Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 21, 2022

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: July 21, 2022

Dear Administrator:

On July 29, 2022, we notified you a remedy was imposed. On August 22, 2022 the Minnesota Department of Health 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 August 19, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 26, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 29, 2022, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 26, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 19, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(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 7/20/22 through 7/21/22, a standard abbreviated 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 complaint was found to be SUBSTANTIATED: H51193244C (MN84949); with a deficiency cited at F689, and an unrelated deficiency cited at F880. 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 689 SS=D	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 §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 interview and document review, the	F 689	R1's care plan/interventions for	8/19/22

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

Electronically Signed | 08/04/2022

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 689	Continued From page 1 facility failed to reassess, and develop interventions to provide adequate supervision and safety for elopement for 1 of 3 residents (R3) identified who exited the facility three times without staff assistance. Findings include: R1's quarterly Minimal Date Set (MDS) dated 5/24/22, indicated R1 had diagnoses which included dementia, hemiplegia and seizure disorder. Further review of MDS indicated R1 exhibited no behaviors of wandering and required extensive assistance of one staff for activities of daily living (ADLs) such as bed mobility, transfers, ambulation, dressing, toileting and R1 was independent with mobility utilizing a wheelchair. Review of R1's Incident Reports indicated: -On 5/11/22, at 2:05 p.m. A staff member was outside in their vehicle and noticed R1 outside of facility walking on grass area between the facility parking lot and the building. R1 stated he was outside to roll up "his car windows" due to it raining. R1's WanderGuard alarm was sounding and R1 was easily redirected back into the facility and continues to be fixated on finding his car. Further review of R1's incident, lacked evidence of R1 being reassessed to determine appropriate interventions to prevent future elopements from facility. -On 5/25/22 at 7:20 p.m. staff was in another resident room and observed R1 walking through East parking lot towards the street south of the facility. As staff walked out of the facility and silenced alarm, R1 was receptive to staff's instructions and a little aggression with not being	F 689	elopement was reviewed and revised. A new elopement assessment and BIMS was done. In the evening the nursing staff will turn on the TV in the pod, where nursing staff can oversee him, to a car overhauling program, having family, and friends to come and spend time with R1 more in the afternoon and evening hours. Having more activities that he would enjoy i.e. putting together nuts and bolts. Staff will continue with 30 minute checks. Nursing staff will test the Wanderguard twice a shift on days and evenings, and once on overnights. A Medical evaluation review will be done by the physician. Physician and family will be notified regarding assessments findings and care plan updates. This could affect all residents that are at risk for elopement. Care plans will be reviewed and revised if necessary and new elopement assessments will be done. Policies/procedures/forms on Elopement will be reviewed and revised if needed. Education on Elopement will be given to all staff on the process of what to do when an Elopement occurs. This completed by 8/17/22. Elopement audits will be done for 3x/wk. for 2 wks., 2x/wk. for 2 wks., and 1 x/wk. for 2 wks. and then monthly thereafter. All audit findings will be brought to QAPI for review and further recommendations.	

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F 689	Continued From page 2 able to leave the facility. R1 was assessed and no injuries noted. Further review of R1's incident report indicated R1's WanderGuard alarm did sound at the time of the incident, staff will continue with 30-minute safety checks, and possible room change to other side of the facility away from parking lot as staff determined R1's reason for wanting to leave the facility was to get to his truck outside of the facility. R1's incident report lacked evidence R1 was reassessed to determine appropriate interventions to prevent future elopements from facility. -On 6/3/22, at 8:00 p.m. staff responded to WanderGuard alarm at the front entrance of the facility and was unable to locate R1 in any direction. Two staff members assisted in the search for R1 and R1 was located at the apartment parking lot located behind the facility attempting to get into a truck. R1 was able to be redirected back into the facility by staff and assessed for injury which none were noted. Staff indicated interventions for R1's wandering and exit seeking behaviors included 30-minute safety checks, offering more activities for his cognition level, WanderGuard bracelet, grand pad to call family, redirection and reorientation, television and attempt to do one-to-one staffing when able. Further review of incident report lacked evidence resident was reassessed following incident to determine appropriate interventions to prevent future elopements from facility. R1's care plan as of 7/20/22, indicated R2 had delusions exhibited by stating "my truck is outside" with interventions of WanderGuard, redirection, and observe me for frequency of delusions. Further review of R1's care plan indicated R1 was at risk of elopement due to	F 689		

