DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 25, 2021

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

RE: CCN: 245270
Cycle Start Date: June 3, 2021

Dear Administrator:

On August 4, 2021, we notified you a remedy was imposed. On August 19, 2021 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 13, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 19, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 16, 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 July 19, 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 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

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August 25, 2021

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

Re: Reinspection Results
Event ID: YBPQ12

Dear Administrator:

On August 19, 2021 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 July 19, 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
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Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered

August 4, 2021

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

RE: CCN: 245270
Cycle Start Date: June 3, 2021

Dear Administrator:

On June 16, 2021, we informed you that we may impose enforcement remedies.

On July 19, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not 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. 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 July 12, 2021, the situation of immediate jeopardy to potential health and safety cited at F600 was removed.

On July 19, 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 19, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 19, 2021. They will also notify the State Medicaid

Agency that they must also deny payment for new Medicaid admissions effective August 19, 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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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, Whitewater Health Services is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 19, 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 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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 December 3, 2021 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (IDR) / 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 electronic 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.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	C 07/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(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 7/15/21-7/19/21, 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 complaints were found to be SUBSTANTIATED: H5270026C (MN00074610), with a deficiency cited at F689. The survey resulted in an Immediate Jeopardy (IJ) at F689. The IJ began on 7/7/21. The IJ was identified on 7/16/21 and the administrator and director of nursing were notified of the immediate jeopardy at 2:23 p.m. on 7/16/21. The IJ was removed on 7/19/21, but noncompliance remained at the lower scope and severity level of D, isolated with the potential to cause more than minimal harm. H5270027C (MN00074620), with a deficiency cited at F600 for PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents The above findings constituted substandard quality of care, and an extended survey was conducted on 7/16/2021. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/10/2021

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 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 observation, interview and document review, the facility failed to ensure residents were free from physical abuse for 1 of 2 residents (R4) reviewed for abuse when R4 had received cares in a rough manner and was slapped in the face. This resulted in an immediate jeopardy (IJ) situation for R4 who was totally dependent on staff for all cares and cognitively unable to report	F 600	Past noncompliance: no plan of correction required.	8/10/21

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F 600	Continued From page 2 any abuse. The immediate jeopardy began on 7/8/21 when it was identified by family member (FM)-D, R4 was treated rough while receiving cares and was identified on 7/15/21. The facility administrator and the director of nursing (DON) were notified of the immediate jeopardy at 6:19 p.m. on 7/15/21. The immediate jeopardy was removed on 7/12/21, and the deficient practice corrected prior to the start of the survey and was therefore Past Noncompliance. Findings include: R4's admission Record indicated following diagnosis: Alzheimer's disease with late onset, muscle weakness (generalized) and aphasia (loss of ability to understand or express speech). R4's care plan included "[R4] is a vulnerable adult and is at risk for abuse/maltreatment r/t [related to] age, nursing home placement, Alzheimer's Dementia, and impaired mobility. She is dependent on staff to report episodes of abuse/maltreatment. She is dependent on staff to help remove her from potentially dangerous situations." During an observation on 7/15/21, at 9:45 a.m. R4 was seen resting in bed, an attempt was made to interview R4, but did not answer any questions. R4's physician progress note dated 7/6/21, included R4 "has progressive dementia, osteoporosis and hypertension. She still has behavioral issues where she will moan	F 600		

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F 600	Continued From page 3	F 600		

repeatedly in the same tone. It is bothersome to other residents and I witnessed that in the lobby today. She is unsteady. She has had slow weight loss which is expected due to her advancing dementia. She does not appear to be any pain [sic]." The note also indicated R4's prognosis was poor.

Review of an email from FM-D to administrator dated on 7/8/21, at 10:26 a.m. requesting trained medication aid (TMA)-A not be alone with R4. FM-D included feeling TMA-A has a lack of empathy and no respect for R4. FM-D included "TMA-A doesn't hurt her that I can tell but he is very rough with her and she is always extremely upset with the way he treats her."

R4's progress note dated on 7/8/21, at 10:45 a.m. a registered nurse clinical consultant (RNCC) wrote: Spoke with [FM-D] regarding concerns she had about care she had observed. She reports she observed [TMA-A] providing care with little empathy and that she did not believe he was hurting [R4], she did feel he was too rough with care. Assured her we will look into the concern and communicate further with her once we have investigated and that caregiver will not be in the facility until investigation is completed. She repeated she did not feel he was hurting her, just that it looked like he was antagonizing on her the video [sic] when helping her dress."

During an interview on 7/15/21, at 9:55 a.m. a registered nurse (RN-B) stated that any reported maltreatment or abuse of a resident should be immediately reported after making sure the person was safe.

