DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 8, 2023

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

Re: Reinspection Results
Event ID: 2ZTJ12

Dear Administrator:

On February 6, 2023 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 December 27, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 8, 2023

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

RE: CCN: 245272
Cycle Start Date: December 27, 2022

Dear Administrator:

On February 6, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 9, 2023

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

RE: CCN: 245272
Cycle Start Date: December 27, 2022

Dear Administrator:

On December 27, 2022, a survey was completed at your facility by the Minnesota Department of Health 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 27, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 27, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 9, 2023

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

Re: State Nursing Home Licensing Orders
Event ID: 2ZTJ11

Dear Administrator:

The above facility was surveyed on December 27, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	C 12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On December 27, 2022, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52726643C (MN00089270) with a deficiency cited at F586 and F661. The following complaints were found to be UNSUBSTANTIATED: H52726966C (MN00089552). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583		1/30/23

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

Electronically Signed | 01/16/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 583	Continued From page 1 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to maintain confidentiality for 2 of 2 residents (R1 and R4). R1 and R4 were discharged from the facility and given each other's confidential medical records. R1 and R4 left the facility with the incorrect medical records. The records had not been returned to the facility and there was no evidence indicated the records were destroyed. Findings include:	F 583	F 583 Corrective Action: R1 and R4 have discharged from the facility. HIPAA Compliance and incident policy was reviewed by Administrator and remains current. RN-A was educated on HIPAA Compliance Policy and procedure. Corrective Action as it applies to other residents: Root-cause analysis performed by the Quality Assurance Performance Improvement Committee (QAPI) to determine how the deficiency occurred.	

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F 583	Continued From page 2 R1's admission Minimal Data Set (MDS) dated 11/5/22, indicated R1 had mild cognitive concerns. R1's diagnoses were Atrial fibrillation (irregular heart rate), heart failure, renal failure, respiratory failure, hip fracture, dementia, and malnutrition. R1 required extensive assistance with transferring, ambulation, dressing and personal cares. R4's admission MDS dated 11/7/22, indicated R4 was cognitively intact. R4's diagnoses were a hip fracture, diabetes, and coronary artery disease. R4 required extensive assistance with transferring, ambulation, dressing and personal cares. A facility email document dated 12/4/22, at 10:50 p.m. from registered nurse (RN)-A to the director of nursing (DON). RN-A reported she "accidentally" switched the discharged papers for R1 and R4. She indicated both the residents had the correct Physician Orders for Sustaining Life Treatment (POLST) form, but the medication list was switched. RN-A stated she called both parties and they promised to come into the facility and switch out the forms, but did not come in. A facility incident report dated 12/4/22, written by the DON indicated discharge medication lists were switched between two residents. RN-A had called both families to alert them of the error and both families stated they would return to the facility to get the correct information. To follow-up, the DON called the spouse of R4 to come to the facility to get the correct orders. The spouse denied and asked for the forms could be emailed. The correct information was emailed to R4 on 12/5/22. The DON called the family (FM)-A for R1 to see if they would come to get the	F 583	Licensed staff to be re-educated on HIPAA Compliance and HIPAA Incidents policy. Date of Completion: 1/30/2023 Reoccurrence will be prevented by: Random Chart audits will be completed 2x per week for 8 weeks to ensure appropriate paperwork is filed in correct residents' charts. Audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee to determine if changes are necessary. HIPAA Incidents will be monitored monthly by QAPI Committee to ensure compliance. The Correction will be monitored by: The DON or designee is responsible for compliance.	

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F 583	Continued From page 3 correct information. The call was not returned to the facility. The report did not indicate what to do with the incorrect confidential information the families had in their possession. A facility health insurance portability and accountability act (HIPAA) incident report dated 12/5/22, at 4:02 p.m. written by the Administrator indicated two residents' paperwork had been switched during discharge. "Some paperwork" went to the correct personnel; however, the medications lists were accidentally switched while printing off paperwork. RN-A noticed the situation after the discharge and notified both families immediately. RN-A asked the families to come in and give the records back and/or destroy them. Both families stated they would come and retrieve the correct documents. The Administrator recommended the nurse who is working on the cart where the resident is living should be doing the discharge with the assistance of the supervisor as needed. The DON will follow-up with the nurses regarding this expectation. The appropriate documentation was sent after both families did not arrive to retrieve the proper records. The policy was reviewed with RN-A. Upon interview on 12/27/22, at 11:00 a.m. R4 stated he had been given the incorrect discharge paperwork. His wife noticed the mistake and notified the facility of the error. R4 stated "if the facility would have gone through the paperwork with me, they would have noticed the error, they just handed me the file and I left." R4 was questioning during the interview what information the other resident had on him. Upon interview on 12/27/22, at 12:49 p.m. R1 stated she heard from her family she had	F 583		

