Electronically delivered
September 29, 2021

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

RE: CCN: 245461
Cycle Start Date: September 2, 2021

Dear Administrator:

On September 2, 2021, a survey was completed at your facility by the Minnesota Departments 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.

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" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 December 2, 2021 (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 March 2, 2022 (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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 09/02/2021

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EVENTIDE LUTHERAN HOME	**1405 7TH STREET SOUTH MOORHEAD, MN 56560**

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F 000	INITIAL COMMENTS On 9/1/21 through 9/2/21, 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: H5461061C (MN76208; MN76003), with a deficiency cited at F622 and F626. H5461062C (MN76006), however no deficiency cited. The following complaints were found to be UNSUBSTANTIATED: H5461063C (MN74440) H5461064C (MN74310) 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 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-	F 622		10/22/21

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

Electronically Signed | 10/08/2021

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F 622	Continued From page 1 (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a	F 622		

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F 622	Continued From page 2	F 622		

resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure

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F 622	Continued From page 3 a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide an adequate discharge notice to 1 of 3 residents (R1) reviewed for discharge who was provided an immediate discharge and not allowed to return to the facility without adequate cause or documentation. Findings include: R1's quarterly minimal data set (MDS) dated 7/9/21, indicated R1's diagnoses included manic depression, schizophrenia and had moderately impaired skills for daily decision making. Further review of MDS, indicated R1 required supervision to extensive assistance of one staff member for activities of daily living (ADLs). R1's care plan printed 9/2/21, indicated R1 had a potential for behaviors related to diagnoses of mild cognitive disorder, bipolar disorder, schizophrenia and insomnia disorder. Care plan identified behavioral triggers as being asked to do something (perform cares, take meds, etc.). Additionally, R1's behaviors include, frequently disrobed and has aggressive behavior (care plan lacked evidence of definition for aggressive behavior) with interventions listed as: - room change to private room due to behaviors 5/27/21; - resident benefits from medications to assist in behaviors- orders to crush and conceal meds as an alternative way to have resident take meds received 7/12/21; - 1:1 staff contact when out of room due to increase in aggressive behaviors; - staff member to be assigned to her each shift;	F 622	F622 Transfer and Discharge Requirements How corrective action will be accomplished for the resident(s) impacted: 1. R1 has been readmitted to the facility on 10/4/2021. A rescission letter has been issued on 10/4/21 for the discharge notice issued on 8/27/2021. How facility will identify other residents who have potential to be affected: 2. All residents in the facility have the potential to be affected. To determine if any other residents were affected, we reviewed all hospital transfers for the past three months and ensured all transfer/discharge notices were completed appropriately. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 3. Education was provided to nurse leadership and social service team regarding discharge requirements. Policy was reviewed and no revisions were found necessary. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: 4. The DON or designee will review all transfer notices until February 1st, 2022 and then as needed. The results of the	

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F 622	Continued From page 4 - discuss opportunities for medication re-evaluation with resident, family and practitioner; - follow resident's preferred, consistent routine as able; if undressing approach calmly and assist with covering her with clothing; - redirect with an activity, snacks, or other distractions. - keep R1 separate from other residents as much as possible. - R1 can go to activities with 1:1 staff contact. - monitor her while ambulating to keep away from other residents; likes 1:1 conversation, utilize as able when having increased behaviors; - if she asks you to leave, leave and re-approach at later time. - mood and behavior monitoring every shift. -offer emotional support, offer to call daughter when having increased behaviors, provide consistent care givers as able. Further review of R1's care plan indicated "long term care anticipated for [R1] due to care and supervision needs with interventions that included assist with discharge planning and offer discharge planning conference if needed and treat resident in an adult and dignified manner." Care plan lacked evidence R1 desired or participated in discharge planning. Care plan additionally noted potential resident to resident altercation 5/25/21, 6/29/21, and 7/1/21 but the resident's record failed to identify evidence of resident to resident abuse because of R1's behavior. Review of facility report dated 6/29/21, indicated a resident living in the facility reported "another resident hit her on the right side of the face."	F 622	audits will be reported to the QAPI committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated.	

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Resident was able to give description of alleged perpetrator which the description fit that of R1. R1 was interviewed by facility staff and denied any altercation with another resident. There was no injury noted to either resident. Further review of report, staff interviews were completed and there was no witnesses to alleged resident to resident altercation and staff were not aware of any other altercations between R1 and another resident.

Review of facility report dated 7/2/21, indicated staff witnessed R1 "brush" another resident's right cheek and staff witness stated "the contact was light and did not appear to harm [resident]."

Review of R1's transfer and discharge report printed 9/2/21, indicated R1 was admitted to the facility on 4/2/21, and discharged 8/16/21. However, report does not indicate where R1 was discharged to.

