DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 19, 2020

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: CCN: 245183
Cycle Start Date: March 9, 2020

Dear Administrator:

On April 9, 2020, May 5, 2020, May 8, 2020, and May 18, 2020, the Minnesota Department of Health completed revisits to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
April 16, 2020

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

SUBJECT: SURVEY RESULTS
CCN: 245183
Cycle Start Date: Cycle Start Date: March 9, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 9, 2020, a survey was completed at your facility by the Minnesota Department of Health. The survey team completed a complaint investigation at North Ridge Health And Rehab to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 9, 2020 survey. North Ridge Health And Rehab may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your

allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Susanne Reuss, Unit Supervisor
Fax: (651) 215-9697
Email: susanne.reuss@state.mn.us

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 9, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Susanne Reuss, Unit Supervisor
Fax: (651) 215-9697
Email: susanne.reuss@state.mn.us

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

North Ridge Health And Rehab may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	245183	A. BUILDING _____ B. WING _____	C 04/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

(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 4/7/20 - 4/9/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints was found to be substantiated: H5183229C and H5183230C. Deficiency issued at Tag F623. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 623 SS=D	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.	F 623		4/27/20

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

Electronically Signed | 04/16/2020

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F 623	Continued From page 1 (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,	F 623		

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F 623	Continued From page 2 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 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	F 623		

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F 623	Continued From page 3 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 a proper discharge process for 1 of 3 residents (R1) who left the facility during COVID-19, and was not allowed to return to the facility. Findings include: R1's diagnoses obtained from the Admission Record dated 4/7/20, included low back pain, visual loss, major depressive disorder and type 2 diabetes. R1's discharge Minimum Data Set (MDS) dated 3/23/20, identified R1 had intact cognition and R1's care plan dated 10/25/19, indicated discharge plans were unknown due to R1 being homeless before admitting to facility. On 4/7/20, at 11:21 a.m., during a telephone interview, the relocation case manager indicated she had found out that R1 was kicked out of the facility because he violated the lockdown rules. The relocation case manager indicated because volunteers who assisted him to read his mail were not allowed at the facility due to the restrictions, a friend had volunteered to come and read it for him. The relocation worker further indicated R1's friend came to the facility and because R1 is blind, he told the front desk person he was going to meet with his friend in	F 623	Identified resident (R1) has been discharge. Facility will ensure a proper discharge process including a written notification of the reason for discharge, a discharge location and appeal rights to include the number for the Ombudsman for all immediate discharges. Social Services, case management and supervisor staff have been educated regarding the proper discharge process including written notification of the reason for discharge, a discharge location and appeal rights to include the number for the Ombudsman for all immediate discharges. The facility will audit to ensure proper discharge process for any resident who received an immediate discharge for one month. Then 3 residents per month for 2 months. Results will be reviewed at facility QAPI meetings Date of Compliance 4/27/2020	

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F 623	Continued From page 4	F 623		

the parking lot and was told if he did not to go beyond the property it was okay. The relocation worker stated she was informed the receptionist had opened the door for R1 and directed him towards his friend. R1 then indicated to her that he went to his friend's car to review the mail and when he came back to the building he was told he had violated the facility COVID-19 restriction rules. The relocation worker further indicated she was not aware if R1 had received information about the consequences of leaving the property and that R1 was not given medication and shelter after he was inappropriately discharged from the facility.

On 4/7/20, at 11:36 a.m. R1 stated "they [facility] kicked me out. I am living at the Holiday Inn." R1 further stated "I had four or five months of mail that had not been read, they gave me a volunteer to help read my mail because I am blind, but when the virus came out, that person couldn't come in to read my mail anymore. So a friend of mine came to the facility, he called and said I am on the street waiting to pull into the parking lot, they won't let me in, will they let you out, so I grabbed a few things and went through the front door, the receptionist got up to open the door, and she let me out, and I went and sat in his car in the front parking lot and he read the mail to me." R1 then stated "when I came back into the facility my stuff was sitting on a dolly and I was told I was being discharged, I'm blind, I had to sit in the chairs, in the front entrance, I sat there all night, into the next morning, I called metro mobility at about 10 a.m., who came and got me, and I went to Salvation Army." R1 further stated "I never left the property, when I got out of the car, they wouldn't let me in. I don't even have my

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F 623	Continued From page 5	F 623		

medications, they did not give me any of them. They [facility staff] wouldn't read my mail to me, they were supposed to, I'd ask, can you read this and I would be told, this is not my job. The nurse's and nursing assistants were too busy to read my mail."

