*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 11, 2024

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: CCN: 245548
Cycle Start Date: September 27, 2023

Dear Administrator:

On December 5, 2023, we notified you a remedy was imposed. On December 26, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 2, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 27, 2023 be discontinued as of January 2, 2024. (42 CFR 488.417 (b))

In our letter of December 5, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 27, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
December 26, 2023

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: CCN: 245548
Cycle Start Date: September 27, 2023

Dear Administrator:

On October 12, 2023, we informed you that we may impose enforcement remedies.

On December 11, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 27, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 27, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 27, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 27, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Tuff Memorial Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 27, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## 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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Office: (507) 251-6264 Mobile: (605) 881-6192

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 27, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

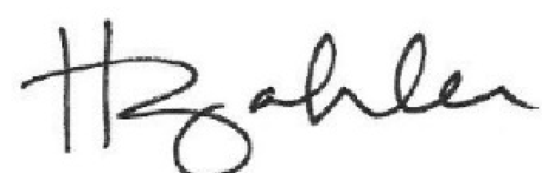
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NH-Dispute-Resolution

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,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245548 | A. BUILDING ______ B. WING ______ | C 12/11/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **TUFF MEMORIAL HOME** | **505 EAST 4TH STREET HILLS, MN 56138** |

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| F 000 | INITIAL COMMENTS<br><br>On 12/11/23 through 12/12/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed with NO deficiencies cited: H55487925C (MN99100).<br><br>The following complaint were reviewed: H554487762C (MN98951) with a deficiency cited at F622.<br><br>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.<br><br>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<br>CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br><br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate | F 622 | | 1/2/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/02/2024

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

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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 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

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| F 622 | Continued From page 2<br>medical record and appropriate information is communicated to the receiving health care institution or provider.<br>(i) Documentation in the resident's medical record must include:<br>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.<br>(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).<br>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-<br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and<br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.<br>(iii) Information provided to the receiving provider must include a minimum of the following:<br>(A) Contact information of the practitioner responsible for the care of the resident.<br>(B) Resident representative information including contact information<br>(C) Advance Directive information<br>(D) All special instructions or precautions for ongoing care, as appropriate.<br>(E) Comprehensive care plan goals;<br>(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 a safe and effective transition of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to appropriately discharge 1 of 1 | F 622 | As of 01/02/2024 The Regulations for Admission, Transfer, and Discharge were | |

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| F 622 | Continued From page 3<br>resident (R1) with known neurocognitive disorder (decreased mental function due to a medical disease other than a psychiatric illness), with behaviors. The facility also failed to ensure policies related to Discharge and Transfer were reviewed yearly for appropriateness and accuracy.<br><br>Findings include:<br><br>Review of the 12/4/23 at 10:40 a.m., State Agency Report (SA) identified R1 was seated in his wheelchair located by a table in the dining room at 11:25 a.m... R2 was wheeled by staff by R1. R2's foot pedal bumped R1's wheelchair. R1 turned and grabbed R2 by the face, knocking her glasses off, and causing scratches to the right side of the neck, right and left sides of her nose, the right corner of her eye and cheek, and right ear lobe. R1 reached for R2 again but contact was blocked by staff in attendance. R2 was "screaming and crying" and was taken back to her room for assessment. R1 turned back around and was removed from the dining room to his room by licensed practical nurse (LPN)- and a second unidentified nurse aide (NA) and assisted to his room. R1 had no response and no expression when questioned about what had happened or why he had done that. The director of nursing (DON) and administrator were notified of the incident and gave instruction to contact the sheriff's office to report the incident and obtain direction. Local emergency medical services (EMS) were notified of a non-emergency transfer to the the regional behavioral hospital in Sioux Falls, SD for evaluation. Family members of both R1 and R2 were contacted to inform them of the incident. | F 622 | reviewed.<br>The facility Policy for Transfer and Discharge was reviewed and dated with the current date.<br><br>The facility has determined that all residents who are transferred or discharged have the potential to be affected.<br><br>An in-service education program was conducted on 01/02/2024 by the Administrator with the Social Services Designee, the DON, and Administrator-In-Training addressing circumstances regarding required notices for residents upon transfer and discharge from the facility.<br><br>For a period of four weeks, the Social Services Designee will conduct a record audit of all residents who will transfer or discharge from the facility to ensure the record includes the appropriate notifications. A transfer/discharge notice will be sent to the State Ombudsman Office at least monthly.<br><br>This plan of correction audits will be monitored at the QAPI meeting until such time consistent substantial compliance has been met. | |