Review of R1's progress notes include the following:
-On 7/29/21, "resident was sent to Sanford ER [emergency room] due to escalated and unpredictable behavioral outburst that involve hitting, slapping, and kicking staff members on multiple occasion, and even a resident on a different floor. She will need a psych evaluation and placement to another facility to make the care needs she requires."
-On 7/29/21, "Notice of transfer complete. Waiting to hear back on bed hold. NOT [notice of transfer] will be sent to ombudsman."
-On 7/30/21, "[guardian] notified of residents behavior on AM shift. Notified that resident hit a staff member, provider was notified and updated of current situation with resident. (currently resident has been 1:1 due to hitting

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staff/residents, she has been refusing to take PRN [as needed] meds [medication] or scheduled, aggressive towards all staff). Transfer initiated to ER [emergency room] for admit. Discussed bed hold with [guardian's name]. Answered [guardian] questions regarding where resident should be discharged to after hospital, that would depend on diagnosis at time of discharge and status or resident. [guardian] did not want to decide on whether or not to hold resident's bed at this time. Will follow up with her today and update social work."
-On 7/30/21, "Got a hold of guardian [name] and she wishes for bed to be held at this time in case alternate placement cannot be found. Bed hold to be emailed to [guardian] for signature."
-On 8/1/21, "admitted to hospital."
-On 8/16/21, "Writer spoke with guardian today and res [resident] is not stable to return and MA [medical assistance] bed hold is up. Guardian state res [resident] is not able to pay for bed hold so will release bed as of today. Staff will pack up belongings per guardian's request."
-On 8/27/21, "New Notice of Transfer/Discharge form issued for today and sent to [guardian]."

Review of doctor's order dated 7/29/21, indicated "OK to send to ER Sanford Hospital. DX [diagnosis] aggression towards staff, uncontrolled behavior, concern for safety of staff and other residents due to physical contact with force."

Review of R1's Notice of Transfer or Discharge dated 7/29/21, indicated the notice was addressed to R1 and guardian, and "the transfer or discharge is necessary for the resident's welfare as the resident's needs cannot be met in the facility." Further, document indicated R1 was transferred to Sanford emergency room on

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7/29/21, because of behaviors. R1's right to appeal was listed on the document, however, facility document was signed by social services (SS)-A and dated 7/29/21, but R1's name was printed on resident line with no date and no guardian signature.

Review of another Notice of Transfer or Discharge was reviewed which was addressed to the guardian and R1 and the reason identified as the "safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident." Further, R1 was "transferred or discharged to Sanford on 7/29/21 because of escalated and unpredictable behavioral outburst involving physical abuse towards others" and the appeal information was provided on document guardian's name is printed and dated 8/27/21, along with SS-B signature.

On 9/1/21, at 12:00 p.m. Ombudsman Advocate (OA) stated R1 "may be challenging but regardless of her challenges, she still has a right to return and a right to proper notice." In addition, in regards to the Immediate discharge notice given to R1 on 8/27/21, OA stated she had requested documentation on the facility's determination of R1's endangerment and the facility declined indicating there was no documentation and continued to state R1 had given up/released her bed hold. OA indicated an appeal for discharge has been made at this time.

On 9/1/21, at 2:25 p.m. hospital social worker (HSS) confirmed a discharge notice was not provided and stated, "I know [R1] is very challenging and has behaviors and there is difficulty there, but they were not following the policy and [R1]'s rights." Further, COMP-B

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indicated an appeal was made for discharge.

On 9/22/21, at 12:30 p.m. trained medication assistant (TMA)-A stated R1 "was a tough one. R1 had a lot of verbal abuse the first incident where she physically hit someone was a housekeeper and the second one they thought she hit another resident on the head."

On 9/2/21, at 12:44 p.m. nursing assistant (NA)-A stated R1 had behaviors which consisted of "refusing cares from us aids. She would yell at us and swear and tell us to get out of her room. I can't recall anything physical off the top of my head."

On 9/2/21, at 12:53 p.m. licensed practical nurse (LPN)-A stated R1 "got physical and slapped an aid. She will tell you how she feels and tell you what she wants. I think she got physical with another resident and they moved her and she was on a 1-1 when outside her room. Someone had to be with her so she didn't get into an altercation. She was very physical hitting and kicking out and got physical with an aid and that's when she went to the hospital and I have not seen her since."

On 9/2/21, at 1:01 p.m. secretary (SEC)-A stated she witnessed R1 "walk by and it was more of a brush. She was trying to pester her [other resident] not hurt her. R1 brushed [resident's] face and kept walking."

On 9/2/21, at 1:10 p.m. registered nurse (RN)-A stated the discharge plan for R1 was to remain at the facility for long term care. Further, RN-A stated R1 did have physical behaviors towards staff and was targeting another resident. RN-A

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indicated the first altercation R1 had with another resident "was not fully substantiated and we couldn't say for certain she did it until she hit her a second time. After the second incident happened we made her a 1-1 immediately." When asked what occurred during the second altercation, RN-A stated it was witnessed by SEC-A that R1 "brushed her [other resident's] cheek."

During interview on 9/2/21, at 2:57 p.m. SS-B stated on the 18th day (8/26/21), "I left a voicemail [to hospital social worker] indicating we could not take [R1] back at this time due to her past behaviors here. We did not feel it was the best interest for [R1] or staff or residents as we felt she posed a safety risk for the vulnerable adults here."