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F 583	Continued From page 4 received the incorrect information from the facility. "It all had somebody else's name on it, not mine." R1 stated that her family was dealing with "that issue." Upon interview on 12/27/22, at 2:39 p.m. a police officer stated when she entered the home of R1, after the discharge from the provider, she was uncertain what R1's baseline level was or what her medications were supposed to be as R1 had another residents' medical records. R1 was transported to the hospital. The officer stated the R1's family (FM)-A took the other residents records with her to the hospital so the hospital could make sure that R1 was not harmed. Upon interview on 12/27/22, at 12:53 p.m. social worker (SW)-A stated it was R1's family who contacted the facility about the medical records error. SW-A stated the incorrect documents are still with the families, however the families were sent the correct records. She was unaware if the facility had re-educated with the correct documents or if the family had received the correct documents. SW-A could not find any documentation of communication with either family since the discharge regarding any follow-up. Upon interview on 12/27/22, at 1:07 p.m. R1's family member (FM)-B stated, another family member reported to her about the incorrect medical record had been sent R1. She stated, she saw the record at the home, but didn't do anything with it. When R1 was taken to the hospital (FM)-C took the record to the hospital to make sure R1 was receiving correct care. FM-B was not certain where the other residents record was currently if FM-C had it or the hospital kept	F 583		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 583	Continued From page 5 them. She stated the family did receive the correct medical records, but R1 was already in the hospital. Upon interview on 12/27/22, at 3:11 p.m. the Administrator stated RN-A noticed the medical records had been switched and she came forward with "everything." The administrator stated the facility will have the nurses double/triple check papers before printing off. The facility may make a change to where the nurse on the cart does the discharge instead of house supervisor. The administrator stated the facility asked both families involved to return the confidential information. The facility was uncertain if the documents were destroyed or where they were currently. She stated neither family came in to "swap out" the documents. No follow-up has been made with the family since the incident when the correct records were emailed by the health unit coordinator (HUC). Upon interview on 12/27/22, at 4:19 p.m. RN-A stated it was R4 who notified the facility that he had received the incorrect discharge record. RN-A stated she incorrect confidential documents given to the individuals were the discharge summary, the recapitulation, and the medication lists. She confirmed it was not just the medication lists. The correct POLST forms were given to R1 and R4. She stated she notified the DON of the incident via email, and she called both families and asked them to return the incorrect documents and the facility would give them the correct ones. She stated the families had not come back to the facility by the time she left for the day. RN-A was not aware if the facility received the incorrect documents back or how the facility got the correct information to the	F 583		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 583	Continued From page 6 families. She stated she has not received any training regarding "HIPPA" from the facility following the incident. A facility policy titled HIPPA Incidents - Reporting dated 3/2022, indicated the facility must be able to effectively detect and respond to privacy and security incidents to protect the confidentiality, integrity and availability of the information maintained. The policy procedure indicated an incident report with dates, affected individuals, brief description of event, personal health information involved will be completed: what was the information that was compromised and the extent of the disclosures. Mitigation and error correction: What is the status of the information (where is it, what happened to it)? What information was retrieved, if yes when was it returned/or how long did the recipient have it in their possession? Sanction/steps to prevent recurrence.	F 583		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.	F 661		1/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

