtain On 7/21/20, at 10:1 reported to work on informed by other far and DON had R8 sidischarged R8 from informed R8 had be stay for a couple of worked the previous exhibited no behavious over the potential to the goal of obtaining On 7/21/20, at 2:00 family member (FM telephone call from discharge from the been "kicked out" of two week hotel stay would be staying af	ge. sial Services Care Code 6/2/20, revealed Rowed improvement andations for dischargeral occasions. sial Services Dischargeral occasions. sial Services Discharged 6/29/20, signed on, revealed R8 discharging assistance with Atration and blood sugmindicated the former on community resourching housing. 5 a.m. LPN-B stated 6/29/20, and had be acility staff the admining the AMA form and the facility. LPN-B we seen brought to a local weeks. LPN-B stated weeks. LPN-B stated so weekend and R8 had ors and expressed	8's nd e had ge 6/30/20, rged ADL's, par er LSW ces to she en istrator d /as I hotel to d she had ad xcitement nesis and nterview a r his had he had a re he I stated	21925			
	On 7/21/20, at 3:06	p.m. former RN-A sta	ated she				

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Minnesota Department of Health

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00938	B. WING			1/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE		
NAIVIL OI I	-NOVIDEN ON SUFFEIEN		OND AVENU	,		
MOORHI	EAD REHABILITATION	N & HFAI THCARI	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21925	Continued From part had worked in the fights touple of weel aware R8 had behat against facility policible behaviors since the informed him if he would be discharge 6/29/20, the adminical Coordinator informed on an unapproved I Former RN-A review record (EHR) and collacked any leaves cover the weekend. Over the telephone weekend and confinitive over the prewas another reside entered R8's room packing R8's belong not break the rules notified interim DOI and R8 was still disinformed the interin not been administed interim DON stated know what he was facility had set up a and did not know we Former RN-A stated discharge and had	acility until approximatley the ks prior. She stated she was aviors in the past of leaving by and confirmed he had no a facility met with him and adid not follow the rules he ad. Former RN-A stated on strator, interim DON and MDS and her R8 had left the facility leave 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 med R8 had not left the vious weekend and in fact it not 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 there he went to after that. d R8 did not initiate the planned on being discharged	21925		TWATE	
	him. On 7/21/20, at 3:50 interview with the M she indicated R8 ha couple of weeks an stated a man who s	housing had been secured for p.m. during a telephone lotel 6 front desk staff (FDS) and stayed at the hotel for a had left the hotel. The FDS she thought was his son picked is not certain where he went to				

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.			c
		00938		B. WING		1	31/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOORH	EAD REHABILITATIOI	N & HEALTHCARI		OND AVENU AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21925	Continued From page 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 h ROLTC indicated R on relocation service to obtain housing.	5 a.m. during an telept COLTC, she indicated R1's discharge plann acility. She confirmed a first and second approvided on 2/24/20. By the facility was reques appeal process and ope for the first time it a had been actively were with a relocation second and received a telephants.	she had ing she had beal to his R8 uired to stated n his life. vorking specialist				
	call from the admin R8 had recently left the facility question facility's COVID 19 the funeral. The ad the possible breach facility felt he needefacility AMA. At that via telephone and r R8 stated he wanted because there was housing after dischipeopardize that plan	istrator on 6/22/20, we the facility for a fune ed if he had followed precautions while he ministrator stated becaused to be discharged from time, ROLTC contact eviewed the facility of ed to leave the facility, a plan in place for lonarge, he did not want in. He stated he would do not leave the facility.	tho stated ral and the was at cause of tions, the rom the sted R8 oncerns. but ng term to follow				
	meeting with R8 and the facility rules regalsences from the would follow the rul jeopardize his long "it is black and whit ROLTC stated she	that day the facility had facility staff and revealed arrived resident leave facility. R8 again states and did not want term housing plans. It will follow that contacted the int 6/26/20, and was told	riewed of ed he o R8 stated ne rules."				

