DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2022

Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

RE: CCN: 245018
Cycle Start Date: October 7, 2021

Dear Administrator:

On October 27, 2021, we notified you a remedy was imposed. On January 4, 2022 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 4, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 26, 2021 be discontinued as of January 4, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 27, 2021, 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 November 5, 2021. 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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 27, 2022

Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

Re: Reinspection Results
Event ID: 8GG212, 5QXY12, and QQN012

Dear Administrator:

On January 4, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on October 26, 2021, November 5, 2021, and December 9, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 22, 2021

Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

RE: CCN: 245018
Cycle Start Date: October 7, 2021

Dear Administrator:

On October 27, 2021, we informed you of imposed enforcement remedies.

On December 9, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. remove this sentence if not SQC and IJ. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On December 6, 2021, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

On December 9, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 26, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 26, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 26, 2021.

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.

As we notified you in our letter of October 27, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 26, 2021. However, due to the extended survey the new NATCEP loss date is November 5, 2021.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Crest View Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 5, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 April 7, 2022 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies.

All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

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
	245018	A. BUILDING _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	**4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421**

(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 12/3/21, through 12/9/21, a standard abbreviated complaint survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5018192C (MN78841) with a deficiency cited at F600. H5018194C (MN78947) with a deficiency cited at F600. H5018195C (MN79029) with a deficency cited at F689. The following complaints were found to be UNSUBSTANTIATED: H5018191C (MN78160) H5018193C (MN78913) The complaint survey resulted in an Immediate Jeopardy (IJ) at F600 when staff observed FM-A kissing and cuddling R1 in the dining room. Later in the day, another staff observed FM-A sexual abusing R1. The IJ began on 11/26/21, and the immediacy was removed on 12/7/21, at 1:25 p.m. The complaint survey also resulted in an IJ at F689 the facility failed to provide interventions to prevent elopement, and R4 was unable to elope from the facility. The IJ began on 12/3/21, and the immediacy was removed on 12/9/21. The above findings constituted substandard quality of care, and an extended survey was conducted on 12/7/21, through 12/8/21.	F 000		

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

Electronically Signed | 12/23/2021

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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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from sexual abuse for 1 of 3 residents (R1) reviewed for sexual abuse allegations. R1's family member (FM)-B engaged in sexual touching with R1. This	F 600	F600 It is the policy of Crest View Lutheran Home to ensure the resident has the right to be free from abuse, neglect, misappropriation of resident property, and	12/29/21

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F 600	Continued From page 2 resulted in an immediate jeopardy for R1, when FM-B sexually abused her. The immediate jeopardy (IJ) began on 11/26/21, when staff observed FM-B kissing and cuddling R1 in the dining room. Later in the day, another staff observed FM-B touching R1's genitals over clothing in her room. R1 was not able to give consent for sexual contact due to advanced dementia The administrator and assistant director of nursing (ADON) were notified of the IJ on 12/3/21, at 6:20 p.m. The IJ was removed on 12/6/21, at 1:25 p.m. but non-compliance remained at the lower scope of a D, isolated, no actual harm, with potential for more than minimal harm. Findings include: R1's Diagnosis List printed 12/9/21, indicated R1's diagnoses included traumatic brain bleeding, fractured left orbital (eye socket), altered mental state, and dementia with behavioral disturbances R1's significant change Minimum Data Set (MDS) dated 11/23/21, indicated R1 had severely impaired cognition, and sometimes understood others. R1's Care Area Assessment (CAA) dated 11/24/21, indicated R1 had a decreased ability to make herself understood and exhibited confusion, disorientation, and forgetfulness. The CAA also indicated R1 had dementia. R1's care plan (CP) dated 12/2/21, indicated R1 was a vulnerable adult with interventions of involving the Ombudsman and psychological services as needed. The CP indicated the door to	F 600	exploitation as defined in their subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. R1 remains in the care of the facility. R1 s care plan was reviewed. R1 s daughter was interviewed, the Ombudsman met with her, and the Law Enforcement Detective met with resident. Law Enforcement decided the it was not a criminal or civil case. Daughter and resident are fine with the relationship. Daughter and resident declined ombudsman assistance. Visitor allowed back into the building and the relationship is now established and documented. Facility is following the resident bill of rights. Resident is discharging back to her Assisted Living on 12/30/2021. Assisted Living knows all elements of situation. For all other residents this defective practice could have affected, Nursing staff and other departmental staff were re-educated on Vulnerable Adult Reporting with an emphasis on sexual abuse reporting and prevention on 12/3/2021. Nursing and other departmental staff will be re-educated through a mandatory staff meeting on 12/29/2021. The Administrator or designee will audit all allegations of potential abuse weekly x 8	