On 9/2/21, at 3:14 p.m. during interview with both DON and administrator, the administrator stated she spoke with vice president of clinical services and chief officer of operations (COO) and they determined "our process was followed, and we said we were not taking [R1] back at this time." In addition, administrator stated, "We had past experiences based on her behaviors here and vulnerable adult reports here which determined she was combative and that is not a profile we would accept back into the facility and there is plenty of behavioral documentation." When asked if the facility comprehensively assessed R1 based on her recent hospitalization and not prior to transfer. DON stated, "We wouldn't normally complete an assessment with the profile if they are not a resident here anymore and if we feel we couldn't meet their needs." DON confirmed R1's progress notes from the hospital did not show any behaviors for R1 but, "we knew the [behaviors]

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	245461	A. BUILDING _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE LUTHERAN HOME	**1405 7TH STREET SOUTH MOORHEAD, MN 56560**

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F 622	Continued From page 10	F 622		

occurred here [Eventide]."

The facility provided clarification on 9/6/21, indicating an assessment of R1's hospital stay was reviewed before the facility initiated the immediate discharge notice. Additionally, the facility provided documentation of communication with R1's team regarding discharge planning, though this documentation did not demonstrate evidence of R1's involvement or agreement to move.

On 9/2/21, at 3:14 p.m. during an interview with both the DON and administrator, the administrator indicated R1 was making an appeal for discharge. Further, administrator indicated a second immediate discharge notice was given on 8/27/21, which was directed by staff at Minnesota Department of Health (MDH), R1 would be considered an immediate discharge due to behaviors.

Per requirement for an immediate discharge, review of R1's record failed to identify sufficient documentation the danger that failure to transfer or discharge would pose.

Review of facility policy titled Discharge revised 12/13, indicated "social services will assist in determining the need for involuntary discharge plan. Upon this determination, a 30-day written notice will be given to the resident/responsible party. This notice will include the following information: the reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharge, a statement that the resident has the right to appeal the action to the State, and the name, address, the telephone number of the

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F 622	Continued From page 11 State Long-Term Care Ombudsman. Social Services will document in the medical record that a notice has been issued."	F 622		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location	F 626		10/22/21

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F 626	Continued From page 12 at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to readmit a resident after hospitalization for 1 of 3 residents (R1) reviewed for transfer/discharge. Findings include: R1's quarterly minimal data set (MDS) dated 7/9/21, indicated R1's diagnoses included manic depression, schizophrenia and had moderately impaired skills for daily decision making. Further review of MDS, indicated R1 required supervision to extensive assistance of one staff member for activities of daily living (ADLs). R1's care plan printed 9/2/21, indicated "long term care anticipated for [R1] due to care and supervision needs with interventions that included assist with discharge planning and offer discharge planning conference if needed and treat resident in an adult and dignified manner." Review of R1's progress notes include the following: On 7/29/21, "resident was sent to emergency room due to escalated and unpredictable behavioral outburst that involve hitting, slapping, and kicking staff members on multiple occasion, and even a resident on a different floor. She will need a psych evaluation and placement to another facility to make the care needs she	F 626	F626 Permitting Residents to Return to Facility How corrective action will be accomplished for the resident(s) impacted: 1. R1 has been readmitted to the facility on 10/4/2021. A rescission letter has been issued on 10/4/21 for the discharge notice issued on 8/27/2021. How facility will identify other residents who have potential to be affected: 2. All residents in the facility have the potential to be affected. To determine if any other residents were affected, we reviewed all bed holds for the past three months to ensure all residents who wanted to return to the facility were allowed to do so. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 3. Bed hold policy was revised. Education was provided to nurse leadership and social service team regarding bed hold requirements and policy change. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: 4. The DON or designee will review all bed holds until February 1st, 2022 and	

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F 626	Continued From page 13 requires." On 7/29/21, "Notice of transfer complete. Waiting to hear back on bed hold. NOT [notice of transfer] will be sent to ombudsman." On 7/30/21, "[guardian] notified of residents behavior on AM shift. Notified that resident hit a staff member, provider was notified and updated of current situation with resident. (currently resident has been 1:1 due to hitting staff/residents, she has been refusing to take PRN [as needed] meds [medication] or scheduled, aggressive towards all staff). Transfer initiated to ER [emergency room] for admit. Discussed bed hold with [guardian's name]. Answered [guardian] questions regarding where resident should be d/c'd [discharged] to after hospital, that would depend on diagnosis at time of discharge and status or resident. [guardian] did not want to decide on whether or not to hold resident's bed at this time. Will follow up with her today and update social work." On 7/30/21, "Got a hold of guardian and she wishes for bed to be held at this time in case alternate placement cannot be found. Bed hold to be emailed to [guardian] for signature." On 8/1/21, "admitted to hospital" On 8/16/21, "Writer spoke with guardian today and res [resident] is not stable to return and MA [medical assistance] bed hold is up. Guardian state res [resident] is not able to pay for bed hold so will release bed as of today. Staff will pack up belongings per guardian's request." Review of facility document titled bed hold with	F 626	then as needed. The results of the audits will be reported to the QAPI committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated.	

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F 626	Continued From page 14	F 626		

date of transfer being 7/29/21, was signed by R1's guardian on 7/30/2, indicating to hold the bed for R1. Bed hold document indicated "Minnesota Medical Assistance: bed hold will be paid for by MNMA [Minnesota medical assistance] for up to 18 days per hospitalization whether the resident is currently being covered by Medicare Part A or MNMA. Should the resident's length of hospitalization extend beyond the 18 days the Eventide Social Worker will contact resident/responsible party to present the option to extend the bed hold by paying privately. Should the bed hold be declined the resident will be discharged from Eventide. If the resident desires to return to Eventide the admission process will be initiated."