On 4/7/20, at 1:00 p.m. the administrator indicated that R1 received education on what COVID-19 is, hand hygiene, risk with community gatherings, visitor limitations and was asked if he had any questions or comments. The administrator further indicated that during the assessment we educated on what would happen if R1 was to leave the facility. The administrator further indicated that he did not know what time R1 was discharged at and stated "I was not involved in that." The administrator then indicated that "I believe [R1] was sent with his medication because that has been our practice, but I don't know that for certain, if the medications were sent with." The administrator then stated "I was looking in the progress notes and I don't see it noted [referring to the medications being sent]." The administrator then stated "my understanding is that he was going to his nephew's home and that he left the facility at [4:56 p.m.] with his nephew." When asked if R1 had slept in the entry way of the facility between the doors, the administrator explained, "We generally ask if we can give them a ride somewhere if they don't have a ride, we wouldn't let that happen."

Review of the medical record lacked evidence that upon the abrupt discharge, R1 had received medications (amount provided), a medication list with directions and discharge instructions of after care in the community.

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F 623	Continued From page 6 On 4/7/20, at 1:27 p.m. the director of nursing (DON) indicated that she was not present during the discharge. The DON also indicated that she knew because of speaking with staff that R1 was given his medications. The DON further indicated that her expectations was that staff would make a nursing note of information such as discharge instructions, medications and medications list given to R1 upon discharge. On 4/7/20, at 1:46 p.m. license practical nurse (LPN)-A indicated that R1 was discharged from the facility between four and five p.m. on 3/23/20, but when she left the facility after her shift at 10:30 p.m., R1 was still sitting in the entryway of the facility waiting for a ride. LPN-A also indicated that the evening supervisor gave R1 medications, medication list and instructions. LPN-A further indicated that staff would document in the nurse's note about the discharge and that she did not make a note of the discharge because she thought maybe the evening supervisor had completed it. On 4/7/20, at 1:54 p.m. registered nurse (RN)-A stated "he [R1] was discharged, I came in at 3 p.m. and he was already discharged by the facility administrator." RN-A then stated "all I did was print his [R1] medication list, contacted a family member, had an aide pack R1's belongings and put them on a cart. I can't remember if I wrote a note." RN-A then stated "I normally write a note but he was already discharged when I got here." RN-A then indicated that R1 was still sitting in the lobby at 11:30 p.m. when he was leaving the facility after his shift and that he had called the administrator and told him	F 623		

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F 623	Continued From page 7 that R1 was still sitting there, trying to find a ride. RN-A then further stated "I asked [R1] why he doesn't call the gentlemen that was here earlier, and [R1] said he is not picking up my calls. I called the administrator before the end of my shift." On 4/7/20, at 2:35 p.m. R1's nephew stated it was not him that had picked R1 up from the facility when he was discharged and he would not have given R1 a ride as he lived out of state. He further stated there were no other relatives that lived in the state that would have assisted R1. The facility Transfer and/or Discharge Policy last approved 1/2020 indicated the resident, and/or representative will be provided with the following information within the notice, in writing and language and manner they understand, prior to transfer: reason for transfer and the location to which the resident is being transferred or discharged. The policy failed to address where and when staff were supposed to document the discharge instruction and any pertinent information about the discharge.	F 623		

Electronically delivered
April 16, 2020

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

Re: State Nursing Home Licensing Orders
Event ID: FVGW11

Dear Administrator:

The above facility was surveyed on April 7, 2020 through April 9, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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 64970
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Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

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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 4/7/2020 4/9/2020, a survey was conducted to determine compliance for State licensure. The following correction orders are issued. Please indicate on your electronic plan of correction that you have reviewed the order, and identify the date of correction.	2 000		

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	00238	A. BUILDING: _____ B. WING _____	C 04/09/2020

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2 000	Continued From page 1 The following complaints were found to be substantiated: H5183229C and H5183230C. Deficiency was issued at State Tag 1925. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	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 the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room	21925		4/27/20

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21925	Continued From page 2 assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a proper discharge process for 1 of 3 residents (R1) who left the facility during COVID-19, and was not allowed to return to the facility. Findings include: R1's diagnoses obtained from the Admission Record dated 4/7/20, included low back pain, visual loss, major depressive disorder and type 2 diabetes. R1's discharge Minimum Data Set (MDS) dated 3/23/20, identified R1 had intact cognition and R1's care plan dated 10/25/19, indicated discharge plans were unknown due to R1 being homeless before admitting to facility. On 4/7/20, at 11:21 a.m., during a telephone interview, the relocation case manager indicated she had found out that R1 was kicked out of the facility because he violated the lockdown rules. The relocation case manager indicated because volunteers who assisted him to read his mail were not allowed at the facility due to the restrictions, a friend had volunteered to come and read it for him. The relocation worker further indicated R1's friend came to the facility and because R1 is blind, he told the front desk person he was going to meet with his friend in the parking lot and was told if he did not to go beyond the property it was okay. The relocation worker stated she was informed the receptionist had opened the door for R1 and directed him	21925	See above	

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21925	Continued From page 3	21925		

towards his friend. R1 then indicated to her that he went to his friend's car to review the mail and when he came back to the building he was told he had violated the facility COVID-19 restriction rules. The relocation worker further indicated she was not aware if R1 had received information about the consequences of leaving the property and that R1 was not given medication and shelter after he was inappropriately discharged from the facility.