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F 661	Continued From page 7 (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a safe discharge for 2 of 2 residents (R1 and R4) reviewed for discharge. The facility did not communicate with the home health agency for R1 to ensure services were secure before discharge. In addition, R1 and R4 and/or representatives post discharge plan of care written instructions were not discussed and conveyed in a manner understood. Findings Include: R1's admission Minimal Data Set (MDS) dated 11/5/22, indicated R1 had mild cognitive concerns. R1's diagnoses were Atrial fibrillation (irregular heart rate), heart failure, renal failure, respiratory failure, hip fracture, dementia, and malnutrition. R1 required extensive assistance with transferring, ambulation, dressing and personal cares. R4's admission MDS dated 11/7/22, indicated R4 was cognitively intact. R4's diagnoses were a hip	F 661	F 661 Corrective Action: R1 and R4 have discharged from the facility. The discharge/transfer policy was reviewed by the interdisciplinary team and remains current. Corrective Action as it applies to other residents: Licensed staff to be re-educated on discharge process and reviewing recapitulation at the time of discharge. Licensed staff to be re-educated on discharge/transfer policy. RN-A was re-educated on discharge/transfer policy. Date of Completion: 1/30/2023 Reoccurrence will be prevented by: Residents that discharged each week to be audited 1x per week for 8 weeks to ensure compliance. Audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee to determine if changes are necessary.	

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	245272	A. BUILDING _____ B. WING _____	C 12/27/2022

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F 661	Continued From page 8 fracture, diabetes, and coronary artery disease. R4 required extensive assistance with transferring, ambulation, dressing and personal cares. R1's discharge instructions and recapitulation dated 12/2/22 identified in Section A R1's date of birth, diagnosis, discharge date to home on 12/3/22, R1's primary care physician with phone number, R1's advance directives, allergies. Section B titled Discharge Instructions identified R1 was to receive Home Care services for physical therapy, occupational therapy, medication set-up, and home health aide/personal care attendant services. The section identified R1's pharmacy. Section C titled Medications identified medication were reconciled on 12/2/22, and a list of medications were given to the resident with understanding of the medications at discharge. Section D titled Functional Level identified R1 required the assistance of one person for most activities of daily living. R1 did not require medical or personal devices. R1 was forgetful, able to make needs known, and was able to communicate needs. R1's skin was intact at the time of discharge. R1 had no infections and vital signs were taken. The discharge summary was provided to R1 with areas checked that the discharge summary was reviewed with R1. The document typed signatures included social worker (SW)-A dated 12/1/22, registered nurse (RN)-B, R1's family (FM)-A with no dates. The document was e-signed by RN-B on 12/2/22. There were no signatures for SW-A, RN-B, R1, and FM-A. R4's discharge instructions and recapitulation dated 12/2/22 identified in Section A R4's date of	F 661	The Correction will be monitored by: The DON or designee is responsible for monitoring and ensuring compliance.	

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F 661	Continued From page 9 birth, diagnosis, discharge date to home on 12/3/22, R4's primary care physician was left blank, R4's advance directives. Section B titled Discharge Instructions identified R4 was to received Home Care services for physical therapy, occupational therapy, medication set-up, and home health aide/personal care attendant services. The section identified R4's pharmacy. Section C titled Medications identified medications were reconciled on 12/2/22, and a list of medication were reviewed and given to the resident. Section D titled Functional Level identified R4 remained independent and required the assistance of one person for some activities of daily living. R4 did not require medical devices or personal devices. R4 able to make needs known and was able to communicate needs. R4's skin was intact at the time of discharge. R4 had no infections and vital signs were taken. The discharge summary was provided to R4 with areas checked the discharge summary was reviewed with R4. The document had typed signatures of SW-A dated 11/30/22, RN-B with no date, and a unidentified resident representative with no date. The document was e-signed by RN-B dated 12/2/22. There was no signature for SW-A. A signature was presnet in the heading Resident/Resident Representative dated 12/3/22. A facility email document dated 12/4/22, at 10:50 p.m. from RN-A to the director of nursing (DON). RN-A reported she "accidentally" switched the discharged papers for R1 and R4. She indicated both the residents had the correct Physician Orders for Sustaining Life Treatment (POLST) form, but the medication list was switched. RN-A stated she called both parties and they promised to come into the facility and switch out the forms, but did not come in.	F 661		