On 9/1/21, at 12:00 p.m. Ombudsman Advocate (OA) involved in R1's appeal was interviewed and stated "I have been trying to pinpoint the reason for not taking [R1] back and they [staff] tell me that [R1] is going to hurt other residents if she is there. [R1] should be afforded that next bed."

On 9/1/21, at 2:25 p.m. OA indicated a bed hold was signed and R1 had been at Sanford since 7/29/21 and "now [facility] is refusing to take her back. We had the bed hold signed. [facility] said [R1] could save the bed but medical assistance would stop paying and [R1] would have to pay privately." OA indicated that R1 is not able to pay privately. OA indicated when contacting the facility regarding R1 returning to the facility after stabilization at the hospital, the facility stated, "you gave up the bed and we are not taking her back."

On 9/1/21, at 3:19 p.m. hospital social worker (HSS) indicated on admission to the hospital, it

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F 626	Continued From page 15	F 626		

was reported that R1 could not return to the facility. HSS then stated "it was her home, and it was where she was living. I was confused." HSS indicated R1 started "showing stability and was not physical or aggressive" and "has been a good patient in terms of a psychiatric patient." Further, HSS stated nursing home reported they were not able to meet R1's needs and HSS stated "what can we do as an organization, the doctor was willing to meet with the nursing home which they declined. [R1]'s goal was to go back to the nursing home, and I felt she deserved a chance to go back there." In addition, HSS stated "[R1] has been stable for quite some time now, and we are trying to figure out where she goes."

On 9/2/21, at 12:53 p.m. licensed practical nurse (LPN)-A stated "I heard [R1] got physical with an aid and [R1] went to the hospital. Since then, I have not seen [R1] and I heard she discharged."

On 9/2/21, at 1:10 p.m. registered nurse (RN)-A stated "[R1] was not medically stable as far as behaviors to come back here. Our director of nursing and social worker has been in touch with the hospital but from what I can read in the charts it says not medically stable to return to facility because of behaviors."

On 9/2/21, at 1:38 p.m. social services (SS)-A stated "[R1] is currently still in the hospital and I have not heard an update as far as I know she is not coming back since she was on her 18th day and they [resident/guardian] released her bed. Per our policy she released it [bed] and she is no longer a resident here. I would think due to her behaviors and level of care I don't think she needs to come back here nor is it appropriate." In addition, SS-A stated, "if their [resident's] bed is

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released we need to reevaluate them and look at their profile and see if they have behaviors and see if we are able to meet their needs at the facility."

On 9/2/21, at 2:57 p.m. when asked what Eventide's bed hold policy is, SS-B stated "the policy states that they [resident] could hold the bed or release the bed. If they hold the bed it will break it down by payor source and what that would mean for them. If they are medical assistance it pays for 18 days and after 18 days, it is private pay. We contact the family or whoever signed the bed hold and let them know it's the 18th day and medical assistance won't cover the bed hold and what would you like to do? This is what it would cost to pay privately and then let the family chose what they want to do. If they can't pay privately the bed is released at that time depending on what the situation is they can re-admit but it starts the whole admission process again and it means that they are discharge from the facility." Further, SS-B indicated she spoke with R1's guardian related to the bed hold and "[R1]'s bed hold is expiring" and R1's guardian indicated R1 cannot afford to private pay and "she would be releasing the bed. We discussed packing belongings. She asked us to store her stuff for a little while and was unsure where [R1] would end up." In addition, SS-B stated, not long after that, the hospital was indicating R1 was ready to return to the facility, and "I left a voicemail [to hospital social worker] indicating we could not take [R1] back at this time due to her past behaviors here. We did not feel it was the best interest for [R1] or staff or residents as we felt she posed a safety risk for the vulnerable adults here." SS-B confirmed there was not a comprehensive assessment completed on R1's

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F 626	Continued From page 17	F 626		

recent hospital stay to determine if it was appropriate for R1 to return to the nursing home. On 9/2/21, at 3:14 p.m. during interview with both DON and administrator, they indicated " if a bed is held through Medicaid it is held for 18 days. On the 18th day, they [resident, family, etc.] decide. If it's given up it is considered a discharge and its voluntary." Further, administrator indicated R1's bed hold was given up on 8/16/21 and the facility received R1's referral on 8/25/21. Administrator stated she spoke with vice president of clinical services and chief officer of operations (COO) and they determined "our process was followed, and we said we were not taking [R1] back at this time." In addition, administrator stated "we had past experiences based on her behaviors here and vulnerable adult reports here which determined she was combative and that is not a profile we would accept back into the facility and there is plenty of behavioral documentation." When asked if the facility comprehensively assessed R1 based on her recent hospitalization and not prior to transfer, DON stated "we wouldn't normally complete an assessment with the profile if they are not a resident here anymore and if we feel we couldn't meet their needs." DON confirmed R1's progress notes from the hospital did not show any behaviors for R1 but, "we knew they [behaviors] occurred here [Eventide]."