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| F 622 | Continued From page 4 | F 622 | | |

R1's 11/14/23 Quarterly Minimum Data Set (MDS) identified his cognition was intact, and there were no behaviors documented. Activities of daily living (ADLs) were identified as independent with eating, and hygiene, and required partial assistance from staff for transfers, toileting, and dressing, and used a wheelchair for mobility. R1 received medications of an anti-psychotic, anti-depressant, "water pill", and an anti-platelet ( used to "thin the blood" to prevent clots) medication. R1's diagnoses included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, major depressive disorder, and anxiety disorder.

R1's 8/13/23 incident report identified a resident to employee incident occurred. R1 became aggressive toward an unidentified NA. The facility implemented 2 staff members to be in attendance with interactions with R1. R1 was scheduled to be seen by psychiatric services. At that time, there was discussion with R1's physician (MD) who agreed R1 could remain in the facility at that time but ensure 2 staff were present with cares. He was to be sent to the regional psychiatric hospital in Sioux Falls, SD if needed or he displayed an aggressive change in behavior.

R1's 8/23/23 at 5:11 p.m., incident report identified he had history of an incident when an unidentified NA reported an unidentified resident was in R1's room attempting to get into his closet. R1 was swatting at other resident but no contact was noted. That resident was removed from the room and R1 questioned why the resident had come to his room. Appropriate notifications completed and intervention to close R1's room door and keep other resident on other wing. No

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| F 622 | Continued From page 5 | F 622 | | |

injuries to either resident noted. there was no mention on the care plan of any heightened measures staff should take when it came to other residents being at risk.

Interview on 12/11/23 at 11:41 a.m. with NA-A reported she was working on 12/3/23 in the dining room when she observed NA-B pushing R2 through the dining room. R2's wheelchair "barely bumped" R1's wheelchair as she was going passed. R1 swung out from the table and began swinging both arms and slapped R2 as she was being pushed past him. NA-B got between R1 and R2 to separate them and R1 attempted to grab NA-B's leg as she was separating the residents and NA-A yelled for the charge nurse. Licensed practical nurse (LPN)-A ran to the dining room and assisted with removing R2 to her room for assessment and to attempt to calm her. R2 was also escorted to his room by 2 staff persons. NA-A reported R1 had previously attempted to choke a staff member as she was attempting to toilet him and had episodes of agitation previously, with no specific triggers that she was aware of. She reported R1 had "seemed paranoid" during COVID and would pace in and out of his room doorway and had also entered other resident rooms and taken objects. NA-B reported she was not aware of any previous altercations with other residents. NA-B reported R1 rarely spoke and was alert but she was not certain if he was oriented. She reported due to the incident that had occurred between a staff member and R1 his care plan had been updated to have 2 staff present when providing cares and he was on 15-minute safety checks immediately following the incident, but the time had been extended when there had been no additional incidents.

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| F 622 | Continued From page 6 | F 622 | | |

R1's current, undated care plan identified he a potential behavior problem due to history of smearing body fluids in room/bathroom and inappropriate voiding and defecation on the floor or in trash can and refusal to change soiled clothing. R1 was to have 2 staff when providing cares in his room related to "behavioral changes" with an incident occurring on 8/13/23. R1 would go to the dining room for meals and then preferred to return to his room. R1 had a history of behavior problem of delusions directed towards staff. Staff were to anticipate and meet the resident's needs, monitor behavior episodes, and report to charge nurse, provide psychotherapy sessions on a biweekly basis, and see psychology.

