MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Walker Methodist Health Ctr
3737 Bryant Avenue South
Minneapolis, MN 55409
Hennepin County

Report#: H5055185

Date: August 1, 2016

Date of Visit: November 12, 2015
Time of Visit: 8:00 a.m. to 5:00 p.m.

By: Elizabeth Swan, RN, Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider
☐ SLF ☐ ICF/IID
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): It is alleged that a resident was neglected when the facility failed to provide supervision to him/her. The resident has not been located and has been missing for multiple hours.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence neglect occurred when the resident left the facility unsupervised and sustained injuries from a fall. The facility staff had knowledge of a prior attempt by the resident to leave the facility. The facility failed to ensure elopement risk factors were evaluated and interventions implemented for adequate supervision.

The resident was admitted to the facility following a hospital stay for acute confusion after being found wandering in the community. On admission to the facility, the resident was identified to have moderately impaired cognition. A Safety Risk Assessment, completed three days after admission, indicated the resident had no history of wandering and/or elopement. The resident's care plan identified the resident was a vulnerable adult due to cognitive impairments with a goal that the resident will be safe in his/her environment. The only intervention directed staff to assist in emergencies.

Approximately one month after admission to the secured short term rehab memory care unit, the resident left the unit by the stairway exit. A Wandergard (bracelet type device that triggers an alarm on all exit doors located on the first floor of the facility) was placed on the resident the following day due to exit seeking behaviors and refusing to return to the unit. Eight days after the placement of the Wanderguard, the resident removed the Wanderguard. There was no evidence that further interventions were implemented to ensure the resident's safety other than the placement of a Wanderguard, which the resident had the ability to remove.

One month after the resident eloped from the secured short term rehab memory care unit, the resident was transferred to the fourth floor long term care unsecured unit. No additional interventions were implemented to ensure the resident's safety. Twenty days after the resident was transferred to the fourth floor of the facility, the door alarm sounded following a church service located on the first floor of the building. It took facility personnel approximately 45 minutes to view the security camera tape to determine the resident had left the building unaccompanied and boarded a city bus outside the facility. The facility initiated a search for the resident at that time. The resident was returned to the facility by a passerby approximately six hours after s/he had left the facility. The resident had a laceration and hematoma to the upper corner of the left eye, abrasions to both arms, and a swollen right knee. The resident was admitted to the hospital for two days for evaluation of the injuries.

During the onsite visit, the resident was interviewed in the secured long term memory care unit. The resident recalled leaving the facility, but did not recall why s/he left.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

Although the facility had procedures for staff to follow in the event the Wanderguard alarm sounded, the facility failed to reassess the resident's safety risk factors when the resident attempted to elope from the facility. In addition, the facility failed to implement interventions to minimize the risks of the resident's ability to leave the facility without adequate supervision.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

☒ Care Guide

☒ Medication Administration Records

☒ Treatment Sheets

☒ Facility Incident Reports

☒ Physician Progress Notes

☒ ADL (Activities of Daily Living) Flow Sheets
☐ Laboratory and X-ray Reports

☒ Physician Orders
☐ Social Service Notes

☒ Nurses Notes
☐ Meal Intake Records

☐ Activities Reports
☐ Weight Records

☐ Therapy and/or Ancillary Services Records
☒ Assessments

☐ Skin Assessments
☒ Care Plan Records

☐ Service Plan
☐ Other, specify: _____

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report ☐ Other, specify: _____

Additional facility records:

☒ Resident/Family Council Minutes
☐ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.
☐ Facility In-service Records

☒ Facility Internal Investigation Reports
☒ Facility Policies and Procedures

☐ Call Light Audits
☐ Other, specify: _____

Number of additional resident(s) reviewed: 3

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: Facility self-report

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 3

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 6

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Physician Assistant interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care ☐ Medication Pass ☐ Meals