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AND DUAN OF CODDECTION INDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00938	B. WING		07/3	1/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOORH	EAD REHABILITATIO	N & HFAI THCARI	OND AVENU			
	T	MOORHE	AD, MN 565			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21925	Continued From pa	ige 20	21925			
	was doing much better, had struggled with quarantine but was redirectable. ROLTC stated on 7/6/20, she had been made					
	and she began call administrator on 7/0 receive a call back	n discharged from the facility ing and emailing the 6/20, 7/7/20, and did not from the administrator until				
	7/8/20. ROLTC stated she had been told by the administrator that R8 had informed them he was leaving the facility AMA on 6/29/20. The administrator stated because there were no					
	openings at the hor local hotel. ROLTC administrator to cla	meless shelter, he went to a stated she had asked the rify how this was an AMA				
	belongings, and dro state in the midst o	e facility had packed up his bye him to a hotel in another f a discharge appeal. She rator was unable to explain				
	ROLTC informed th	offered no further information. ne administrator she needed a rm and indicated she would be appeal judge.				
	On 7/22/20, at 12:41 p.m. LPN-A stated on 6/29/20, when he arrived at the facility that morning there had been nothing reported to him about plans to discharge R8. LPN-A stated he was informed later in the morning by the former LSW R8 was being discharged and to give R8 his medications. LPN-A stated R8 appeared agitated, angry and was cursing after learning he was being discharged. LPN-A stated he talked to					
	R8 and he did not know why he was being discharged. LPN-A offered medication education to R8 and he refused. LPN-A stated he was told the facility provided lodging and transportation for					
	R8 to a local hotel.	LPN-A stated R8 received confirmed R8 did not				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
711012711	OF CONTRACTION	IDENTIFICATION NONBERG	A. BUILDING:			
		00938	B. WING	B. WING) 1/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
		2810 SF	COND AVENU	,		
MOORH	EAD REHABILITATIOI	Ν & ΗΕΔΙΤΗCΔRΙ	EAD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT 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 APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETE DATE
21925	Continued From pa	nge 21	21925			
	administer his own	insulin.				
	On 7/22/20, at 1:37 facility and ROLTC inform him if the be smoking outside of intoxication continu from the facility. Int follow the rules of the on 6/29/20, the faci following the facility and former LSW must behaviors and remit to him prior to this to behaviors continued did not care and he and did not provide communication about a stated the option of shelter was discuss not care. The facility homeless shelter a available and only is stated the facility wo option and paid for R8 contacted a femshe was at the facil Interim DON confirm of R8 leaving the face designated times on progress notes doe 6/23/20. Interim DON sinformed of R8 beir must have been ab went on leaves prior Interim DON stated.	r p.m. interim DON stated the met with R8 on 6/23/20, to haviors of leaving the facility, designated times and alcoholed 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 let with R8 to discuss his inded R8 the facility had talked time of immediate discharge if d. R8 responded by saying he wanted to leave the facility				

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AND DI AN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00938	B. WING		l l	C 31/2020
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		<u> </u>
MOORH	EAD REHABILITATION	I & HFAI THCARI	OND AVENU			
(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 E APPROPRIATE	(X5) COMPLETE DATE
21925	Continued From pa	ge 22	21925			
21925	Interim DON stated in his room after he room. On 7/22/20, at 2:29 (MDSC) stated she prior to 6/29/20, and telephone call about unsupervised. MDS the specifics of the document it anywhous on 7/22/20, at 3:03 R8 was provided with 2/24/20, to Meadow The ROLTC contacts sometime after the R8 did not have an Meadowlane and the on 3/30/20, followed.	the administrator met with R8 r and former LSW left R8's p.m. MDS Coordinator took call over the weekend d stated she had received a t R8 going outside C stated she could not recall call and indicated she did not ere. p.m. the administrator stated th a notice of discharge on plane nursing home in Benson. ted the administrator notice was given and stated				
	happened due to Confirmed R8 was of second appeal whee 6/29/20. The admin meeting was held with to discuss concerns facility for days at a the courtyard to sm substances in his rock R8 had agreed to for conversations with Administrator stated informed of R8's be weekend and could behaviors. Administrators and she with the courty and the conversations with the conversations and she with the conversations and she with the confirmed of R8's between the conversations and she with the confirmed of R8's between the conversations and she with the confirmed of R8's between the conversations and she with the confirmed of R8's between the conversations and the conversations are conversations are conversations and the conversations are conversations are conversations are conversations are conversations are conversations.	OVID-19 restrictions and currently in the midst of a n he was discharged on istrator stated on 6/23/20, a vith R8, the facility and ROLTC with behaviors of leaving the time, going out his window to oke and lighting up from. The administrator stated ollow the rules through				