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F 661	Continued From page 10 A facility incident report dated 12/4/22, written by the DON indicated discharge medication lists were switched between two residents. RN-A had called both families to alert them of the error and both families stated they would return to the facility to get the correct information. To follow-up, the DON called the spouse of R4 to come to the facility to get the correct orders. The spouse denied and asked for the forms could be emailed. The correct information was emailed to R4 on 12/5/22. The DON called the FM-A for R1 to see if they would come in to get the correct information. The call was not returned to the facility. The report did not indicate what to do with the incorrect confidential information the families had in their possession. A facility health insurance portability and accountability act (HIPAA) incident report dated 12/5/22, at 4:02 p.m. written by the Administrator indicated two residents' paperwork had been switched during discharge. "Some paperwork" went to the correct personnel; however, the medications lists were accidentally switched while printing off paperwork. RN-A noticed the situation after the discharge and notified both families immediately. RN-A asked the families to come in and give the records back and/or destroy them. Both families stated they would come and retrieve the correct documents. The Administrator recommended the nurse who is working on the cart where the resident is living should be doing the discharge with the assistance of the supervisor as needed. The DON will follow-up with the nurses regarding this expectation. The appropriate documentation was sent after both families did not arrive to retrieve the proper records. The policy was reviewed with RN-A.	F 661		

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F 661	Continued From page 11 Upon interview on 12/27/22, at 11:00 a.m. R4 stated he had been given the incorrect discharge paperwork. His wife noticed the mistake and notified the facility of the error. R4 stated "if the facility would have gone through the paperwork with me, they would have noticed the error, they just handed me the file and I left." R4 was questioning during the interview what information the other resident had on him. Upon interview on 12/27/22, at 12:49 p.m. R1 stated she heard from her family she had received the incorrect information from the facility. "It all had somebody else's name on it, not mine." R1 stated that her family was dealing with "that issue." R1 stated she spent "a lot" of time in the hospital before being admitted to the new facility. She stated her family member (FM)-B came to her house, it was afternoon, she had another lady with her. They found her still in bed unable to get up to the bathroom, and that she and her bed were urine soaked. R1 stated, she does sleep in late in the morning, she denied having anyone in the home to help her that day. She reported she had nine medications she was supposed to take for the morning and two pills at night but had not been taking them because she was unsure what they were. R1 thought her family along with her previous home care agency were going to take care of her. R1 could not recall whether she had oxygen at home or not. She stated she wanted to go home if a good plan is in place. R1 denied any education prior to leaving the facility. Upon interview on 12/27/22, at 1:12 p.m. staff from the home care agency reported they received an order from the facility for home care	F 661		

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F 661	Continued From page 12 services on 12/7/22, but the order was denied. R1 was not admitted for home health care services. Upon interview on 12/27/22, at 12:23 p.m. RN-B stated the entire team is involved in the discharges. He stated the social workers set-up the homecare. He recalled R1 would have needed services in the home and that there was a "lot of family dynamics" going on. He stated with the right cares he did not have a concern about her being at home. He stated the facility does not do an overnight leave of absence to see if the resident can manage at home to ensure the discharge plan would be effective. Upon interview on 12/27/22, at 12:53 p.m. social worker (SW)-A reported she was not the social worker who did the discharge, but as the manager she is involved in all discharges. She stated she found an email from the social worker who did the discharge. The note indicated R1 was to go home with 24-hour family support. She required oxygen and there was a delay in getting the oxygen order, but that was cleared-up. SW-A stated most of the education was probably discussed at the last care conference. The plan from that care conference was for the grandson's girlfriend to take her from 6:30 a.m. until 1:00 p.m. and then return at around 7:00 p.m. in hopes homecare could be able to be in the home between 1:00 p.m. and 7:00 p.m. SW-A could not provide a confirmation from the home care agency that home care had been approved. She stated her expectation is for the facility to circle back if they had not heard from the homecare agency prior to discharge. Upon interview on 12/27/22, at 1:07 p.m. R1's	F 661		

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F 661	Continued From page 13 family member (FM)-A stated she did leave R1 unattended on the day of incident as she had to be at work early that morning. She stated she was going to call the home care agency after she returned from work that day to set-up the services. She stated prior to R1's discharge there was no information given, except the discussion from the care conference a week ago. The facility reached out to her with the discharge date when they were sure they had the oxygen set-up to be delivered. FM-A stated she thought R1 could use the bathroom alone and was not certain if R1 had taken her medications. FM-A stated by the time she returned from work R1 had been transferred to the hospital. Upon interview on 12/27/22, at 2:39 p.m. a police officer stated when she entered the home after R1's discharge from the provider, she was uncertain what R1's baseline level was or what her medications were supposed to be as R1 had another residents' medical records. The officer stated the house smelled of strong urine, the house was a mess, and it was clear R1 had been sitting in urine for quite some time. R1 was transported to the hospital. Upon interview on 12/27/22, at 3:11 p.m. the Administrator stated discharge happens in many steps, with all the departments. It is her expectation that at the time of discharge education would be completed when all the orders are prepared and then the resident can ask clarification questions. Upon interview on 12/27/22, at 4:19 p.m. RN-A stated she did not give R1 or the family discharge education. She stated she has never done the education with discharging residents. She stated	F 661		