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F 600	Continued From page 3 her room should be left open when R1 had visitors. On 10/26/21, a progress note indicated R1 was disoriented and confused upon arrival to the facility. The note also indicated R1 could not make her needs known. On 11/3/21, R1's admitting nurse practitioner (NP) progress note indicated R1 was admitted after being hospitalized for a fractured orbital bone and closed head injury following a fall. The note indicated R1 was very agitated, and exhibited signs of acute delirium and dementia. On 11/25/21, a progress note indicated R1 was moved to the Memory Care Unit (locked unit) because of behaviors toward other residents. On 11/26/21, at 4:21 p.m. a progress note indicated a nursing assistant (NA) observed R1 and family member (FM)-B kissing in the dining room, and touching each other's genitals over clothing in R1's room. On 11/27/21, at 6:29 p.m. a progress note indicated local law enforcement (LE) was called, and were informed of the allegations of sexual abuse. On 11/30/21, at 11:46 a.m. a progress note indicated LE provided the facility with direction to not allow FM-B back into the building while the investigation was ongoing. On 11/30/21, at 4:00 p.m. a progress note indicated the administrator notified FM-B he could not come into the facility until an investigation was completed. The note also indicated FM-B stated	F 600	weeks then monthly ongoing. The results of those audits will be taken to QAPI to determine compliance. The Administrator will audit staff knowledge of abuse reporting with an emphasis on sexual exploitation- five staff members will be quizzed on abuse reporting with emphasis on sexual exploitation each week for eight weeks. The results of those audits will be taken to QAPI to determine compliance. Education and audits will be reviewed at facility's next QAPI to ensure compliance. The Resident Protection Plan was reviewed and revised on 12/7/2021 and staff were re-educated on the Protection Plan on 12/7/2021. Administrator would have been re-educated by the Campus Administrator on 12/27/2021 on the importance of waiting for an investigation to be cleared by the Law Enforcement Detective before bringing a visitor back but Administrator will not be returning to Crest View and last day worked was 12/20/2021. The Administrator will be responsible for compliance Date of Compliance: 12/29/2021	

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F 600	Continued From page 4 his relationship with R1 was "not conventional." On 12/2/21, at 8:48 a.m. a progress note indicated the facility contacted the Ombudsman, and the Ombudsman recommended the care plan be updated to indicate a conference should be held with FM-B before he visited again, and any inappropriate situations should be reported to FM-A. On 12/2/21, at 1:43 p.m. a progress note indicated social worker (SW)-A, the assistant director of nursing (ADON), the administrator, and FM-B met via phone to establish visitation parameters. These parameters were to have the bedroom door open during visits, FM-B would stay off the bed, staff would report any suspicious behaviors to FM-A, and any suspicious behavior would be reported immediately. On 12/2/21, at 3:30 p.m. a progress note indicated R1 mistakenly referred to FM-B as her (deceased) husband. On 12/3;/21, at 9:41 a.ma an email was received from the Ombudsman. The Ombudsman indicated she had no iformation regarding the incident, and had no information regading the resident. On 12/3/21, at 2:22 p.m. a progress note indicated R1 was sad her boyfriend (FM-B) left, and she had a good visit with him. On 12/3/21, at 4:08 p.m. a progress note indicated LE informed the administrator there was still an open investigation. The note indicated the administrator contacted FM-B law enforcement was still investigating, and he could not visit the	F 600		