On 4/7/20, at 11:36 a.m. R1 stated "they [facility] kicked me out. I am living at the Holiday Inn." R1 further stated "I had four or five months of mail that had not been read, they gave me a volunteer to help read my mail because I am blind, but when the virus came out, that person couldn't come in to read my mail anymore. So a friend of mine came to the facility, he called and said I am on the street waiting to pull into the parking lot, they won't let me in, will they let you out, so I grabbed a few things and went through the front door, the receptionist got up to open the door, and she let me out, and I went and sat in his car in the front parking lot and he read the mail to me." R1 then stated "when I came back into the facility my stuff was sitting on a dolly and I was told I was being discharged, I'm blind, I had to sit in the chairs, in the front entrance, I sat there all night, into the next morning, I called metro mobility at about 10 a.m., who came and got me, and I went to Salvation Army." R1 further stated "I never left the property, when I got out of the car, they wouldn't let me in. I don't even have my medications, they did not give me any of them. They [facility staff] wouldn't read my mail to me, they were supposed to, I'd ask, can you read this and I would be told, this is not my job. The nurse's and nursing assistants were too busy to

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21925	Continued From page 4 read my mail." On 4/7/20, at 1:00 p.m. the administrator indicated that R1 received education on what COVID-19 is, hand hygiene, risk with community gatherings, visitor limitations and was asked if he had any questions or comments. The administrator further indicated that during the assessment we educated on what would happen if R1 was to leave the facility. The administrator further indicated that he did not know what time R1 was discharged at and stated "I was not involved in that." The administrator then indicated that "I believe [R1] was sent with his medication because that has been our practice, but I don't know that for certain, if the medications were sent with." The administrator then stated "I was looking in the progress notes and I don't see it noted [referring to the medications being sent]." The administrator then stated "my understanding is that he was going to his nephew's home and that he left the facility at [4:56 p.m.] with his nephew." When asked if R1 had slept in the entry way of the facility between the doors, the administrator explained, "We generally ask if we can give them a ride somewhere if they don't have a ride, we wouldn't let that happen." Review of the medical record lacked evidence that upon the abrupt discharge, R1 had received medications (amount provided), a medication list with directions and discharge instructions of after care in the community. On 4/7/20, at 1:27 p.m. the director of nursing (DON) indicated that she was not present during the discharge. The DON also indicated that she knew because of speaking with staff that R1 was given his medications. The DON further indicated	21925		

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21925	Continued From page 5 that her expectations was that staff would make a nursing note of information such as discharge instructions, medications and medications list given to R1 upon discharge. On 4/7/20, at 1:46 p.m. license practical nurse (LPN)-A indicated that R1 was discharged from the facility between four and five p.m. on 3/23/20, but when she left the facility after her shift at 10:30 p.m., R1 was still sitting in the entryway of the facility waiting for a ride. LPN-A also indicated that the evening supervisor gave R1 medications, medication list and instructions. LPN-A further indicated that staff would document in the nurse's note about the discharge and that she did not make a note of the discharge because she thought maybe the evening supervisor had completed it. On 4/7/20, at 1:54 p.m. registered nurse (RN)-A stated "he [R1] was discharged, I came in at 3 p.m. and he was already discharged by the facility administrator." RN-A then stated "all I did was print his [R1] medication list, contacted a family member, had an aide pack R1's belongings and put them on a cart. I can't remember if I wrote a note." RN-A then stated "I normally write a note but he was already discharged when I got here." RN-A then indicated that R1 was still sitting in the lobby at 11:30 p.m. when he was leaving the facility after his shift and that he had called the administrator and told him that R1 was still sitting there, trying to find a ride. RN-A then further stated "I asked [R1] why he doesn't call the gentlemen that was here earlier, and [R1] said he is not picking up my calls. I called the administrator before the end of my shift."	21925		

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21925	Continued From page 6 On 4/7/20, at 2:35 p.m. R1's nephew stated it was not him that had picked R1 up from the facility when he was discharged and he would not have given R1 a ride as he lived out of state. He further stated there were no other relatives that lived in the state that would have assisted R1. The facility Transfer and/or Discharge Policy last approved 1/2020 indicated the resident, and/or representative will be provided with the following information within the notice, in writing and language and manner they understand, prior to transfer: reason for transfer and the location to which the resident is being transferred or discharged. The policy failed to address where and when staff were supposed to document the discharge instruction and any pertinent information about the discharge. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21925		