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F 689	Continued From page 3 cognitive status and exit seeking behaviors and interventions included change WanderGuard per manufacturer recommendations or as needed, room change close to Nurse's station for supervision, room change further distance from front exit, perform safety checks at frequency determined by assessment; provide a WanderGuard and perform checks per facility policy; 30-minute safety checks. On 7/20/22, at 10:25 a.m. R1 was observed self propelling in his wheelchair in his room. R1 had a WanderGuard on his left ankle. R1 would not respond to questions but stated "I would be better if I could get out of here" and stated he did not leave the facility without staff assistance. On 7/20/22, at 2:00 p.m. nursing assistant (NA)-A stated R1 required assistance with ADLs and was confused often tried to "escape". NA-A stated a couple months ago, NA-A was assisting another resident and happened to look out the window and observed R1 in the apartment complex's parking lot behind the facility without his wheelchair or walker. NA-A stated R1 was outside for approximately 10 minutes. NA-A was not aware of any other incidents of R1 exiting the facility without staff's knowledge. NA-A stated R1 required frequent redirection and reorientation and other interventions for exit seeking behaviors included offering a snack, fluids, newspaper, television, visiting with other residents and also R1 was on 30-minute safety checks. On 7/20/22, at 2:20 p.m. NA-B indicated R2 had confusion and behaviors included wandering through out the facility. NA-B stated a couple months prior Aitkin County was in a severe storm warning and while assisting another resident back	F 689		

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F 689	Continued From page 4 to their room, NA-B observed, out of a resident window, R2 running down the street and attempting to get into a vehicle located in the apartment parking lot behind the facility. Staff went outside to redirect R1 back into the facility and it was still raining at that time. Further, NA-B stated a couple weeks after the incident R2 "did the same thing again" and was found again in the parking lot behind the facility. NA-B stated interventions for R2's exit seeking behaviors included food, offering rest, and 30-minute safety checks. On 7/20/22, at 3:42 p.m. licensed practical nurse (LPN)-A stated R1 had poor cognition related to recent stroke and R2 would exit seek in the evening with interventions that include utilizing "grand pad" (electronic device) to call family, visiting and spending time with R2. LPN-A stated R2 had been found outside of the facility in the parking lot while it was raining looking for his truck to roll up the windows. On 7/20/22, at 4:22 p.m. LPN-B stated R1 required assistance by one staff for ADLs and was able to propel self in wheelchair around the facility. LPN-B stated R1 was confused and forgetful and would often get upset about staff taking his truck and would exit seek. LPN-B stated interventions of offering a snack and 30-minute safety checks were in place for R1's wandering and exit seeking behaviors. On 7/20/21, at 9:02 a.m. LPN-C stated R1's cognition and safety awareness had declined. LPN-C stated R1's behaviors consisted of eloping from the facility and interventions for R1's behaviors were "very minimal" but included offering snack, visits with other residents, 30-	F 689		

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F 689	Continued From page 5 minute safety checks and the WanderGuard system alarm. Further LPN-C stated a room change for R1 had not occurred but was unsure why. LPN-C stated R1's elopement on 5/25/22, was reported to the director of nursing (DON) however LPN-C felt the DON's interest was "depleted" and no new interventions had been implemented. On 7/21/22, at 10:03 a.m. LPN-D stated R1's cognition was poor due to recent stroke affecting R1's ability to understand concepts and safety concerns. LPN-D stated R1 had behaviors which included attempting to "escape constantly" and interventions included monitoring R1, and WanderGuard alarm. LPN-D stated R1 had left the facility and was found in the parking lot on one of her shifts and noted R1 to be quick. On 7/21/22, at 11:54 interview with MDS coordinator, nurse manager (NM) and administrator, defined an elopement as when a resident exits the building, and no staff witnessed the resident leaving and the resident is found outside. Review R1's incident dated 5/11/22, was determined not to be an elopement due to R1's WanderGuard setting off the alarm and was working properly even though R1 was found outside and exited the facility without staff, and intervention was to continue 30-minute safety checks. Staff confirmed R1 was not reassessed following incident and no additional interventions were implemented to prevent future elopements. Review of facility policy titled Elopement dated 2/24/22, defined elopement as a resident who is cognitively, physically, mentally, emotionally, and or chemically impaired wanders away, walks away, runs away, escapes or otherwise leaves a	F 689		