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F 600	Continued From page 5 facility. On 12/3/21, at 11:06 a.m. FM-A was interviewed. FM-A stated FM-B was R1's son-in-law, and had been married to R1's daughter. FM-A stated when R1's husband died, and FM-B's wife died, R1 and FM-B became roommates. FM-A stated their relationship was platonic and because they were Italian, they would hug and kiss. FM-A described the kissing as a peck on the cheek or a peek on the lip, and stated there were no lingering kisses on the lips. FM-A stated R1's mental decline began two years ago, and had progressed where she could not use the television remote, the phone, or other household items she usually used. On 12/3/21, at 1:06 p.m. licensed practical nurse (LPN)-B was interviewed. LPN-B stated on 11/26/21, the life enrichment aide (LEA)-A had come to her and told her FM-B was kissing R1 on the lips in the dining room. LPN-B stated she went into the dining room, and observed FM-B sitting with his legs spread open, with R1's wheelchair between his legs. LPN-A stated R1 was facing FM-B. LPN-B stated she immediately reported this to her supervisor LPN-A. LPN-B stated after lunch, FM-B took R1 back to her room. LPN-B stated a short time later, nursing assistant (NA)-A told her FM-B was laying on R1's bed. NA-A reported to her R1 was in the wheelchair next to the bed. LPN-A stated NA-A reported FM-B was touching R1 between the thighs, and R1 was touching FM-A between the thighs. LPN-B stated she reported this immediately to LPN-A, but received no direction from LPN-A on what to do. LPN-B stated she went into R1's room and FM-B was sitting on the bed. LPN-B stated R1 was "far away" from the	F 600		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	**4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421**

(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 600	Continued From page 6 bed. FM-B then left. On 12/3/21, at 1:31 p.m. LPN-A was interviewed. LPN-A stated when LPN-B notified her of R1 and FM-B kissing in the dining room, she had been aware because LEA-A had told her. LPN-B stated she observed FM-B and R1 sitting close together in the dining room, but did not have time to do anything about it because she was busy with an admission. LPN-A stated later that day, NA-A had notified her FM-B was lying on bed R1's bed, and FM-B and R1 were "touching each other's genitals over clothing." LPN-A stated she then notified the assistant director of nursing (ADON) and the administrator, but she did not inform them of the kissing in the dining room earlier. LPN-B stated she interviewed R1 who informed her FM-B was "like my boyfriend" and when he kissed her, she said, "I like it when he did that." LPN-A stated R1 had dementia. LPN-A stated FM-B was allowed back in the facility today after a care conference yesterday. On 12/3/21, at 1:56 p.m. NA-A was interviewed and stated right before lunch, LEA-A told her about FM-B and R1 kissing in the dining room, and she had instructed her to notify LPN-B. NA-A stated after lunch, around 12:30 p.m. she entered R1's room and observed FM-B on the bed and R1 in the wheelchair next to the bed. NA-A stated both were rubbing each other's genitals. NA-A stated she told FM-B he could not lay on R1's bed, and then she reported this to LPN-B. NA-A stated after about thirty minutes, FM-B left. NA-A stated FM-B had been back in the facility visiting R1 this morning. On 12/3/21, at 2:11 p.m. NA-B was interviewed and stated R1 "kisses everyone." NA-B stated R1	F 600		

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	245018	A. BUILDING _____ B. WING _____	C 12/09/2021

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F 600	Continued From page 7	F 600		

would grab other male residents and kiss them because she thought they were her husband. NA-B described R1 as very confused and very blind, and stated she could not see very well.

On 12/3/21, at 2:19 p.m. the administrator and the ADON were interviewed. The administrator stated the Ombudsman told them to let FM-B visit again. The administrator stated FM-B had admitted to non-sexual kissing of R1, and to lying on R1's bed, but denied any touching of each other's genitals over clothing. The ADON stated she was not aware of the nature of FM-B and R1's relationship, but FM-B told them it was not a romantic relationship. The administrator stated when they told FM-B he could come back in the building, he had to keep R1's door open, he could not be on the bed, and "no inappropriate touch," FM-B responded, "Now I know."