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Millinesc	ota Department of He	aitri				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	- <u></u> -	COMP	LETED
						`
		00938	B. WING		07/3	, 1/2020
		00330			0773	1/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2810 SEC	OND AVENU	IE NORTH		
MOORH	EAD REHABILITATION	N & HEALTHCARI MOORHE	AD, MN 565	60		
(V4) ID	SHMMARV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
21925	Continued From pa	nge 23	21925			
	-					
		d she entered R8's room and				
		oom at the time. When he				
		administrator attempted to talk				
	_	ned to discuss the situation				
		d the administrator he would				
		gings and would leave the				
	1	or 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				
	· ·	pack R8's belongings. d former LSW contacted a				
		b beds were available and the				
		ay 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				
		ninistrator stated LPN-A gave				
		ations and indicated she was				
		peen on insulin. Administrator				
		sure who provided R8 with the				
	AMA form to sign.	P				
	J					
	On 7/22/20, at 4:04	p.m. maintenance supervisor				
		asked by the administrator				
	and interim DON to	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				
		ne facility van. R8's girlfriend				
		ok some of his belongings to				
		nsported R8 to the Motel 6				
		and stated the only thing R8				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:			OOM! LETED		
		00938		B. WING		I	C 31/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			2810 SEC	OND AVENU	E NORTH		
MOORH	EAD REHABILITATION	N & HEALTHCARI		AD, MN 565			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE	S	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY SC IDENTIFYING INFORMA		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLÉTE DATE
21925	Continued From pa	ge 24		21925			
	asked was why was he going to Fargo when he only had ties in Moorhead. MS stated he had repaired R8's window in the past due to R8 going out his window, and stated there had been no further repairs needed at the time of R8's discharge.						
	interview former LS working in the facilistated she was aware 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 pshe was informed in R8 had exhibited by the nurses station to leaving the facility than the interim DO discharged. Forme had lacked docume exhibited over the publication operating officer (Cobehavioral concern R8 from the facility "would just take the LSW went to R8's in his bed with blan interim DON asked behaviors reported DON reminded R8 it was discussed here."	15 p.m. during telephology stated she had be ty until the previous ware R8 had been activassistance to obtain a soft approval for disast to discharge him process. Former LSW on the IDT meeting on the activities room to smoke over the weak to the activities room to smoke over the weak to the activities room to smoke over the weak to the activities room to smoke over the weak to the activities room to smoke over the weak to the activities room to smoke over the weak to consultant (RCC) and the previous weekend. For the facility about the facility about the smoking over the weekend. It of the 6/23/20, meeting the would be discharge thaviors and R8 did not the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking of the facility and the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend. It of the 6/23/20, meeting the smoking over the weekend.	een week. She week. She vely housing, ability and ior to d been in ad been R8 / stated i 6/29/20, e key from and eekend to be 's EHR viors R8 ormer had talked d the chief out R8's scharge the facility and former sleeping ad and ing ing where d if he				

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STATE FORM 2TUO11 If continuation sheet 25 of 30

Minnesota Department of Health

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE	SURVEY LETED	
					C	
		00938	B. WING		07/3	1/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MOORH	EAD REHABILITATIOI	N & HFAI THCARI	OND AVENU			
	OLUMBA DV OTA		AD, MN 565			
(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	.D BE	(X5) COMPLETE DATE
21925	Continued From pa	ge 25	21925			
	leave, informed him to get his belongings together and stated the facility was discharging R8 from the facility. R8 did not respond as he was still sleeping.					
	homeless shelters openings for beds a interim DON and excomfortable with the facility paid for a hotel in Fargo ND. administrator and a belongings while Refacing the door and stated the administ sign the AMA form. R8 via facility transfemale acquaintant too. Former LSW sout the behaviors reexhibited by another facility. Former LSW administrator and hote in R8's EHR of stated she was informed to stated she was informed to state the Modern additional two with the behavioral two with the modeless and the former LSW stated director (AD) received a telephor from staff at the Modern additional two with the modeless and the former LSW stated director (AD) received and living under a telephor and living under a telephor from R8, who are formed R8, who are formed R8.					
	the administrator ap to take R8 out for a was being discharg	5 a.m. AD stated on 6/29/20, oproached her and asked her cigarette. R8 informed AD he ed by the facility, said a curse adicated he had nowhere else				