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F 661	Continued From page 14 she makes copies and give the residents the forms. "If I am supposed to be doing it, no one has told me." She stated she believed the entire team had a part in the education process and this was all completed before the actual discharge day. A facility policy titled Transfer and Discharge from the facility dated 4/2022, indicated the facility works in conjunction with the primary care provider, works with the resident and their representative to prepare proper education and support a safe discharge. When the health of the resident has improved and the resident no longer needs the services provided by the facility, the care team assists the residents and representative with the arrangements needed to discharge to the appropriate setting. The resident's health information necessary for the care is provided to necessary parties.	F 661		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. 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. 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. INITIAL COMMENTS: On December 27, 2022, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/16/23

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H52726643C (MN00089270), with a licensing order issued at 1885 and 0690. The following complaint was found to be UNSUBSTANTIATED: H52726966C (MN00089552). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for 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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a safe discharge for 2 of 2 residents (R1 and R4) reviewed for discharge. The facility did not communicate with the home health agency for R1 to ensure services were secure before discharge. In addition, R1 and R4 and/or representatives post discharge plan of care written instructions were not discussed and conveyed in a manner understood.	2 690	Corrected	1/30/23

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2 690	Continued From page 3 Findings Include: R1's admission Minimal Data Set (MDS) dated 11/5/22, indicated R1 had mild cognitive concerns. R1's diagnoses were Atrial fibrillation (irregular heart rate), heart failure, renal failure, respiratory failure, hip fracture, dementia, and malnutrition. R1 required extensive assistance with transferring, ambulation, dressing and personal cares. R4's admission MDS dated 11/7/22, indicated R4 was cognitively intact. R4's diagnoses were a hip fracture, diabetes, and coronary artery disease. R4 required extensive assistance with transferring, ambulation, dressing and personal cares. R1's discharge instructions and recapitulation dated 12/2/22 identified in Section A R1's date of birth, diagnosis, discharge date to home on 12/3/22, R1's primary care physician with phone number, R1's advance directives, allergies. Section B titled Discharge Instructions identified R1 was to receive Home Care services for physical therapy, occupational therapy, medication set-up, and home health aide/personal care attendant services. The section identified R1's pharmacy. Section C titled Medications identified medication were reconciled on 12/2/22, and a list of medications were given to the resident with understanding of the medications at discharge. Section D titled Functional Level identified R1 required the assistance of one person for most activities of daily living. R1 did not require medical or personal devices. R1 was forgetful, able to make needs known, and was able to communicate needs. R1's skin was intact at the time of	2 690		