On 12/3/21, at 3:11 p.m. LEA-A was interviewed and stated on 11/26/21, around 10:00 a.m. there was a group activity in the dining room. LEA-A stated she observed FM-B enter the dining room and sit down beside R1 who was seated at a table. LEA-A stated FM-B positioned R1's wheelchair between his legs "really close" with her facing him, and he began repeatedly kissing R1 on the lips. LEA-A stated this was not a "peck" on the lips, and it went on for several seconds LEA-A stated the two were rubbing each other's shoulders and backs.
LEA-A stated she felt very uncomfortable, especially knowing FM-B was R1's son-in-law and did not think it was appropriate so she reported it to LPN-B.

On 12/3/21, at 6:51 p.m. FM-B was interviewed. FM-B stated he did not do anything wrong with

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R1 because they were from an Italian family and very affectionate, they hugged and kissed. FM-B denied any lingering kissing or touching of genitals over the clothing. FM-B stated staff did not understand how much they loved each other and cared for each other. FM-B also stated he had not seen R1 for a few days so he was being extra snuggly and nice to her that night. FM-B stated they snuggled and kissed in her room. FM-B acknowledged R1 had dementia and stated, "Hell, I don't know if she knows it's me or thinks I'm her [deceased] husband." FM-B stated R1 had macular degeneration and was "legally blind." FM-B stated he thought people were misinterpreting their relationship because they had not seen them together before she was admitted to the facility and they just did not understand.

On 12/3/21, at 6:57 p.m. law enforcement detective (LED)-A was interviewed and stated he instructed the facility to keep FM-B out of the facility until LE had completed their investigation.

On 12/3/21, at approximately 3:30 p.m. the administrator was interviewed. The administrator stated they let FM-B back into the facility to visit R1 because he had denied any inappropriate contact. The administrator stated she had not followed LE's recommendations to keep FM-B out of the facility, because she thought their investigation was closed.

On 12/6/21, at 2:00 p.m. R1 was interviewed and stated she was tired and wanted to take a nap. A bag of McDonald's fast food was on the bedside table. R1 stated her husband brought it and she missed him. R1 stated her husband was family member (FM)-B. R1 stated FM-B usually visited

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F 600	Continued From page 9 every day but he "doesn't hear." The facility's Resident Protection Plan dated January 2021, indicated sexual abuse was defined as non-consensual sexual contact of any type with a resident. The Plan lacked indication of how consent was obtained or established. The Plan also directed investigations of allegations of abuse would begin immediately, and a root cause investigation and analysis would be completed. The Plan directed while the investigation was being completed, alleged perpetrators who were visitors would have visitation restricted, and any allegations of suspected sexual abuse would be reported immediately to law enforcement. The immediate jeopardy that began on 11/26/21, was removed on 12/7/21, at 1:25 p.m. when the facility successfully implemented a removal plan which included: a thorough investigation of the incident was completed, the Resident Protection Plan was reviewed and revised, and staff were educated on the Resident Protection Plan. R1 had a Protection Plan put into place, and staff was educated on the Protection Plan. Other residents were interviewed and had no concerns with FM-A. This was verified on 12/7/21, with staff interviews verifying the education, and review of the Resident Protection Plan and R1's Protection Plan.	F 600		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		12/29/21

