STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	04/09/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 REDACTED]. R1's discharge Minimum Data Set ((MDS) dated [DATE], 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 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 [MEDICAL CONDITION] 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 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 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. 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.

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