Minnesota Department of Health

AND DI AN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С
		00938	B. WING			31/2020
NAME OF	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, S	STATE, ZIP CODE		
		2810 SE	COND AVENU	JE NORTH		
MOORH	EAD REHABILITATION	N & HEALTHCARI MOORH	IEAD, MN 565	660		
(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 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21925	Continued From pa	ge 26	21925			
	disability and housin LSW and they had live. AD stated R8 cover the weekend to happen. R8 stated the did not follow the would be dischafacility via the facility 7/21/20, AD stated from R8 and he stadrugs and needed to R8 if he was hungry food and asked him food and brought it wheelchair under a On 7/28/20, at 11:13 6/29/20, the administration of the state of the stat	AD he had been working on an assistance with former been trying to find a place to did not say what he had done or cause the discharge to the interim DON had told him a facility rules and as a result reged. AD stated R8 left the y van driven by MS. On she received a phone call ted he was homeless, back or borrow money. AD informery she would buy him some in where he was. AD bought to R8 who was in his bridge in Moorhead, MN.	n d			
	with packing up R8's belongings. NA-B stated while the administrator and herself packed up R8's belongings, R8 was upset, swearing and the administrator informed R8 to stop that behavior.					
	(HUC) stated on 6/2 regarding R8's disc R8 wheeled himself administrator met hasked the administridentified he was hogo. Administrator to a two week stay at administrator where the administrator where and HUC was not sasked for a third timhis two weeks were	6 a.m. health unit coordinator 29/20, she heard discussion harge and about an hour late f to the front desk and the im 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 he would go after that and or plied he was on a waiting list ture what that meant. R8 he where he was going after a up and there was no administrator. HUC stated she	г			

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Minnesota Department of Health

AND DIAN OF CORRECTION TO TRENTIFICATION NUMBERS		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	00938	B. WING		07/3	, 1/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOORHEAD REHABILITATION	& HEALTHCARL	OND AVENU AD, MN 565			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
administrator and he him. HUC stated the the AMA form and at form and then he sai form. HUC stated a creceived a phone ca asking about an extensive she forwarded the castated R8 did call up asked to speak to AL homeless, had no migoing back on drugs transferred the call to the completed on R8. The R8 had not been located on T/31/20, at 10:46 dispatch (MPDD) state report on T/30/20, recompleted on R8. The report on T/30/20, recompleted on R8. The information had been since his last known room in Fargo, ND. Review of facility pol Against Medical Advant AMA discharge we leave the facility. The and administrator we impending AMA discount to discussion the resident to discussion to the resident to discussion the resident to discussion the resident to discussion to the resident to discussion the resident the reside	cussing and swearing at the told her she just discharged administrator had R8 sign first R8 would not sign the id " forget it" and signed the couple of weeks later she ll from the Motel 6 staff ension to keep R8's room and all to the administrator. HUC to the facility one day and D. R8 informed HUC he was oney and was thinking about again. HUC stated she had to the AD. If a.m. the Fargo PD intake stated the facility had filed a questing a well check be ne FPDIS stated at that time atted by the PD. If a.m. the Moorhead PD atted the facility had filed a questing a well check be ne FPDIS at a well check be atted the facility had filed a questing a well check be	21925			

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Minnesota Department of Health

AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
			A. BUILDING.			c	
		00938		B. WING		I	31/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOORH	EAD REHABILITATIOI	N & HEALTHCARI		OND AVENU AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21925	The IJ that began of 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 provided members about the discharge policy and facility provided edu AMA procedure and The noncompliance and severity level D Governor Tim Walz Order(EO) 20-14, sidentified beginning and continuing for the emergency, all resisterminating resident pendency of the emergency of th	on 7/28/20, was remo- facility contacted the and the Fargo, ND F 8. Additionally, the fact accept R8 back as decided he wanted to decided he wanted h	PD to icility a resident oreturn. The icility. The icility. The icility. The icility icility. The icility icility. The icility icility icility. The icility icility icility. The icility icility icility icility. The icility	21925			
		iew and/or develop p					

Minnesota Department of Health

AND DUAN OF CORRECTION IN IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		00938	B. WING		I	C 31/2020
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 0170	3172020
		2810 SEC	OND AVENU			
WOORH	EAD REHABILITATION	MOORHE.	AD, MN 565	660		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21925	Continued From pa	ge 29	21925			
21925	procedures that prosafe discharges fro medical advice (AN could educate staff periodically. The reviewed by the quaensure compliance.	ovide guidance on proper and m the facility to include against (IA) discharges. The facility on these policies and audit sults of these audits will be ality assessment committee to				

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