The facility provided clarification on 9/6/21 indicating an assessment of R1's hospital stay was reviewed before the facility initiated the immediate discharge notice. Additionally, the facility provided documentation of communication with R1's team regarding planning, though this documentation did not demonstrate evidence of R1's involvement.

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F 626	Continued From page 18 Review of facility policy titled Bed Hold revised 12/13, indicates "upon transfer/admission to the hospital, the Social Worker or designee reviews the following information with the resident/responsible party: review bed hold form and obtain signature, and file signed forms in resident's record. Refer to bed hold and Notice of Transfer for Hospitalization form(s)."	F 626		

Electronically delivered
September 29, 2021

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

Re: State Nursing Home Licensing Orders
Event ID: M42B11

Dear Administrator:

The above facility was surveyed on September 1, 2021 through September 2, 2021 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/02/2021

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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 9/1/21 through 9/2/21, 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		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5461061C (MN76208; MN76003), with a licensing order issued at S0340 and S1925. H5461062C (MN76006) The following complaints were found to be UNSUBSTANTIATED: H5461063C (MN74440) H5461064C (MN74310) 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	2 000		

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	00072	A. BUILDING: _____ B. WING _____	C 09/02/2021

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2 000	Continued From page 2 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. 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		
2 340	MN Rule 4658.0135 Subp. 1,2 Policy Records Subpart 1. Availability of policies. All policies and procedures directly related to resident care adopted by the home must be placed on file and be made available upon request to nursing home personnel, residents, legal representatives, and designated representatives. Subp. 2. Admission policies. Admission policies must be made available upon request to prospective residents, family members, legal representatives, and designated representatives. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to readmit a resident after hospitalization for 1 of 3 residents (R1) reviewed for transfer/discharge. Findings include: R1's quarterly minimal data set (MDS) dated 7/9/21, indicated R1's diagnoses included manic depression, schizophrenia and had moderately	2 340	Corrected.	10/8/21

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2 340	Continued From page 3 impaired skills for daily decision making. Further review of MDS, indicated R1 required supervision to extensive assistance of one staff member for activities of daily living (ADLs). R1's care plan printed 9/2/21, indicated "long term care anticipated for [R1] due to care and supervision needs with interventions that included assist with discharge planning and offer discharge planning conference if needed and treat resident in an adult and dignified manner." Review of R1's progress notes include the following: On 7/29/21, "resident was sent to emergency room due to escalated and unpredictable behavioral outburst that involve hitting, slapping, and kicking staff members on multiple occasion, and even a resident on a different floor. She will need a psych evaluation and placement to another facility to make the care needs she requires." On 7/29/21, "Notice of transfer complete. Waiting to hear back on bed hold. NOT [notice of transfer] will be sent to ombudsman." On 7/30/21, "[guardian] notified of residents behavior on AM shift. Notified that resident hit a staff member, provider was notified and updated of current situation with resident. (currently resident has been 1:1 due to hitting staff/residents, she has been refusing to take PRN [as needed] meds [medication] or scheduled, aggressive towards all staff). Transfer initiated to ER [emergency room] for admit. Discussed bed hold with [guardian's name].	2 340		

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2 340	Continued From page 4 Answered [guardian] questions regarding where resident should be d/c'd [discharged] to after hospital, that would depend on diagnosis at time of discharge and status or resident. [guardian] did not want to decide on whether or not to hold resident's bed at this time. Will follow up with her today and update social work." On 7/30/21, "Got a hold of guardian and she wishes for bed to be held at this time in case alternate placement cannot be found. Bed hold to be emailed to [guardian] for signature." On 8/1/21, "admitted to hospital" On 8/16/21, "Writer spoke with guardian today and res [resident] is not stable to return and MA [medical assistance] bed hold is up. Guardian state res [resident] is not able to pay for bed hold so will release bed as of today. Staff will pack up belongings per guardian's request." Review of facility document titled bed hold with date of transfer being 7/29/21, was signed by R1's guardian on 7/30/2, indicating to hold the bed for R1. Bed hold document indicated "Minnesota Medical Assistance: bed hold will be paid for by MNMA [Minnesota medical assistance] for up to 18 days per hospitalization whether the resident is currently being covered by Medicare Part A or MNMA. Should the resident's length of hospitalization extend beyond the 18 days the Eventide Social Worker will contact resident/responsible party to present the option to extend the bed hold by paying privately. Should the bed hold be declined the resident will be discharged from Eventide. If the resident desires to return to Eventide the admission process will be initiated."	2 340		

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2 340	Continued From page 5 On 9/1/21, at 12:00 p.m. Ombudsman Advocate (OA) involved in R1's appeal was interviewed and stated "I have been trying to pinpoint the reason for not taking [R1] back and they [staff] tell me that [R1] is going to hurt other residents if she is there. [R1] should be afforded that next bed." On 9/1/21, at 2:25 p.m. OA indicated a bed hold was signed and R1 had been at Sanford since 7/29/21 and "now [facility] is refusing to take her back. We had the bed hold signed. [facility] said [R1] could save the bed but medical assistance would stop paying and [R1] would have to pay privately." OA indicated that R1 is not able to pay privately. OA indicated when contacting the facility regarding R1 returning to the facility after stabilization at the hospital, the facility stated, "you gave up the bed and we are not taking her back." On 9/1/21, at 3:19 p.m. hospital social worker (HSS) indicated on admission to the hospital, it was reported that R1 could not return to the facility. HSS then stated "it was her home, and it was where she was living. I was confused." HSS indicated R1 started "showing stability and was not physical or aggressive" and "has been a good patient in terms of a psychiatric patient." Further, HSS stated nursing home reported they were not able to meet R1's needs and HSS stated "what can we do as an organization, the doctor was willing to meet with the nursing home which they declined. [R1]'s goal was to go back to the nursing home, and I felt she deserved a chance to go back there." In addition, HSS stated "[R1] has been stable for quite some time now, and we are trying to figure out where she goes." On 9/2/21, at 12:53 p.m. licensed practical nurse (LPN)-A stated "I heard [R1] got physical with an	2 340		