R1's 11/15/23 through 12/2/23 progress notes identified R1 had no aggressive behaviors and was cooperative with staff other than grabbing at overnight NA's arms during assistance with morning cares. The notes identified a telehealth visit with psychotherapy was performed on 11/29/23.

Email response from the Ombudsman on 12/11/23 at 8:04 a.m. identified the facility had sent R1 to the ER for behaviors and then R1 was subsequently discharged. The facility and the Ombudsman had a care conference to discuss potential re-admission. The psychiatric MD at the regional behavioral psychiatric hospital stated R1 was clinically cleared to return to the facility as his acute episode of aggression and was clinically stable to return. The psychiatric hospital had reviewed R1's medications and had decreased some of his medications as the MD felt R1 may have been overly sedated.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245548 | A. BUILDING _____ B. WING _____ | C 12/11/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TUFF MEMORIAL HOME | 505 EAST 4TH STREET HILLS, MN 56138 |

| (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 |
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| F 622 | Continued From page 7 | F 622 | | |

Interview on 12/11/23 at 12:20 p.m., with R1's power of attorney (POA) reported R1 had a history of "odd" behaviors since he had been in his 20's. She reported R1's behavior had been discussed with geriatric psychiatry and following review of laboratory results he was diagnosed with hyperparathyroidism and resulting eye issues, which had caused some paranoia. R1 had multiple medical issues and following surgery and development of Tetanus and he had "never been right after that". The POA reported R1 had a history of psychiatric issues and some aggression issues prior to his surgery, but nothing since until the complaints at the nursing home. R1 liked to be alone and enjoyed watching TV in is room. She reported R1 was very quiet and had a history of minimal interaction with other persons. The POA reported she thought the staff incident could have been caused by R1 having a strong fear of falling and he did not like showers, which the NA was trying to do when the incident occurred. She thought R1 could have been grabbing out due to fear of falling when the incident occurred. The POA reported R1 was receiving tub baths since that time and there had not been any further issues. She reported that on 12/3/23 she had been notified that a resident had run into his wheelchair, and he had lashed out and he was being transferred to the psychiatric hospital for evaluation.

Interview on 12/11/23 at 4:47 p.m., with the interim administrator reported the decision not to accept R1 back to the facility was based on the rights of other facility residents and their representatives. The interim administrator reported she had not had any communication with either Avera Behavioral Health or R1's family

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|---|---|---|---|
| | 245548 | A. BUILDING ______<br>B. WING ______ | C<br>12/11/2023 |

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|---|---|
| TUFF MEMORIAL HOME | 505 EAST 4TH STREET<br>HILLS, MN 56138 |

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| F 622 | Continued From page 8<br>members. She reported she was aware of the regulation for reassessment of a resident prior to determining status of a readmission, but due to concerns for the safety of other residents in the facility he would not be allowed to return. She confirmed there had been no attempt made to reassess R1 since he left the facility on 12/3/23. The facility did not have the ability to meet R1's emotional needs and the decision to not allow R1 to return was based on the incident preceding his transfer on 12/3/23, in addition to previous aggressive incidents directed toward staff. The interim administrator was aware of the need to not base refusal of re-admission on R1's status prior to his transfer to the psychiatric hospital, but how R1 was at the current time he would tentatively be returning.<br><br>Review of the July 28, 2021, facility policy Resident Transfer & Discharge Policy identified it was the facility policy to make attempts to allow a resident to remain in the facility. Prior to transfer or discharge of a resident the facility was to notify the resident or their representative of the transfer and/or discharge along with the reasons in writing and in an understandable manner. The reasons for transfer and/or discharge were to be recorded in the resident's medical record. The notice of discharge or transfer was also to include a statement of the right to appeal the transfer or discharge along with the information on how to complete the request. | F 622 | | |