☐ Personal Care ☐ Dignity/Privacy Issues ☐ Restorative Care

☒ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A Specify: _____

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A Specify: _____

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minneapolis City Police Department
Hennepin County Attorney
Minneapolis City Attorney
The Office of the Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	C 02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(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 An abbreviated standard survey was conducted to investigate case #H5055185. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 ensure elopement risk factors were evaluated and interventions implemented for adequate supervision for one of three (R1) residents with a history of elopement. Harm occurred when R1 wandered from the facility and had a fall with injuries that included a laceration and hematoma to the upper coner of the left eye, abrasions to bilateral arms and a swollen right knee. The findings include: R1's medical record was reviewed. Nursing home	F 323		

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

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 323	Continued From page 1 admission notes identified that R1 was admitted to the facility's short term rehab memory care unit located on the third floor on August 18, 2015, following a hospital admission for acute confusion when found by EMS wandering and dropping winter coats on the street. The hospital discharge summary dated August 18, 2015, identified the resident's family had noticed cognitive impairments over the past year, and long term memory care placement was being considered. The resident's admission Safety Risk Assessment completed on August 21, 2015, indicated "No" for history of wandering and/or elopement, even though the resident was admitted for confusion and wandering in the community. The resident's Care Plan printed for review on November 12, 2015, identified the resident was a vulnerable adult due to cognitive impairments with a goal that the resident will be safe in his/her environment. The only intervention directed staff to assist in emergencies. Nursing notes dated September 21, 2015, revealed R1 exited the secured short term rehab memory care unit on September 21, 2015, by the stairway. The nursing notes indicated the resident initially insisted that s/he wanted to go to the post office and that the resident was difficult to redirect back to the unit. On September 22, 2015, the nursing notes identified the resident had a Wanderguard (bracelet type device that triggers an alarm on all exit doors located on the first floor of the facility) due to seeking to exit from the unit and refusing to return to the unit. On October 1, 2015, the nursing notes identified the resident cut off the Wanderguard, and that staff pinned the Wanderguard to the back of the resident's sweater, and that 30 minute checks were	F 323		

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F 323	Continued From page 2 completed. The resident's record lacked evidence of documentation that a reassessment of the Safety Risk Assessment was done. The record also lacked documentation that further interventions were implemented to ensure the resident's safety other than the placement of a Wanderguard, in which the resident had the ability to remove. On October 21, 2015, the resident transferred from the secured short term memory care rehab unit to the fourth floor long term care unsecured unit. The resident's record revealed that on November 10, 2015, at approximately 10:15 a.m., R1 left the facility, and traveled to Northeast Minneapolis. The nursing notes dated November 10, 2015, identified the resident was returned to the facility by a passerby six hours after s/he left the facility. The resident presented with a laceration and hematoma to the upper corner of the left eye, abrasions to bilateral arms, and a swollen right knee. The resident was sent and admitted to the hospital for evaluation of the injuries. The resident was readmitted to the facility on November 12, 2015. Registered nurse (RN)-A was interviewed on November 12, 2015, at 9:30 a.m. RN-A voiced awareness of the resident's attempt to elope prior to being transferred to the fourth floor. RN-A stated the facility had a bed management team that discussed admissions and placement of residents. RN-A stated R1 was fearful of elevators and would not go on one, therefore it was suspected the resident had the ability to watch staff exit to the stairwell by pressing the button to release the door. RN-A stated the	F 323		

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F 323	Continued From page 3 resident was not due for his/her quarterly assessment when asked if a reassessment for safety risk factors was completed. The DON, interviewed on November 12, 2015, at 12:25 p.m., verified R1 had a history of wandering prior to admission to the facility, and had succeeded in leaving the secured rehab unit by the stairwell prior to the elopement on November 10, 2015. The DON stated an evaluation was completed by the interdisciplinary team (IDT) prior to the resident being transferred to the unsecured long term care unit and that the IDT deemed this was an appropriate placement for the resident. The DON stated there was no documentation of the evaluation, or what factors were considered when this decision was made. Observation of the resident's room on the fourth floor, revealed the room was located on the back side and out of view from the nursing station and in the same hallway as the stairwell door. The elevator doors were located directly across from the nursing station. On November 12, 2015, the resident was readmitted to the secured long term memory care unit on the second floor of the facility. Observation completed at 2:45 p.m., revealed R1 as well-groomed and dressed with an abrasion of approximately three centimeters (cm) above the left eyebrow with light gray/blue bruising noted on the eyelid and slightly below the left eye. R1 stated s/he had a fall at Walgreens and knew s/he had left the facility, but unsure why.	F 323		