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2 340	Continued From page 6	2 340		

aid and [R1] went to the hospital. Since then, I have not seen [R1] and I heard she discharged."

On 9/2/21, at 1:10 p.m. registered nurse (RN)-A stated "[R1] was not medically stable as far as behaviors to come back here. Our director of nursing and social worker has been in touch with the hospital but from what I can read in the charts it says not medically stable to return to facility because of behaviors."

On 9/2/21, at 1:38 p.m. social services (SS)-A stated "[R1] is currently still in the hospital and I have not heard an update as far as I know she is not coming back since she was on her 18th day and they [resident/guardian] released her bed. Per our policy she released it [bed] and she is no longer a resident here. I would think due to her behaviors and level of care I don't think she needs to come back here nor is it appropriate." In addition, SS-A stated, "if their [resident's] bed is released we need to reevaluate them and look at their profile and see if they have behaviors and see if we are able to meet their needs at the facility."

On 9/2/21, at 2:57 p.m. when asked what Eventide's bed hold policy is, SS-B stated "the policy states that they [resident] could hold the bed or release the bed. If they hold the bed it will break it down by payor source and what that would mean for them. If they are medical assistance it pays for 18 days and after 18 days, it is private pay. We contact the family or whoever signed the bed hold and let them know it's the 18th day and medical assistance won't cover the bed hold and what would you like to do? This is what it would cost to pay privately and then let the family chose what they want to do. If they can't pay privately the bed is released at that time

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2 340	Continued From page 7	2 340		

depending on what the situation is they can re-admit but it starts the whole admission process again and it means that they are discharge from the facility." Further, SS-B indicated she spoke with R1's guardian related to the bed hold and "[R1]'s bed hold is expiring" and R1's guardian indicated R1 cannot afford to private pay and "she would be releasing the bed. We discussed packing belongings. She asked us to store her stuff for a little while and was unsure where [R1] would end up." In addition, SS-B stated, not long after that, the hospital was indicating R1 was ready to return to the facility, and "I left a voicemail [to hospital social worker] indicating we could not take [R1] back at this time due to her past behaviors here. We did not feel it was the best interest for [R1] or staff or residents as we felt she posed a safety risk for the vulnerable adults here." SS-B confirmed there was not a comprehensive assessment completed on R1's recent hospital stay to determine if it was appropriate for R1 to return to the nursing home. On 9/2/21, at 3:14 p.m. during interview with both DON and administrator, they indicated " if a bed is held through Medicaid it is held for 18 days. On the 18th day, they [resident, family, etc.] decide. If it's given up it is considered a discharge and its voluntary." Further, administrator indicated R1's bed hold was given up on 8/16/21 and the facility received R1's referral on 8/25/21. Administrator stated she spoke with vice president of clinical services and chief officer of operations (COO) and they determined "our process was followed, and we said we were not taking [R1] back at this time." In addition, administrator stated "we had past experiences based on her behaviors here and vulnerable adult reports here which determined she was combative and that is not a profile we would accept back into the facility and there is plenty of behavioral documentation."

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2 340	Continued From page 8 When asked if the facility comprehensively assessed R1 based on her recent hospitalization and not prior to transfer, DON stated "we wouldn't normally complete an assessment with the profile if they are not a resident here anymore and if we feel we couldn't meet their needs." DON confirmed R1's progress notes from the hospital did not show any behaviors for R1 but, "we knew they [behaviors] occurred here [Eventide]." The facility provided clarification on 9/6/21 indicating an assessment of R1's hospital stay was reviewed before the facility initiated the immediate discharge notice. Additionally, the facility provided documentation of communication with R1's team regarding planning, though this documentation did not demonstrate evidence of R1's involvement. Review of facility policy titled Bed Hold revised 12/13, indicates "upon transfer/admission to the hospital, the Social Worker or designee reviews the following information with the resident/responsible party: review bed hold form and obtain signature, and file signed forms in resident's record. Refer to bed hold and Notice of Transfer for Hospitalization form(s)." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan by the interdisciplinary team to ensure proper bed hold notice and requirements were met . The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) proper bed hold was given and followed through with related to the regulation requirements. The results of these audits will be reviewed by the quality assurance committee to ensure compliance.	2 340		

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2 340	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 340		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide an adequate discharge notice to 1 of 3 residents (R1) reviewed for discharge who was provided an immediate	21925	Corrected.	10/8/21