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2 690	Continued From page 4 discharge. R1 had no infections and vital signs were taken. The discharge summary was provided to R1 with areas checked that the discharge summary was reviewed with R1. The document typed signatures included social worker (SW)-A dated 12/1/22, registered nurse (RN)-B, R1's family (FM)-A with no dates. The document was e-signed by RN-B on 12/2/22. There were no signatures for SW-A, RN-B, R1, and FM-A. R4's discharge instructions and recapitulation dated 12/2/22 identified in Section A R4's date of birth, diagnosis, discharge date to home on 12/3/22, R4's primary care physician was left blank, R4's advance directives. Section B titled Discharge Instructions identified R4 was to received Home Care services for physical therapy, occupational therapy, medication set-up, and home health aide/personal care attendant services. The section identified R4's pharmacy. Section C titled Medications identified medications were reconciled on 12/2/22, and a list of medication were reviewed and given to the resident. Section D titled Functional Level identified R4 remained independent and required the assistance of one person for some activities of daily living. R4 did not require medical devices or personal devices. R4 able to make needs known and was able to communicate needs. R4's skin was intact at the time of discharge. R4 had no infections and vital signs were taken. The discharge summary was provided to R4 with areas checked the discharge summary was reviewed with R4. The document had typed signatures of SW-A dated 11/30/22, RN-B with no date, and a unidentified resident representative with no date. The document was e-signed by RN-B dated 12/2/22. There was no signature for SW-A. A signature was presnet in the heading	2 690		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 690	Continued From page 5 Resident/Resident Representative dated 12/3/22. A facility email document dated 12/4/22, at 10:50 p.m. from RN-A to the director of nursing (DON). RN-A reported she "accidentally" switched the discharged papers for R1 and R4. She indicated both the residents had the correct Physician Orders for Sustaining Life Treatment (POLST) form, but the medication list was switched. RN-A stated she called both parties and they promised to come into the facility and switch out the forms, but did not come in. A facility incident report dated 12/4/22, written by the DON indicated discharge medication lists were switched between two residents. RN-A had called both families to alert them of the error and both families stated they would return to the facility to get the correct information. To follow-up, the DON called the spouse of R4 to come to the facility to get the correct orders. The spouse denied and asked for the forms could be emailed. The correct information was emailed to R4 on 12/5/22. The DON called the FM-A for R1 to see if they would come in to get the correct information. The call was not returned to the facility. The report did not indicate what to do with the incorrect confidential information the families had in their possession. A facility health insurance portability and accountability act (HIPAA) incident report dated 12/5/22, at 4:02 p.m. written by the Administrator indicated two residents' paperwork had been switched during discharge. "Some paperwork" went to the correct personnel; however, the medications lists were accidentally switched while printing off paperwork. RN-A noticed the situation after the discharge and notified both families immediately. RN-A asked the families to come in	2 690		

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	00227	A. BUILDING: _____ B. WING _____	C 12/27/2022

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2 690	Continued From page 6 and give the records back and/or destroy them. Both families stated they would come and retrieve the correct documents. The Administrator recommended the nurse who is working on the cart where the resident is living should be doing the discharge with the assistance of the supervisor as needed. The DON will follow-up with the nurses regarding this expectation. The appropriate documentation was sent after both families did not arrive to retrieve the proper records. The policy was reviewed with RN-A. Upon interview on 12/27/22, at 11:00 a.m. R4 stated he had been given the incorrect discharge paperwork. His wife noticed the mistake and notified the facility of the error. R4 stated "if the facility would have gone through the paperwork with me, they would have noticed the error, they just handed me the file and I left." R4 was questioning during the interview what information the other resident had on him. Upon interview on 12/27/22, at 12:49 p.m. R1 stated she heard from her family she had received the incorrect information from the facility. "It all had somebody else's name on it, not mine." R1 stated that her family was dealing with "that issue." R1 stated she spent "a lot" of time in the hospital before being admitted to the new facility. She stated her family member (FM)-B came to her house, it was afternoon, she had another lady with her. They found her still in bed unable to get up to the bathroom, and that she and her bed were urine soaked. R1 stated, she does sleep in late in the morning, she denied having anyone in the home to help her that day. She reported she had nine medications she was supposed to take for the morning and two pills at night but had not been taking them because she was unsure what they were. R1 thought her	2 690		

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2 690	Continued From page 7 family along with her previous home care agency were going to take care of her. R1 could not recall whether she had oxygen at home or not. She stated she wanted to go home if a good plan is in place. R1 denied any education prior to leaving the facility. Upon interview on 12/27/22, at 1:12 p.m. staff from the home care agency reported they received an order from the facility for home care services on 12/7/22, but the order was denied. R1 was not admitted for home health care services. Upon interview on 12/27/22, at 12:23 p.m. RN-B stated the entire team is involved in the discharges. He stated the social workers set-up the homecare. He recalled R1 would have needed services in the home and that there was a "lot of family dynamics" going on. He stated with the right cares he did not have a concern about her being at home. He stated the facility does not do an overnight leave of absence to see if the resident can manage at home to ensure the discharge plan would be effective. Upon interview on 12/27/22, at 12:53 p.m. social worker (SW)-A reported she was not the social worker who did the discharge, but as the manager she is involved in all discharges. She stated she found an email from the social worker who did the discharge. The note indicated R1 was to go home with 24-hour family support. She required oxygen and there was a delay in getting the oxygen order, but that was cleared-up. SW-A stated most of the education was probably discussed at the last care conference. The plan from that care conference was for the grandson's girlfriend to take her from 6:30 a.m. until 1:00 p.m. and then return at around 7:00 p.m. in hopes	2 690		

