DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 24, 2021

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

RE: CCN: 245507
Cycle Start Date: November 4, 2021

Dear Administrator:

On November 4, 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.

Deficiencies found as a result of this survey were determined to be only isolated deficiencies, with the potential for causing or resulting in no more than minimal harm (Level A). You will find enclosed a form (CMS "A") setting forth these deficiencies.

You are not required to submit a plan of correction for these deficiencies, however, it is expected that the deficiencies will be corrected in a timely manner.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE MANKATO, MN 56001**

(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 11/2/21, through 11/4/21, 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 was found to be SUBSTANTIATED: H5507063C (MN78079), with deficiencies cited at F623. The following complaints were found to be SUBSTANTIATED: H5507064C (MN780868), and H5507066C, (MN74405), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5507065C (MN76962) and H5507067C (MN76314) 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		

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

Electronically Signed

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 ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245507	A. BUILDING: _____ B. WING _____	11/4/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTER	714 SOUTHBEND AVENUE MANKATO, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

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HILLCREST CARE & REHABILITATION CENTER	**714 SOUTHBEND AVENUE MANKATO, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure written discharge notice was provided to the resident or resident representative following a facility-initiated discharge when the resident was transferred to the hospital for 1 of 3 residents (R3) reviewed for discharge after hospitalization.

Findings include:

R3's admission record printed 11/3/21, indicated R3 was admitted to the facility 8/9/21, diagnoses included dementia, restlessness, agitation, and major depressive disorder.

R3's significant change in status Minimum Data Set (MDS) assessment dated 9/16/21, indicated R3 had severe cognitive impairment and required extensive assistance with activities of daily living.

R3's discharge assessment return anticipated MDS assessment dated 9/23/21, indicated on 9/23/21, R3 had an unplanned transfer to the hospital.

Documented titled bed hold notice for hospital transfer and therapeutic leave indicated on 9/23/01 [21], R3 was transferred from the facility to the hospital for dementia with violent behaviors.

Progress note dated 10/11/21, indicated social service director spoke with daughter via phone and discussed continued bed hold, and R3 was unstable for return to the facility and released bed hold due to meeting the maximum 15d [day] hold and VA[veterans affairs] contract being terminated on day 16 of hospitalization, facility would reassess for appropriateness of placement upon referral from hospital, and continued concerns for need of geri psych stay to appropriately mange aggressive behaviors.

Document titled Admission/Discharge To/From Report printed 11/1/21, indicated on 10/11/21, R3 was discharged from the facility to the hospital. The medical record lacked evidence written notice of the discharge was provided to R3 or R3's representative.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2

During interview on 11/2/21, at 2:02 p.m. social worker (SW) stated she was responsible for transfer and discharge notifications and the SW indicated R3 was discharged from the facility per the bed hold policy of 19 days on 10/11/21, and would be assessed as a new admission to the facility. The SW stated a notification of discharge was not provided to the resident or resident representative as the bed hold notice was given.

During an interview on 11/3/21, at 12:00 p.m. administrator stated R3 or resident representative was not provided a discharge notice, the administrator stated the facility practice was when a resident met the the max bed hold the resident was discharged from the facility and a discharge notification was not completed. The administrator stated based on the bed hold notification on 9/23/21, the facility's practice was the resident was discharged and notification of discharge was included in the bed hold. The administrator confirmed the facility did not complete a discharge notification to R3 or R3's representative and stated the facility's practice was the bed hold notification.

During an interview with family member (FM)-A 11/4/21, at 12:14 p.m. FM-A. stated the facility called her via telephone on 10/11/21, and the facility indicated R3's 18 day bed hold was up and the facility would not hold R3's bed any longer and R3 was discharged from the facility. FM-A verified a notification of discharge was not provided to the resident or resident representative.

Document titled Transfer or Discharge Notice dated 12/16, indicated:
-Our facility shall provide a resident and/or the resident's representative with a thirty day written notice of an impending transfer or discharge.
- Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge:
- The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility ;
- The transfer discharge is appropriate because their resident's health has improved sufficiently so the resident no longer need the services provided by the facility ;
- The safety of individuals in the facility is endangered;
- The health of individuals in the facility would otherwise be endangered;
- The resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility;
- An immediate transfer discharge is required by the resident's urgent medical needs;
- The resident has not resided in the facility for 30 days ;
The resident and or resident representative will be notified in writing the following information:
- Reason for transfer or discharge;
-The effective date of the transfer discharge;
-The location to which the residents being transferred or discharged
- A statement of the resident's rights to appeal the transfer or discharge including:
-The name, address, email and telephone number of the entity which receives such requests
- Information how to obtain complete and submit an appeal form and how to get assistance completing the appeal process
-The name and address and telephone number of the office of state long term care ombudsman

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F 623	Continued From Page 3

-The name, address, email and telephone number of the agency responsible for protection and advocacy of residents with intellectual and developmental disabilities

-The name address email and telephone number of the agency responsible for the protection and advocacy of residents with mental disorder related disabilities

-The name address telephone number of the state health department agency that's been designated handled appeals of transfers and discharge notices

-A copy of the notice will be sent to the office of the state long term care ombudsman

-The reasons for the transfer or discharge will be documented in the resident's medical record

Electronically delivered
November 24, 2021

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

Re: State Nursing Home Licensing Orders
Event ID: Z1EU11

Dear Administrator:

The above facility was surveyed on November 2, 2021 through November 4, 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HILLCREST CARE & REHABILITATION CENTE	714 SOUTHBEND AVENUE MANKATO, MN 56001