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21925	Continued From page 10 discharge and not allowed to return to the facility without adequate cause or documentation. Findings include: R1's quarterly minimal data set (MDS) dated 7/9/21, indicated R1's diagnoses included manic depression, schizophrenia and had moderately impaired skills for daily decision making. Further review of MDS, indicated R1 required supervision to extensive assistance of one staff member for activities of daily living (ADLs). R1's care plan printed 9/2/21, indicated R1 had a potential for behaviors related to diagnoses of mild cognitive disorder, bipolar disorder, schizophrenia and insomnia disorder. Care plan identified behavioral triggers as being asked to do something (perform cares, take meds, etc.). Additionally, R1's behaviors include, frequently disrobed and has aggressive behavior (care plan lacked evidence of definition for aggressive behavior) with interventions listed as: - room change to private room due to behaviors 5/27/21; - resident benefits from medications to assist in behaviors- orders to crush and conceal meds as an alternative way to have resident take meds received 7/12/21; - 1:1 staff contact when out of room due to increase in aggressive behaviors; - staff member to be assigned to her each shift; - discuss opportunities for medication re-evaluation with resident, family and practitioner; - follow resident's preferred, consistent routine as able; if undressing approach calmly and assist with covering her with clothing; - redirect with an activity, snacks, or other distractions.	21925		

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- keep R1 separate from other residents as much as possible.
- R1 can go to activities with 1:1 staff contact.
- monitor her while ambulating to keep away from other residents; likes 1:1 conversation, utilize as able when having increased behaviors;
- if she asks you to leave, leave and re-approach at later time.
- mood and behavior monitoring every shift.
-offer emotional support, offer to call daughter when having increased behaviors, provide consistent care givers as able.

Further review of R1's care plan indicated "long term care anticipated for [R1] due to care and supervision needs with interventions that included assist with discharge planning and offer discharge planning conference if needed and treat resident in an adult and dignified manner." Care plan lacked evidence R1 desired or participated in discharge planning.

Care plan additionally noted potential resident to resident altercation 5/25/21, 6/29/21, and 7/1/21 but the resident's record failed to identify evidence of resident to resident abuse because of R1's behavior.

Review of facility report dated 6/29/21, indicated a resident living in the facility reported "another resident hit her on the right side of the face." Resident was able to give description of alleged perpetrator which the description fit that of R1. R1 was interviewed by facility staff and denied any altercation with another resident. There was no injury noted to either resident. Further review of report, staff interviews were completed and there was no witnesses to alleged resident to resident altercation and staff were not aware of any other altercations between R1 and another resident.

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21925	Continued From page 12 Review of facility report dated 7/2/21, indicated staff witnessed R1 "brush" another resident's right cheek and staff witness stated "the contact was light and did not appear to harm [resident]." Review of R1's transfer and discharge report printed 9/2/21, indicated R1 was admitted to the facility on 4/2/21, and discharged 8/16/21. However, report does not indicate where R1 was discharged to. Review of R1's progress notes include the following: -On 7/29/21, "resident was sent to Sanford ER [emergency room] due to escalated and unpredictable behavioral outburst that involve hitting, slapping, and kicking staff members on multiple occasion, and even a resident on a different floor. She will need a psych evaluation and placement to another facility to make the care needs she requires." -On 7/29/21, "Notice of transfer complete. Waiting to hear back on bed hold. NOT [notice of transfer] will be sent to ombudsman." -On 7/30/21, "[guardian] notified of residents behavior on AM shift. Notified that resident hit a staff member, provider was notified and updated of current situation with resident. (currently resident has been 1:1 due to hitting staff/residents, she has been refusing to take PRN [as needed] meds [medication] or scheduled, aggressive towards all staff). Transfer initiated to ER [emergency room] for admit. Discussed bed hold with [guardian's name]. Answered [guardian] questions regarding where resident should be discharged to after hospital, that would depend on diagnosis at time of discharge and status or resident. [guardian] did not want to decide on whether or not to hold	21925		

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21925	Continued From page 13	21925		

resident's bed at this time. Will follow up with her today and update social work."
-On 7/30/21, "Got a hold of guardian [name] and she wishes for bed to be held at this time in case alternate placement cannot be found. Bed hold to be emailed to [guardian] for signature."
-On 8/1/21, "admitted to hospital."
-On 8/16/21, "Writer spoke with guardian today and res [resident] is not stable to return and MA [medical assistance] bed hold is up. Guardian state res [resident] is not able to pay for bed hold so will release bed as of today. Staff will pack up belongings per guardian's request."
-On 8/27/21, "New Notice of Transfer/Discharge form issued for today and sent to [guardian]."

Review of doctor's order dated 7/29/21, indicated "OK to send to ER Sanford Hospital. DX [diagnosis] aggression towards staff, uncontrolled behavior, concern for safety of staff and other residents due to physical contact with force."

Review of R1's Notice of Transfer or Discharge dated 7/29/21, indicated the notice was addressed to R1 and guardian, and "the transfer or discharge is necessary for the resident's welfare as the resident's needs cannot be met in the facility." Further, document indicated R1 was transferred to Sanford emergency room on 7/29/21, because of behaviors. R1's right to appeal was listed on the document, however, facility document was signed by social services (SS)-A and dated 7/29/21, but R1's name was printed on resident line with no date and no guardian signature.