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2 690	Continued From page 8 homecare could be able to be in the home between 1:00 p.m. and 7:00 p.m. SW-A could not provide a confirmation from the home care agency that home care had been approved. She stated her expectation is for the facility to circle back if they had not heard from the homecare agency prior to discharge. Upon interview on 12/27/22, at 1:07 p.m. R1's family member (FM)-A stated she did leave R1 unattended on the day of incident as she had to be at work early that morning. She stated she was going to call the home care agency after she returned from work that day to set-up the services. She stated prior to R1's discharge there was no information given, except the discussion from the care conference a week ago. The facility reached out to her with the discharge date when they were sure they had the oxygen set-up to be delivered. FM-A stated she thought R1 could use the bathroom alone and was not certain if R1 had taken her medications. FM-A stated by the time she returned from work R1 had been transferred to the hospital. Upon interview on 12/27/22, at 2:39 p.m. a police officer stated when she entered the home after R1's discharge from the provider, she was uncertain what R1's baseline level was or what her medications were supposed to be as R1 had another residents' medical records. The officer stated the house smelled of strong urine, the house was a mess, and it was clear R1 had been sitting in urine for quite some time. R1 was transported to the hospital. Upon interview on 12/27/22, at 3:11 p.m. the Administrator stated discharge happens in many steps, with all the departments. It is her expectation that at the time of discharge	2 690		

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2 690	Continued From page 9 education would be completed when all the orders are prepared and then the resident can ask clarification questions. Upon interview on 12/27/22, at 4:19 p.m. RN-A stated she did not give R1 or the family discharge education. She stated she has never done the education with discharging residents. She stated she makes copies and give the residents the forms. "If I am supposed to be doing it, no one has told me." She stated she believed the entire team had a part in the education process and this was all completed before the actual discharge day. A facility policy titled Transfer and Discharge from the facility dated 4/2022, indicated the facility works in conjunction with the primary care provider, works with the resident and their representative to prepare proper education and support a safe discharge. When the health of the resident has improved and the resident no longer needs the services provided by the facility, the care team assists the residents and representative with the arrangements needed to discharge to the appropriate setting. The resident's health information necessary for the care is provided to necessary parties. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 690		

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21885	Continued From page 10	21885		
21885	MN St. Statute 144.651 Subd. 21 Patients & Residents Of HC Fac.Bill of Rights Subd. 21. Communication privacy. Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. (Only portions indicated of this subdivision are subject to assessment.) This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to maintain confidentiality for 2 of 2 residents (R1 and R4). R1 and R4 were discharged from the facility and given each other's confidential medical records. R1 and R4 left the facility with the incorrect medical records. The records had not been returned to the facility and there was no evidence indicated the records were destroyed. Findings include: R1's admission Minimal Data Set (MDS) dated 11/5/22, indicated R1 had mild cognitive concerns. R1's diagnoses were Atrial fibrillation (irregular heart rate), heart failure, renal failure, respiratory failure, hip fracture, dementia, and malnutrition. R1 required extensive assistance with transferring, ambulation, dressing and personal cares.	21885	Corrected	1/30/23

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21885	Continued From page 11 R4's admission MDS dated 11/7/22, indicated R4 was cognitively intact. R4's diagnoses were a hip fracture, diabetes, and coronary artery disease. R4 required extensive assistance with transferring, ambulation, dressing and personal cares. A facility email document dated 12/4/22, at 10:50 p.m. from registered nurse (RN)-A to the director of nursing (DON). RN-A reported she "accidentally" switched the discharged papers for R1 and R4. She indicated both the residents had the correct Physician Orders for Sustaining Life Treatment (POLST) form, but the medication list was switched. RN-A stated she called both parties and they promised to come into the facility and switch out the forms, but did not come in. A facility incident report dated 12/4/22, written by the DON indicated discharge medication lists were switched between two residents. RN-A had called both families to alert them of the error and both families stated they would return to the facility to get the correct information. To follow-up, the DON called the spouse of R4 to come to the facility to get the correct orders. The spouse denied and asked for the forms could be emailed. The correct information was emailed to R4 on 12/5/22. The DON called the family (FM)-A for R1 to see if they would come to get the correct information. The call was not returned to the facility. The report did not indicate what to do with the incorrect confidential information the families had in their possession. A facility health insurance portability and accountability act (HIPAA) incident report dated 12/5/22, at 4:02 p.m. written by the Administrator indicated two residents' paperwork had been switched during discharge. "Some paperwork"	21885		