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F 689	Continued From page 6 care center environment unsupervised, unnoticed and or prior to their scheduled discharge. Further, facility policy indicated all resident will be assess on admission for risk of wandering or eloping and when a resident was identified at risk for elopement a plan would be put into place to include interventions to prevent elopement. Facility policy directed staff if an elopement does occur staff would need to complete a medical evaluation to identify potential injuries, notify family, notify physician, investigate to determine how the elopement occurred in order to correct any underlying contributing factors, complete an Incident Report, and report the elopement to the state agency. In addition, the facility policy failed to address the need to reassess a resident following a successful elopement and determine a root cause to what interventions currently place are working and which interventions are not working and the need to determine new appropriate interventions to prevent future elopements.	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/19/22

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F 880	Continued From page 7 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 8 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure the use of personal protective equipment (PPE) was implemented to prevent the spread of COVID-19 per guidance by the Centers of Disease Control (CDC) when staff were observed not wearing eye protection in resident care areas when the facility was determined to be in high community transmission level, this had the potential to affect all 37 residents who were residing in the facility at the time of survey. Findings include: As of 7/20/22, at 10:23 a.m. according to CDC website for community transmission level, Aitkin County was in a high transmission rate. In review of Minnesota Department of Health (MDS) COVID PPE and Source Control Grids dated 4/7/22, high community transmission level direct staff to wear a face mask and eye protection while working with residents without suspected or confirmed COVID-19 virus.	F 880	AHS will ensure that the proper eye protection is used by staff to prevent the spread of COVID-19. All staff has the potential to be affected by not utilizing the proper eye protection. Education was provided to all staff by 8/17/22 on the proper eye protection to use, when to wear them. The policy for COVID-19 prevention, screening and identification was reviewed/revised. The DON or designee will do ransom audits 4X/week X 1 week, 2X/week x 1 week and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 880	Continued From page 9 On 7/20/22, at 9:05 a.m. three nursing staff were observed on the Townsquare Unit wearing a surgical mask and not utilizing eye protection. Two of the nursing staff enter room 135. On 7/20/22, at 10:12 a.m. an activity staff member was observed, wearing a surgical mask and regular prescription eyeglasses, in the courtyard of Townsquare unit assisting residents into the area to begin a game. The floor nurse on Townsquare unit was observed wearing a surgical mask and not utilizing eye protection and entered a resident room. On 7/20/22, at 2:00 p.m. nursing assistant (NA)-A stated staff were expected to wear a surgical mask while working with resident's and staff are expected to wear eye protection only in isolation rooms. On 7/20/22, at 2:20 p.m. NA-B stated staff are expected to wear a mask and eye protection while in resident care areas. When asked why NA-B did not have eye protection on, NA-B stated she forgot and was not sure why no other staff were wearing them at that time. NA-B stated the importance of wearing eye protection was to protect and minimize the spread of COVID-19 virus. On 7/20/22, at 2:53 p.m. therapy staff was observed wearing a surgical mask and no eye protection while in room 104. On 7/20/22, at 2:58 p.m. NA-C stated staff were expected to wear a surgical mask and eye protection while in resident care areas. When asked why NA-C did not have eye protection on, NA-C stated due to wearing prescription eye	F 880		

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F 880	Continued From page 10 protection goggles "don't work" and NA-C was unaware of facility providing a full-face shield as an option. Further, NA-C stated other staff have not been wearing any eye protection "by choice". On 7/20/22, at 3:42 p.m. licensed practical nurse (LPN)-A stated staff were expected to wear a surgical mask in resident care areas. LPN-A stated administration sends a notification to all staff on PPE requirements and staff have not been wearing eye protection for at least two weeks. On 7/21/22, at 11:54 a.m. nurse manager (NM) stated corporate will send an email to NM every Friday with the county level and Aitkin County at that time was in low status, so staff were expected to wear a surgical mask in resident care areas. On 7/25/22, at 1:38 p.m. returned call from corporate registered nurse (RN) stated each week an update is sent by the corporate office to each facility with their community transmission level rate whether its high, moderate or low and based on that the facility would be expected to refer to the facility policy to determine what PPE staff were required to wear. Corporate RN confirmed email dated 7/14/22, to the facility Aitkin County was in a high community transmission level which staff then are expected to wear eye protection and a mask in resident care areas. Review of facility policy titled Coronavirus Prevention, Screening, and Identification dated 2/11/22, directed staff to wear a mask and eye protection in all resident areas during working hours. However, facility policy lacked evidence of	F 880		