Review of another Notice of Transfer or Discharge was reviewed which was addressed to the guardian and R1 and the reason identified as the "safety of individuals in the facility is

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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
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endangered due to the clinical or behavioral status of the resident." Further, R1 was "transferred or discharged to Sanford on 7/29/21 because of escalated and unpredictable behavioral outburst involving physical abuse towards others" and the appeal information was provided on document guardian's name is printed and dated 8/27/21, along with SS-B signature.

On 9/1/21, at 12:00 p.m. Ombudsman Advocate (OA) stated R1 "may be challenging but regardless of her challenges, she still has a right to return and a right to proper notice." In addition, in regards to the Immediate discharge notice given to R1 on 8/27/21, OA stated she had requested documentation on the facility's determination of R1's endangerment and the facility declined indicating there was no documentation and continued to state R1 had given up/released her bed hold. OA indicated an appeal for discharge has been made at this time.

On 9/1/21, at 2:25 p.m. hospital social worker (HSS) confirmed a discharge notice was not provided and stated, "I know [R1] is very challenging and has behaviors and there is difficulty there, but they were not following the policy and [R1]'s rights." Further, COMP-B indicated an appeal was made for discharge.

On 9/22/21, at 12:30 p.m. trained medication assistant (TMA)-A stated R1 "was a tough one. R1 had a lot of verbal abuse the first incident where she physically hit someone was a housekeeper and the second one they thought she hit another resident on the head."

On 9/2/21, at 12:44 p.m. nursing assistant (NA)-A stated R1 had behaviors which consisted of "refusing cares from us aids. She would yell at us

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	00072	A. BUILDING: _____ B. WING _____	C 09/02/2021

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and swear and tell us to get out of her room. I can't recall anything physical off the top of my head."

On 9/2/21, at 12:53 p.m. licensed practical nurse (LPN)-A stated R1 "got physical and slapped an aid. She will tell you how she feels and tell you what she wants. I think she got physical with another resident and they moved her and she was on a 1-1 when outside her room. Someone had to be with her so she didn't get into an altercation. She was very physical hitting and kicking out and got physical with an aid and that's when she went to the hospital and I have not seen her since."

On 9/2/21, at 1:01 p.m. secretary (SEC)-A stated she witnessed R1 "walk by and it was more of a brush. She was trying to pester her [other resident] not hurt her. R1 brushed [resident's] face and kept walking."

On 9/2/21, at 1:10 p.m. registered nurse (RN)-A stated the discharge plan for R1 was to remain at the facility for long term care. Further, RN-A stated R1 did have physical behaviors towards staff and was targeting another resident. RN-A indicated the first altercation R1 had with another resident "was not fully substantiated and we couldn't say for certain she did it until she hit her a second time. After the second incident happened we made her a 1-1 immediately." When asked what occurred during the second altercation, RN-A stated it was witnessed by SEC-A that R1 "brushed her [other resident's] cheek."

During interview on 9/2/21, at 2:57 p.m. SS-B stated on the 18th day (8/26/21), "I left a voicemail [to hospital social worker] indicating we

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could not take [R1] back at this time due to her past behaviors here. We did not feel it was the best interest for [R1] or staff or residents as we felt she posed a safety risk for the vulnerable adults here."

On 9/2/21, at 3:14 p.m. during interview with both DON and administrator, the administrator stated she spoke with vice president of clinical services and chief officer of operations (COO) and they determined "our process was followed, and we said we were not taking [R1] back at this time." In addition, administrator stated, "We had past experiences based on her behaviors here and vulnerable adult reports here which determined she was combative and that is not a profile we would accept back into the facility and there is plenty of behavioral documentation." When asked if the facility comprehensively assessed R1 based on her recent hospitalization and not prior to transfer. DON stated, "We wouldn't normally complete an assessment with the profile if they are not a resident here anymore and if we feel we couldn't meet their needs." DON confirmed R1's progress notes from the hospital did not show any behaviors for R1 but, "we knew the [behaviors] occurred here [Eventide]."

The facility provided clarification on 9/6/21, indicating an assessment of R1's hospital stay was reviewed before the facility initiated the immediate discharge notice. Additionally, the facility provided documentation of communication with R1's team regarding discharge planning, though this documentation did not demonstrate evidence of R1's involvement or agreement to move.

On 9/2/21, at 3:14 p.m. during an interview with both the DON and administrator, the

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administrator indicated R1 was making an appeal for discharge. Further, administrator indicated a second immediate discharge notice was given on 8/27/21, which was directed by staff at Minnesota Department of Health (MDH), R1 would be considered an immediate discharge due to behaviors.

Per requirement for an immediate discharge, review of R1's record failed to identify sufficient documentation the danger that failure to transfer or discharge would pose.

Review of facility policy titled Discharge revised 12/13, indicated "social services will assist in determining the need for involuntary discharge plan. Upon this determination, a 30-day written notice will be given to the resident/responsible party. This notice will include the following information: the reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharge, a statement that the resident has the right to appeal the action to the State, and the name, address, the telephone number of the State Long-Term Care Ombudsman. Social Services will document in the medical record that a notice has been issued."

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure proper discharge notice is given for residents. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) proper discharge occured. The results of these audits will be reviewed by the quality assurance committee to ensure compliance.

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