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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: A complaint investigation was conducted to investigate complaint #H5055185. As a result the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health .state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the work "corrected" in the box available for text. 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.	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 ensure elopement risk factors were evaluated and interventions implemented for adequate supervision for one of three (R1) residents with a history of elopement. Harm occurred when R1 wandered from the	2 830		

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2 830	Continued From page 2 facility and had a fall with injuries that included a laceration and hematoma to the upper coner of the left eye, abrasions to bilateral arms and a swollen right knee. The findings include: R1's medical record was reviewed. Nursing home admission notes identified that R1 was admitted to the facility's short term rehab memory care unit located on the third floor on August 18, 2015, following a hospital admission for acute confusion when found by EMS wandering and dropping winter coats on the street. The hospital discharge summary dated August 18, 2015, identified the resident's family had noticed cognitive impairments over the past year, and long term memory care placement was being considered. The resident's admission Safety Risk Assessment completed on August 21, 2015, indicated "No" for history of wandering and/or elopement, even though the resident was admitted for confusion and wandering in the community. The resident's Care Plan printed for review on November 12, 2015, identified the resident was a vulnerable adult due to cognitive impairments with a goal that the resident will be safe in his/her environment. The only intervention directed staff to assist in emergencies. Nursing notes dated September 21, 2015, revealed R1 exited the secured short term rehab memory care unit on September 21, 2015, by the stairway. The nursing notes indicated the resident initially insisted that s/he wanted to go to the post office and that the resident was difficult to redirect back to the unit. On September 22, 2015, the nursing notes identified the resident had a Wanderguard (bracelet type device that triggers	2 830		

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2 830	Continued From page 3 an alarm on all exit doors located on the first floor of the facility) due to seeking to exit from the unit and refusing to return to the unit. On October 1, 2015, the nursing notes identified the resident cut off the Wanderguard, and that staff pinned the Wanderguard to the back of the resident's sweater, and that 30 minute checks were completed. The resident's record lacked evidence of documentation that a reassessment of the Safety Risk Assessment was done. The record also lacked documentation that further interventions were implemented to ensure the resident's safety other than the placement of a Wanderguard, in which the resident had the ability to remove. On October 21, 2015, the resident transferred from the secured short term memory care rehab unit to the fourth floor long term care unsecured unit. The resident's record revealed that on November 10, 2015, at approximately 10:15 a.m., R1 left the facility, and traveled to Northeast Minneapolis. The nursing notes dated November 10, 2015, identified the resident was returned to the facility by a passerby six hours after s/he left the facility. The resident presented with a laceration and hematoma to the upper corner of the left eye, abrasions to bilateral arms, and a swollen right knee. The resident was sent and admitted to the hospital for evaluation of the injuries. The resident was readmitted to the facility on November 12, 2015. Registered nurse (RN)-A was interviewed on November 12, 2015, at 9:30 a.m. RN-A voiced awareness of the resident's attempt to elope prior to being transferred to the fourth floor. RN-A stated the facility had a bed management team	2 830		