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F 880	Continued From page 11 procedure to ensure CDC guidance in regards to community transmission levels are being followed. Review of facility policy titled COVID-19 Testing dated 3/10/22, indicated transmission rates will be reviewed by corporate staff weekly and will be notified of eye protection requirements. Further review of policy directed staff eye protection was to be worn in all resident care areas as indicated by county transmission rate.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 21, 2022

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

Re: Reinspection Results
Event ID: 99SX12

Dear Administrator:

On August 22, 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 survey completed on August 22, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00002	A. BUILDING: _____ B. WING _____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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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 7/20/22 through 7/21/22, 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/04/22

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H51193244C (MN84949) with a licensing order issued at 0830. 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 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.	2 000		

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2 000	Continued From page 2 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 interview and document review, the facility failed to reassess, and develop interventions to provide adequate supervision and safety for elopement for 1 of 3 residents (R3) identified who exited the facility three times without staff assistance. Findings include: R1's quarterly Minimal Date Set (MDS) dated 5/24/22, indicated R1 had diagnoses which included dementia, hemiplegia and seizure	2 830	Corrected	8/19/22

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2 830	Continued From page 3 disorder. Further review of MDS indicated R1 exhibited no behaviors of wandering and required extensive assistance of one staff for activities of daily living (ADLs) such as bed mobility, transfers, ambulation, dressing, toileting and R1 was independent with mobility utilizing a wheelchair. Review of R1's Incident Reports indicated: -On 5/11/22, at 2:05 p.m. A staff member was outside in their vehicle and noticed R1 outside of facility walking on grass area between the facility parking lot and the building. R1 stated he was outside to roll up "his car windows" due to it raining. R1's WanderGuard alarm was sounding and R1 was easily redirected back into the facility and continues to be fixated on finding his car. Further review of R1's incident, lacked evidence of R1 being reassessed to determine appropriate interventions to prevent future elopements from facility. -On 5/25/22 at 7:20 p.m. staff was in another resident room and observed R1 walking through East parking lot towards the street south of the facility. As staff walked out of the facility and silenced alarm, R1 was receptive to staff's instructions and a little aggression with not being able to leave the facility. R1 was assessed and no injuries noted. Further review of R1's incident report indicated R1's WanderGuard alarm did sound at the time of the incident, staff will continue with 30-minute safety checks, and possible room change to other side of the facility away from parking lot as staff determined R1's reason for wanting to leave the facility was to get to his truck outside of the facility. R1's incident report lacked evidence R1 was reassessed to determine appropriate interventions to prevent future elopements from facility.	2 830		

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2 830	Continued From page 4 -On 6/3/22, at 8:00 p.m. staff responded to WanderGuard alarm at the front entrance of the facility and was unable to locate R1 in any direction. Two staff members assisted in the search for R1 and R1 was located at the apartment parking lot located behind the facility attempting to get into a truck. R1 was able to be redirected back into the facility by staff and assessed for injury which none were noted. Staff indicated interventions for R1's wandering and exit seeking behaviors included 30-minute safety checks, offering more activities for his cognition level, WanderGuard bracelet, grand pad to call family, redirection and reorientation, television and attempt to do one-to-one staffing when able. Further review of incident report lacked evidence resident was reassessed following incident to determine appropriate interventions to prevent future elopements from facility. R1's care plan as of 7/20/22, indicated R2 had delusions exhibited by stating "my truck is outside" with interventions of WanderGuard, redirection, and observe me for frequency of delusions. Further review of R1's care plan indicated R1 was at risk of elopement due to cognitive status and exit seeking behaviors and interventions included change WanderGuard per manufacturer recommendations or as needed, room change close to Nurse's station for supervision, room change further distance from front exit, perform safety checks at frequency determined by assessment; provide a WanderGuard and perform checks per facility policy; 30-minute safety checks. On 7/20/22, at 10:25 a.m. R1 was observed self propelling in his wheelchair in his room. R1 had a WanderGuard on his left ankle. R1 would not	2 830		