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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 11/2/21, through 11/4/21, 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 complaint was found to be SUBSTANTIATED: H5507063C (MN78079) with a licensing order issued at 144.651 Subd. 29. The following complaints were found to be SUBSTANTIATED: H5507064C (MN780868), and H5507066C, (MN74405), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5507065C (MN76962) and H5507067C (MN76314) 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 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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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		
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	21925		12/8/21

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21925	Continued From page 3 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 ensure written discharge notice was provided to the resident or resident representative following a facility-initiated discharge when the resident was transferred to the hospital for 1 of 3 residents (R3) reviewed for discharge after hospitalization. Findings include: R3's admission record printed 11/3/21, indicated R3 was admitted to the facility 8/9/21, diagnoses included dementia, restlessness, agitation, and major depressive disorder. R3's significant change in status Minimum Data Set (MDS) assessment dated 9/16/21, indicated R3 had severe cognitive impairment and required extensive assistance with activities of daily living. R3's discharge assessment return anticipated MDS assessment dated 9/23/21, indicated on 9/23/21, R3 had an unplanned transfer to the hospital. Documented titled bed hold notice for hospital transfer and therapeutic leave indicated on 9/23/01 [21], R3 was transferred from the facility to the hospital for dementia with violent behaviors. Progress note dated 10/11/21, indicated social service director spoke with daughter via phone and discussed continued bed hold, and R3 was	21925	The affected resident (R3) and POAs were issued a Notice of Discharge on 11/19/21. All residents who had facility initiated discharges within the last 3 months were reviewed to ensure a Notice of Discharge was appropriately issued. Social Services will provide a Notice of Discharge, as soon as it is practicable, for all residents who experience a facility initiated discharge. All Social Services and Nursing Leadership staff were re educated on the discharge process and the documentation required in the resident's medical record. Social Services Director or designee will conduct random audits of facility initiated discharge residents to ensure a Notice of Discharge was appropriately issued. Audits will be completed weekly x4, monthly x2 and will report to the QA committee for further review and recommendations.	

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unstable for return to the facility and released bed hold due to meeting the maximum 15d [day] hold and VA[veterans affairs] contract being terminated on day 16 of hospitalization, facility would reassess for appropriateness of placement upon referral from hospital, and continued concerns for need of geri psych stay to appropriately mange aggressive behaviors.

Document titled Admission/Discharge To/From Report printed 11/1/21, indicated on 10/11/21, R3 was discharged from the facility to the hospital. The medical record lacked evidence written notice of the discharge was provided to R3 or R3's representative.

During interview on 11/2/21, at 2:02 p.m. social worker (SW) stated she was responsible for transfer and discharge notifications and the SW indicated R3 was discharged from the facility per the bed hold policy of 19 days on 10/11/21, and would be assessed as a new admission to the facility. The SW stated a notification of discharge was not provided to the resident or resident representative as the bed hold notice was given.

During an interview on 11/3/21, at 12:00 p.m. administrator stated R3 or resident representative was not provided a discharge notice, the administrator stated the facility practice was when a resident met the the max bed hold the resident was discharged from the facility and a discharge notification was not completed. The administrator stated based on the bed hold notification on 9/23/21, the facility's practice was the resident was discharged and notification of discharge was included in the bed hold. The administrator confirmed the facility did not complete a discharge notification to R3 or R3's representative and stated the facility's practice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00031	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTE	714 SOUTHBEND AVENUE MANKATO, MN 56001

(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
21925	Continued From page 5 was the bed hold notification. During an interview with family member (FM)-A 11/4/21, at 12:14 p.m. FM-A. stated the facility called her via telephone on 10/11/21, and the facility indicated R3's 18 day bed hold was up and the facility would not hold R3's bed any longer and R3 was discharged from the facility. FM-A verified a notification of discharge was not provided to the resident or resident representative. Document titled Transfer or Discharge Notice dated 12/16, indicated: -Our facility shall provide a resident and/or the resident's representative with a thirty day written notice of an impending transfer or discharge. - Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: - The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility ; - The transfer discharge is appropriate because their resident's health has improved sufficiently so the resident no longer need the services provided by the facility ; - The safety of individuals in the facility is endangered; - The health of individuals in the facility would otherwise be endangered; - The resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility; - An immediate transfer discharge is required by the resident's urgent medical needs; - The resident has not resided in the facility for 30 days ; The resident and or resident representative will be notified in writing the following information:	21925		

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21925	Continued From page 6 - Reason for transfer or discharge; -The effective date of the transfer discharge; -The location to which the residents being transferred or discharged - A statement of the resident's rights to appeal the transfer or discharge including: -The name, address, email and telephone number of the entity which receives such requests - Information how to obtain complete and submit an appeal form and how to get assistance completing the appeal process -The name and address and telephone number of the office of state long term care ombudsman -The name, address, email and telephone number of the agency responsible for protection and advocacy of residents with intellectual and developmental disabilities -The name address email and telephone number of the agency responsible for the protection and advocacy of residents with mental disorder related disabilities -The name address telephone number of the state health department agency that's been designated handled appeals of transfers and discharge notices -A copy of the notice will be sent to the office of the state long term care ombudsman -The reasons for the transfer or discharge will be documented in the resident's medical record SUGGESTED METHOD OF CORRECTION: The Director of Social Work or designee could develop a system to ensure residents' receive proper notification when the resident is involuntarily discharged and educate appropriate staff regarding system. The Director of Social Work or designee, along with the quality committee could audit and monitor on a regular	21925		

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21925	Continued From page 7 basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		