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21885	Continued From page 12 went to the correct personnel; however, the medications lists were accidentally switched while printing off paperwork. RN-A noticed the situation after the discharge and notified both families immediately. RN-A asked the families to come in and give the records back and/or destroy them. Both families stated they would come and retrieve the correct documents. The Administrator recommended the nurse who is working on the cart where the resident is living should be doing the discharge with the assistance of the supervisor as needed. The DON will follow-up with the nurses regarding this expectation. The appropriate documentation was sent after both families did not arrive to retrieve the proper records. The policy was reviewed with RN-A. Upon interview on 12/27/22, at 11:00 a.m. R4 stated he had been given the incorrect discharge paperwork. His wife noticed the mistake and notified the facility of the error. R4 stated "if the facility would have gone through the paperwork with me, they would have noticed the error, they just handed me the file and I left." R4 was questioning during the interview what information the other resident had on him. Upon interview on 12/27/22, at 12:49 p.m. R1 stated she heard from her family she had received the incorrect information from the facility. "It all had somebody else's name on it, not mine." R1 stated that her family was dealing with "that issue." Upon interview on 12/27/22, at 2:39 p.m. a police officer stated when she entered the home of R1 on 12/5/22 she was uncertain what R1's baseline level was or what her medications were supposed to be as R1 had another residents' medical records. R1 was transported to the hospital. The	21885		

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21885	Continued From page 13 officer stated the R1's family (FM)-A took the other residents records with her to the hospital so the hospital could make sure that R1 was not harmed. Upon interview on 12/27/22, at 12:53 p.m. social worker (SW)-A stated it was R1's family who contacted the facility about the medical records error. SW-A stated the incorrect documents are still with the families, however the families were sent the correct records. She was unaware if the facility had re-educated with the correct documents or if the family had received the correct documents. SW-A could not find any documentation of communication with either family since the discharge regarding any follow-up. Upon interview on 12/27/22, at 1:07 p.m. R1's family member (FM)-B stated, another family member reported to her about the incorrect medical record had been sent R1. She stated, she saw the record at the home, but didn't do anything with it. When R1 was taken to the hospital (FM)-C took the record to the hospital to make sure R1 was receiving correct care. FM-B was not certain where the other residents record was currently if FM-C had it or the hospital kept them. She stated the family did receive the correct medical records, but R1 was already in the hospital. Upon interview on 12/27/22, at 3:11 p.m. the Administrator stated RN-A noticed the medical records had been switched and she came forward with "everything." The administrator stated the facility will have the nurses double/triple check papers before printing off. The facility may make a change to where the nurse on the cart does the discharge instead of	21885		

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21885	Continued From page 14 house supervisor. The administrator stated the facility asked both families involved to return the confidential information. The facility was uncertain if the documents were destroyed or where they were currently. She stated neither family came in to "swap out" the documents. No follow-up has been made with the family since the incident when the correct records were emailed by the health unit coordinator (HUC). Upon interview on 12/27/22, at 4:19 p.m. RN-A stated it was R4 who notified the facility that he had received the incorrect discharge record. RN-A stated she incorrect confidential documents given to the individuals were the discharge summary, the recapitulation, and the medication lists. She confirmed it was not just the medication lists. The correct POLST forms were given to R1 and R4. She stated she notified the DON of the incident via email, and she called both families and asked them to return the incorrect documents and the facility would give them the correct ones. She stated the families had not come back to the facility by the time she left for the day. RN-A was not aware if the facility received the incorrect documents back or how the facility got the correct information to the families. She stated she has not received any training regarding "HIPPA" from the facility following the incident. A facility policy titled HIPPA Incidents - Reporting dated 3/2022, indicated the facility must be able to effectively detect and respond to privacy and security incidents to protect the confidentiality, integrity and availability of the information maintained. The policy procedure indicated an incident report with dates, affected individuals, brief description of event, personal health information involved will be completed: what was	21885		

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21885	Continued From page 15 the information that was compromised and the extent of the disclosures. Mitigation and error correction: What is the status of the information (where is it, what happened to it)? What information was retrieved, if yes when was it returned/or how long did the recipient have it in their possession? Sanction/steps to prevent recurrence. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21885		