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F 689	Continued From page 10 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide interventions to prevent elopements for 1 of 3 residents (R4) reviewed for elopement. This resulted in an immediate jeopardy for R4, who eloped from the facility. The immediate jeopardy (IJ) began on 12/3/21, when R4 eloped from the facility and was found by local law enforcement 0.6 miles from the facility. The WanderGuard did not alert staff that R4 left the facility unsupervised as the device was not working. The administrator and director of nursing (DON) were notified of the IJ on 12/8/21, at 10:15 a.m. The IJ was removed on 12/9/21 at 3:30 p.m. but non-compliance remained at the lower scope of a D, isolated, no actual harm, with potential for more than minimal harm. Findings include: On 12/3/21, a progress note indicated local law enforcement (LE) found R4 approximately 0.6 miles from the facility with feces on him. LE alerted the facility, and the campus administrator picked up R4 and brought him back to the facility. R4's Diagnosis List printed 12/9/21, indicated R4's diagnoses included Lewy Body dementia and history of falling. R4's quarterly Minimum Data Set (MDS) dated 12/5/21, indicated R4 had a moderate cognitive impairment, and exhibited behaviors of fluctuating	F 689	F689 It is the policy of Crest View Lutheran Home to ensure the resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistance to prevent accidents. R4 s elopement assessment, wanderguard and care plan were assessed and revised as necessary on 12/8/2021. Wanderguard on resident was expired so it did not go off properly. Wanderguard system connected to door works perfectly and is audited each week by Maintenance personnel. New WanderGuard spread sheet that staff were educated on, adding it to the Treatment Administration Record and education on checking the WanderGuards each shift for workability and date was completed on 12/8/2021 by the Director of Nursing. For all other residents this deficient practice could have affected, a whole house audit on wanderguards and elopement assessments was performed on 12/8/2021 by the RN Nurse Consultant. The Treatment Administration Record (TAR) for the wanderguards to be	

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F 689	Continued From page 11 attention and disorganized thinking. R4's care plan dated 8/24/21, indicated R4 was an elopement risk because of his poor safety awareness. The care plan indicated R4 should have a WanderGuard (a monitoring system to alert the facility if a resident tried to leave) placed under his wheelchair seat. In addition, the care plan directed staff to check the WanderGuard and its functionality every shift. On 11/9/21, at 12:58 a.m. a progress note indicated another resident's family member called the facility and reported "there was a resident wheeling himself down the street." The note also indicated R4 had poor decision-making skills. R4's Provider Order dated 11/9/21, ordered 15-minute checks for R4 because he was an elopement risk. On 11/9/21, at 1:09 p.m. a progress note indicated R4 was spotted "heading down the hill" and staff brought him back to the facility. R4's Treatment Administration Record (TAR) dated November 2021, indicated 15-minute checks began on the evening of 11/9/21, and were discontinued on the evening of 11/12/21 (72 hours later). On 11/10/21, R4's interdisciplinary team (IDT) note indicated the facility replaced R4's current WanderGuard with a new WanderGuard. R4's Provider Order dated 11/11/21, indicated R4 should have a WanderGuard for safety, with check of placement and function every shift. R4's provider progress note written by nurse	F 689	checked for placement and workability every shift and maintenance to check the physical door alarm every Thursday was audited on 12/8/2021 by the Director of Nursing. The Wanderguard Policy was revised on 12/23/2021 to provide direction on the process for placing, activating, testing and monitoring the WanderGuard for function. Nursing department and other departmental staff will be education on the new policy and elopement procedure during the staff education meeting on 12/29/2021. Staff were educating on how to activate a WanderGuard and test that it is working properly on 12/8/2021. All residents will be re-accessed for elopement risk and appropriate interventions in place by 12/29/2021. Director of Nursing or designee will audit that the WanderGuard Spreadsheet is being filled out correctly and the Treatment Administration Record (TAR) will be done weekly for each resident on a Wanderguard x4 weeks. The results of those audits will be taken to QAPI to determine compliance. Director of Nursing or designee will audit all resident with elopement risks to assure appropriate care planning and interventions to reduce the risk of	

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F 689	Continued From page 12 practitioner (NP)-A dated 11/12/21, indicated R4 was cognitively intact but showed poor decision skills and poor safety awareness. The note indicated the provider ordered neurocognitive testing and psychotherapy. On 12/3/21, a facility report to the state agency (SA) indicated local law enforcement went to the facility to report R4 was alone and seen approximately 0.6 miles from the facility, and had been incontinent of bowel. The campus administrator went to the location and brought R4 back to the facility. R4's Provider Order dated 12/3/21, indicated R4 should have 15-minute checks on all shifts. On 12/6/21, at 2:45 p.m. NP-A was interviewed and stated she wrote an order for a WanderGuard for R4 on 11/9/21, along with 15-minute checks. NP-A stated she wanted a WanderGuard on both R4's person and his wheelchair. NP-A stated she also ordered a neurocognitive testing because R4 had poor safety awareness. NP-A stated the facility had not made an appointment for the neurocognitive testing. On 12/6/21, at 3:47 p.m. trained medication aide (TMA)-B stated R1 had a WanderGuard on his wheelchair but she was not aware he eloped during her shift. On 12/7/21, at 9:54 a.m. TMA-A stated he was not aware R4 had eloped; he could not remember if a WanderGuard was on R1's wheelchair. On 12/7/21, at 1:34 p.m. licensed practical nurse (LPN)-D stated was unaware R1 had eloped	F 689	elopement weekly x4 weeks. The results of those audits will be taken to QAPI to determine compliance. The Director of Nursing will be responsible for compliance. Date of compliance: 12/29/2021	