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2 830	Continued From page 5 respond to questions but stated "I would be better if I could get out of here" and stated he did not leave the facility without staff assistance. On 7/20/22, at 2:00 p.m. nursing assistant (NA)-A stated R1 required assistance with ADLs and was confused often tried to "escape". NA-A stated a couple months ago, NA-A was assisting another resident and happened to look out the window and observed R1 in the apartment complex's parking lot behind the facility without his wheelchair or walker. NA-A stated R1 was outside for approximately 10 minutes. NA-A was not aware of any other incidents of R1 exiting the facility without staff's knowledge. NA-A stated R1 required frequent redirection and reorientation and other interventions for exit seeking behaviors included offering a snack, fluids, newspaper, television, visiting with other residents and also R1 was on 30-minute safety checks. On 7/20/22, at 2:20 p.m. NA-B indicated R2 had confusion and behaviors included wandering through out the facility. NA-B stated a couple months prior Aitkin County was in a severe storm warning and while assisting another resident back to their room, NA-B observed, out of a resident window, R2 running down the street and attempting to get into a vehicle located in the apartment parking lot behind the facility. Staff went outside to redirect R1 back into the facility and it was still raining at that time. Further, NA-B stated a couple weeks after the incident R2 "did the same thing again" and was found again in the parking lot behind the facility. NA-B stated interventions for R2's exit seeking behaviors included food, offering rest, and 30-minute safety checks. On 7/20/22, at 3:42 p.m. licensed practical nurse	2 830		

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2 830	Continued From page 6 (LPN)-A stated R1 had poor cognition related to recent stroke and R2 would exit seek in the evening with interventions that include utilizing "grand pad" (electronic device) to call family, visiting and spending time with R2. LPN-A stated R2 had been found outside of the facility in the parking lot while it was raining looking for his truck to roll up the windows. On 7/20/22, at 4:22 p.m. LPN-B stated R1 required assistance by one staff for ADLs and was able to propel self in wheelchair around the facility. LPN-B stated R1 was confused and forgetful and would often get upset about staff taking his truck and would exit seek. LPN-B stated interventions of offering a snack and 30-minute safety checks were in place for R1's wandering and exit seeking behaviors. On 7/20/21, at 9:02 a.m. LPN-C stated R1's cognition and safety awareness had declined. LPN-C stated R1's behaviors consisted of eloping from the facility and interventions for R1's behaviors were "very minimal" but included offering snack, visits with other residents, 30-minute safety checks and the WanderGuard system alarm. Further LPN-C stated a room change for R1 had not occurred but was unsure why. LPN-C stated R1's elopement on 5/25/22, was reported to the director of nursing (DON) however LPN-C felt the DON's interest was "depleted" and no new interventions had been implemented. On 7/21/22, at 10:03 a.m. LPN-D stated R1's cognition was poor due to recent stroke affecting R1's ability to understand concepts and safety concerns. LPN-D stated R1 had behaviors which included attempting to "escape constantly" and interventions included monitoring R1, and	2 830		

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2 830	Continued From page 7 WanderGuard alarm. LPN-D stated R1 had left the facility and was found in the parking lot on one of her shifts and noted R1 to be quick. On 7/21/22, at 11:54 interview with MDS coordinator, nurse manager (NM) and administrator, defined an elopement as when a resident exits the building, and no staff witnessed the resident leaving and the resident is found outside. Review R1's incident dated 5/11/22, was determined not to be an elopement due to R1's WanderGuard setting off the alarm and was working properly even though R1 was found outside and exited the facility without staff, and intervention was to continue 30-minute safety checks. Staff confirmed R1 was not reassessed following incident and no additional interventions were implemented to prevent future elopements. Review of facility policy titled Elopement dated 2/24/22, defined elopement as a resident who is cognitively, physically, mentally, emotionally, and or chemically impaired wanders away, walks away, runs away, escapes or otherwise leaves a care center environment unsupervised, unnoticed and or prior to their scheduled discharge. Further, facility policy indicated all resident will be assess on admission for risk of wandering or eloping and when a resident was identified at risk for elopement a plan would be put into place to include interventions to prevent elopement. Facility policy directed staff if an elopement does occur staff would need to complete a medical evaluation to identify potential injuries, notify family, notify physician, investigate to determine how the elopement occurred in order to correct any underlying contributing factors, complete an Incident Report, and report the elopement to the state agency. In addition, the facility policy failed to address the need to reassess a resident	2 830		

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2 830	Continued From page 8 following a successful elopement and determine a root cause to what interventions currently place are working and which interventions are not working and the need to determine new appropriate interventions to prevent future elopements. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to appropriate supervision to prevent elopement or respond to exit-seeking behavior. The DON or designee could also and ensure appropriate comprehensive assessments and interventions were developed and implemented for all residents with the potential to be affected. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk for exit-seeking behaviors and elopement. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures and audit to prevent potential elopements and/identify exit-seeking behaviors. The DON or designee should also ensure staff perform a comprehensive assessment or root cause analysis as needed to ensure interventions are effective, in place and re-evaluated as often as necessary. The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		