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2 830	Continued From page 4 that discussed admissions and placement of residents. RN-A stated R1 was fearful of elevators and would not go on one, therefore it was suspected the resident had the ability to watch staff exit to the stairwell by pressing the button to release the door. RN-A stated the resident was not due for his/her quarterly assessment when asked if a reassessment for safety risk factors was completed. The DON, interviewed on November 12, 2015, at 12:25 p.m., verified R1 had a history of wandering prior to admission to the facility, and had succeeded in leaving the secured rehab unit by the stairwell prior to the elopement on November 10, 2015. The DON stated an evaluation was completed by the interdisciplinary team (IDT) prior to the resident being transferred to the unsecured long term care unit and that the IDT deemed this was an appropriate placement for the resident. The DON stated there was no documentation of the evaluation, or what factors were considered when this decision was made. Observation of the resident's room on the fourth floor, revealed the room was located on the back side and out of view from the nursing station and in the same hallway as the stairwell door. The elevator doors were located directly across from the nursing station. On November 12, 2015, the resident was readmitted to the secured long term memory care unit on the second floor of the facility. Observation completed at 2:45 p.m., revealed R1 as well-groomed and dressed with an abrasion of approximately three centimeters (cm) above the left eyebrow with light gray/blue bruising noted on the eyelid and slightly below the left eye. R1 stated s/he had a fall at Walgreens and knew	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00276	A. BUILDING: _____ B. WING _____	C 02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 5 s/he had left the facility, but unsure why. SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses or designee could review and revise, if necessary, the facility's policy and procedure regarding elopement risk factors and the interventions that would minimize a resident's ability to leave the facility without supervision. The administrator, director of nurses or designee could educate all staff on the safety of residents who have been identified as an elopement risk. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21850		

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21850	Continued From page 6 review, the facility failed to ensure elopement risk factors were evaluated and interventions implemented for adequate supervision for one of three (R1) residents with a history of elopement. The findings include: R1's medical record was reviewed. Nursing home admission notes identified that R1 was admitted to the facility's short term rehab memory care unit located on the third floor on August 18, 2015, following a hospital admission for acute confusion when found by EMS wandering and dropping winter coats on the street. The hospital discharge summary dated August 18, 2015, identified the resident's family had noticed cognitive impairments over the past year, and long term memory care placement was being considered. The resident's admission Safety Risk Assessment completed on August 21, 2015, indicated "No" for history of wandering and/or elopement, even though the resident was admitted for confusion and wandering in the community. The resident's Care Plan printed for review on November 12, 2015, identified the resident was a vulnerable adult due to cognitive impairments with a goal that the resident will be safe in his/her environment. The only intervention directed staff to assist in emergencies. Nursing notes dated September 21, 2015, revealed R1 exited the secured short term rehab memory care unit on September 21, 2015, by the stairway. The nursing notes indicated the resident initially insisted that s/he wanted to go to the post office and that the resident was difficult to redirect back to the unit. On September 22, 2015, the nursing notes identified the resident had a Wanderguard (bracelet type device that triggers	21850		

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21850	Continued From page 7 an alarm on all exit doors located on the first floor of the facility) due to seeking to exit from the unit and refusing to return to the unit. On October 1, 2015, the nursing notes identified the resident cut off the Wanderguard, and that staff pinned the Wanderguard to the back of the resident's sweater, and that 30 minute checks were completed. The resident's record lacked evidence of documentation that a reassessment of the Safety Risk Assessment was done. The record also lacked documentation that further interventions were implemented to ensure the resident's safety other than the placement of a Wanderguard, in which the resident had the ability to remove. On October 21, 2015, the resident transferred from the secured short term memory care rehab unit to the fourth floor long term care unsecured unit. The resident's record revealed that on November 10, 2015, at approximately 10:15 a.m., R1 left the facility, and traveled to Northeast Minneapolis. The nursing notes dated November 10, 2015, identified the resident was returned to the facility by a passerby six hours after s/he left the facility. The resident presented with a laceration and hematoma to the upper corner of the left eye, abrasions to bilateral arms, and a swollen right knee. The resident was sent and admitted to the hospital for evaluation of the injuries. The resident was readmitted to the facility on November 12, 2015. Registered nurse (RN)-A was interviewed on November 12, 2015, at 9:30 a.m. RN-A voiced awareness of the resident's attempt to elope prior to being transferred to the fourth floor. RN-A stated the facility had a bed management team	21850		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245055 Y1	A. Building B. Wing Y2	3/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 03/22/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/8/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
00276	A. Building B. Wing	3/22/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 03/22/2016	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 03/22/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/8/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: LYQS12

STATE FORM: REVISIT REPORT (11/06)