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F 689	Continued From page 13 during her shift. On 12/7/21, at 4:22 p.m. licensed practical nurse (LPN)-C was interviewed and stated she was working 12/3/21, when R4 eloped. LPN-C stated she thought R1's WanderGuard was still on his wheelchair, but she was not sure. LPN-C stated no one knew he was gone until LE contacted the facility. On 12/7/21, at 4:27 p.m. LPN-D was observed moving R4 through the front doors accompanied by the receptionist. LPN-B stated they were checking to see if R4's WanderGuard was working. The receptionist stated, "It's not working." R1's WanderGuard did not alarm as R4 passed through the doors. LPN-B stated she would contact maintenance to determine why the WanderGuard was not working. On 12/8/21, a progress note indicated a new WanderGuard was placed on R1's wheelchair and activated. On 12/8/21, at 9:08 a.m. the campus administrator was interviewed. The campus administrator stated she was checking mail around 2:30 p.m. on 12/3/21, and saw the police officer at the reception desk. The campus administrator stated the officer told her R1 was at 42nd and Fillmore street. The campus administrator stated she got a blanket and walked to get R1. The campus administrator stated she pushed R1 in his wheelchair back to the facility. The campus administrator stated R1 was wearing a hat, jacket, and gloves over his shirt and pants; he had on shoes and socks. The campus administrator stated R1's WanderGuard was still on his wheelchair, but it was expired so she gave	F 689		

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F 689	Continued From page 14 LPN-A a new WanderGuard to replace it. The campus administrator stated she did not verify this was done, and acknowledged it was not recorded in their log. The campus administrator stated R4's WanderGuard was expired, it was placed on 8/6/21, and was only good for 90 days. The campus administrator stated the WanderGuard should have been replaced on 11/6/21, therefore, it was expired when R4 eloped on 12/3/21. The campus administrator stated the WanderGuard log had not been updated since August of 2021. The facility's Elopement and Wandering Policy and Procedure dated 12/21/20, directed residents who were assessed for elopement risk would have a WanderGuard placed on their wrist, and if the WanderGuard was found to be not working staff should immediately notify the administrator, DON, and Director of Environmental Services. The policy lacked direction of the process for placing, activating, testing, and monitoring the WanderGuard for function. The immediate jeopardy that began on 12/3/21, was removed on 12/9/21, at 3:30 p.m. when the facility successfully implemented a removal plan which included: elopement assessments were conducted on all residents with WanderGuards, all current WanderGuards with replaced with new WanderGuards and their activation was verified, the Elopement policy was reviewed and revised, and staff was educated on how to activate the WanderGuard, monitoring and verifying WanderGuard placement, and elopement precautions. This was verified on 12/9/21, with staff interviews verifying the education, the WanderGuards were verified in working order, and the Elopement policy was reviewed.	F 689		

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 22, 2021

Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

Re: State Nursing Home Licensing Orders
Event ID: QQN011

Dear Administrator:

The above facility was surveyed on December 3, 2021 through December 9, 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Minnesota Department of Health

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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 12/3/21, through 12/9/21, 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		

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

Electronically Signed | 12/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 12/09/2021

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5018192C (MN78841), H5018194C (MN78947), and H5018195C (MN79029) with a licensing order issued at 4658.0250 Subp 1. The following complaints were found to be UNSUBSTANTIATED: H5018191C (MN78160) and H5018193C (MN78913). 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 electronic State licensure process, under the heading completion date, the date your orders will	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide interventions to prevent elopements for 1 of 3 residents (R4) reviewed for elopement. This resulted in an immediate jeopardy for R4, who eloped from the facility.	2 830	F830 It is the policy of Crest View Lutheran Home that a resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident	12/29/21

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2 830	Continued From page 3 The immediate jeopardy (IJ) began on 12/3/21, when R4 eloped from the facility and was found by local law enforcement 0.6 miles from the facility. The WanderGuard did not alert staff that R4 left the facility unsupervised as the device was not working. The administrator and director of nursing (DON) were notified of the IJ on 12/8/21, at 10:15 a.m. The IJ was removed on 12/9/21 at 3:30 p.m. but non-compliance remained at the lower scope of a D, isolated, no actual harm, with potential for more than minimal harm. Findings include: On 12/3/21, a progress note indicated local law enforcement (LE) found R4 approximately 0.6 miles from the facility with feces on him. LE alerted the facility, and the campus administrator picked up R4 and brought him back to the facility. R4's Diagnosis List printed 12/9/21, indicated R4's diagnoses included Lewy Body dementia and history of falling. R4's quarterly Minimum Data Set (MDS) dated 12/5/21, indicated R4 had a moderate cognitive impairment, and exhibited behaviors of fluctuating attention and disorganized thinking. R4's care plan dated 8/24/21, indicated R4 was an elopement risk because of his poor safety awareness. The care plan indicated R4 should have a WanderGuard (a monitoring system to alert the facility if a resident tried to leave) placed under his wheelchair seat. In addition, the care plan directed staff to check the WanderGuard and its functionality every shift. On 11/9/21, at 12:58 a.m. a progress note indicated another resident's family member called	2 830	assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. R4's elopement assessment, wanderguard and care plan were assessed and revised as necessary on 12/8/2021. For all other residents this deficient practice could have affected, a whole house audit on wanderguards and elopement assessments was performed on 12/8/2021. The Treatment Administration Record (TAR) for the wanderguards to be checked for placement and workability every shift and maintenance to check the physical door alarm every Thursday was audited on 12/8/2021. The Wanderguard Policy was revised on 12/23/2021 to provide direction on the process for placing, activating, testing and monitoring the WanderGuard for function. Nursing department and other departmental staff will be education on the new policy and elopement procedure during the staff education meeting on 12/29/2021. Staff were educating on how to activate a WanderGuard and test that it is working properly on 12/8/2021. All residents will be re-accessed for elopement risk and appropriate interventions in place by 12/29/2021. Random audits for all resident with elopement risks to assure appropriate care planning and interventions and	

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2 830	Continued From page 4 the facility and reported "there was a resident wheeling himself down the street." The note also indicated R4 had poor decision-making skills. R4's Provider Order dated 11/9/21, ordered 15-minute checks for R4 because he was an elopement risk. On 11/9/21, at 1:09 p.m. a progress note indicated R4 was spotted "heading down the hill" and staff brought him back to the facility. R4's Treatment Administration Record (TAR) dated November 2021, indicated 15-minute checks began on the evening of 11/9/21, and were discontinued on the evening of 11/12/21 (72 hours later). On 11/10/21, R4's interdisciplinary team (IDT) note indicated the facility replaced R4's current WanderGuard with a new WanderGuard. R4's Provider Order dated 11/11/21, indicated R4 should have a WanderGuard for safety, with check of placement and function every shift. R4's provider progress note written by nurse practitioner (NP)-A dated 11/12/21, indicated R4 was cognitively intact but showed poor decision skills and poor safety awareness. The note indicated the provider ordered neurocognitive testing and psychotherapy. On 12/3/21, a facility report to the state agency (SA) indicated local law enforcement went to the facility to report R4 was alone and seen approximately 0.6 miles from the facility, and had been incontinent of bowel. The campus administrator went to the location and brought R4 back to the facility.	2 830	reduce risk of elopement will be conducted by the Director of Nursing of 5 residents a week for four weeks and then re-accessed at QAPI after that. The Director of Nursing will be responsible for compliance. Date of compliance: 12/29/2021	

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2 830	Continued From page 5 R4's Provider Order dated 12/3/21, indicated R4 should have 15-minute checks on all shifts. On 12/6/21, at 2:45 p.m. NP-A was interviewed and stated she wrote an order for a WanderGuard for R4 on 11/9/21, along with 15-minute checks. NP-A stated she wanted a WanderGuard on both R4's person and his wheelchair. NP-A stated she also ordered a neurocognitive testing because R4 had poor safety awareness. NP-A stated the facility had not made an appointment for the neurocognitive testing. On 12/6/21, at 3:47 p.m. trained medication aide (TMA)-B stated R1 had a WanderGuard on his wheelchair but she was not aware he eloped during her shift. On 12/7/21, at 9:54 a.m. TMA-A stated he was not aware R4 had eloped; he could not remember if a WanderGuard was on R1's wheelchair. On 12/7/21, at 1:34 p.m. licensed practical nurse (LPN)-D stated was unaware R1 had eloped during her shift. On 12/7/21, at 4:22 p.m. licensed practical nurse (LPN)-C was interviewed and stated she was working 12/3/21, when R4 eloped. LPN-C stated she thought R1's WanderGuard was still on his wheelchair, but she was not sure. LPN-C stated no one knew he was gone until LE contacted the facility. On 12/7/21, at 4:27 p.m. LPN-D was observed moving R4 through the front doors accompanied by the receptionist. LPN-B stated they were checking to see if R4's WanderGuard was working. The receptionist stated, "It's not	2 830		

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2 830	Continued From page 6 working." R1's WanderGuard did not alarm as R4 passed through the doors. LPN-B stated she would contact maintenance to determine why the WanderGuard was not working. On 12/8/21, a progress note indicated a new WanderGuard was placed on R1's wheelchair and activated. On 12/8/21, at 9:08 a.m. the campus administrator was interviewed. The campus administrator stated she was checking mail around 2:30 p.m. on 12/3/21, and saw the police officer at the reception desk. The campus administrator stated the officer told her R1 was at 42nd and Fillmore street. The campus administrator stated she got a blanket and walked to get R1. The campus administrator stated she pushed R1 in his wheelchair back to the facility. The campus administrator stated R1 was wearing a hat, jacket, and gloves over his shirt and pants; he had on shoes and socks. The campus administrator stated R1's WanderGuard was still on his wheelchair, but it was expired so she gave LPN-A a new WanderGuard to replace it. The campus administrator stated she did not verify this was done, and acknowledged it was not recorded in their log. The campus administrator stated R4's WanderGuard was expired, it was placed on 8/6/21, and was only good for 90 days. The campus administrator stated the WanderGuard should have been replaced on 11/6/21, therefore, it was expired when R4 eloped on 12/3/21. The campus administrator stated the WanderGuard log had not been updated since August of 2021. The facility's Elopement and Wandering Policy and Procedure dated 12/21/20, directed residents who were assessed for elopement risk would	2 830		

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2 830	Continued From page 7 have a WanderGuard placed on their wrist, and if the WanderGuard was found to be not working staff should immediately notify the administrator, DON, and Director of Environmental Services. The policy lacked direction of the process for placing, activating, testing, and monitoring the WanderGuard for function. The immediate jeopardy that began on 12/3/21, was removed on 12/9/21, at 3:30 p.m. when the facility successfully implemented a removal plan which included: elopement assessments were conducted on all residents with WanderGuards, all current WanderGuards with replaced with new WanderGuards and their activation was verified, the Elopement policy was reviewed and revised, and staff was educated on how to activate the WanderGuard, monitoring and verifying WanderGuard placement, and elopement precautions. This was verified on 12/9/21, with staff interviews verifying the education, the WanderGuards were verified in working order, and the Elopement policy was reviewed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could assess all residents for elopement risks, to assure appropriate interventions are in place to prevent resident elopement. The director of nursing or designee, could conduct random audits of all residents with elopement risks to ensure appropriate care planning and interventions are implemented and reduce the risk of resident elopement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		