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F 600	Continued From page 4 According to an interview on 7/15/21, at 12:40 p.m. the social worker (SW-A) stated she had not been in contact with FM-D in relation to her allegation of "rough handling". SW-A stated that due to the "gravity of the situation" she was not initially made aware of the incident, but had since been "filled in." SW-A stated she was unaware of any previous complaints against TMA-A, but stated residents had said TMA-A was a very large and strong person. During an interview on 7/15/21, at 12:49 p.m. administrator reported FM-D had contacted him on 7/8/21 in the morning, asking for his Email address and indicating she did not want R4 to be cared for by TMA-A anymore. Administrator stated he then received an Email from FM-D with her concerns. Administrator stated that a conference call was then arranged with himself, the director of nursing (DON) and RNCC in attendance. At that time, FM-D told them she had placed a camera in R4's room. FM-D told the facility the camera was motion activated and would capture a minute long video that was stored in a chip in the camera and FM-D could view it remotely. Administrator said FM-D told them she had two videos in which TMA-A appeared to be handling R4 in a rough manner and after seeing the second one, FM-D decided to report the behavior to the facility. The administrator said they had asked to view the videos and FM-D brought her phone in on 7/9/21 and they were able to watch them. The administrator described what he saw as this: TMA-A picking R4 up out of bed like a little kid (administrator demonstrated picking up a child in a cradle hold) and added that is not a typical	F 600		

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F 600	Continued From page 5 transfer. TMA-A was getting her dressed and tugging on her arms and her sleeves. TMA-A was putting R4's shirt on; he pulled behind her shoulders, kind of aggressive, and quick (administrator mimed pulling someone suddenly forward with one arm and yanking clothing down). TMA-A could have been more careful. At the end of first video, he looked like he hit her in the face. TMA-A had put a shirt on with a collar up, TMA-A made a motion across her face (administrator acted out the motion, hand open, arm extended and moving rapidly from one side to another in a typical slapping motion). Then she reacted. It's possible he was pulling her collar straight, but it looked like he hit her." The administrator also reported what he had observed when he viewed the second video on FM-D's phone: "In that one, it starts out, he had thrown the covers on the bed; it looks like he threw them over her face, but then he whips them off. Then he picks her up in the same way, and the same yanking on the arms and pulling/pushing from the back of the neck forward to get the shirt pulled down. She was being resistant, but that is her norm." Administrator indicated they were not in possession of the videos. He also stated they had called and suspended TMA-A as soon as they were aware of the allegation. Furthermore, administrator stated TMA-A had called them on 7/9/21 and gave his two-week termination notice, saying he was going to work at a different facility where he had been offered more money. On 7/13/21, the administrator stated both he and DON attempted to call TMA-A as they had completed their investigation and they planned to tell TMA-A that his termination was immediate, but he did not	F 600		

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F 600	Continued From page 6	F 600		

respond to their phone calls. DON added that when TMA-A had made the slapping motion in the first video, it looked as though R4 raised her arm as if to protect herself. DON stated R4 was mostly non-verbal with dementia and needed staff to anticipate her needs. She stated it was difficult for R4 to understand others, but would tolerate the provision of cares if people would take their time. She stated they had assessed R4 for any injuries after the incident, but did not see any, and no change in behavior was noted. DON stated one other resident (R5) had complained of TMA-A's care at some time in the past, likely a year or so previous. R5 had said TMA-A rushed through cares and he didn't want TMA-A to wrap his legs anymore as his legs were sensitive and TMA-A's hurry irritated them.

According to an interview with R5 on 7/15/21, 4:20 p.m. he was unable to remember any specific concerns he may have had with TMA-A. R5's quarterly MDS assessment dated 6/10/21 indicated he was mildly cognitively impaired

An attempted was made to contact TMA-A on 7/15/21 at 12:01 p.m. and a voice mail was left asking for a return call, but no call was received.

Two attempts were made to contact FM-D on 7/15/21 and one on 7/16/21, but there was no answer and the voicemail box was full so there was no ability to leave a message. An Email was also sent to FM-D request a return call with no response.

The facility had implemented intervention in response to the situation by 7/12/21; therefore, this is an issue of past non-compliance.

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WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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F 600	Continued From page 7 Interventions verified as having been implemented by the provider included immediate suspension of TMA-A, assessment of R4's physical condition, police notification, education on abuse prevention and reporting to staff, the initiation of care audits of persons similar to R4, and interviews of alert and oriented residents to continue for a period of two months. TMA-A was terminated from employment. Facility policy titled Abuse Prevention Program, dated February 2019. The policy mission statement indicates, "our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms." The past noncompliance immediate jeopardy began on 7/8/21. The immediate jeopardy was removed and the deficient practice corrected by 7/12/21, after the facility implemented a systemic plan that included the following actions: implemented an action plan to provide for R4's safety, TMA-A is no longer working at the facility, facility reviewed abuse policy and procedures and completed education and training to include staff burn out.	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		8/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	C 07/19/2021

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F 689	Continued From page 8 §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 prevent an elopement and provide safety for 1 or 2 residents (R1) identified at risk for elopement who successfully eloped from the building and was found outside. This deficient practices resulted in immediate jeopardy for R1. The IJ began on 7/7/21 at 7:00 p.m. when R1 exited the building and staff were unaware until staff saw R1 through a window and alerted staff of R1 being outside. The IJ was identified on 7/16/21 and the administrator and director of nursing (DON) were notified of the immediate jeopardy at 2:23 p.m. on 7/16/21. The IJ was removed on 7/19/21, but noncompliance remained at the lower scope and severity level of D, isolated with the potential to cause more than minimal harm. Findings include: R1's Admission Record, included diagnosis of Alzheimer's disease, anxiety, disorder,bilateral osteoarthritis of knee (bony degeneration of both knee joints) and type 2 Diabetes Mellitus. R1's care plan dated 8/30/19 with revision, for self-care deficit r/t [related to] cognitive deficits, impaired mobility as evidenced by R1 reliance on staff to assist with bathing, grooming and dressing. Intervention included R1 was	F 689	R1 was reassessed and care plan updated on July 17, 2021. Residents have the potential to be impacted by this practice. Assessments were completed to validate those that may be at risk for unattended exit from the facility on July 17, 2021. Care plans were updated if indicated based on these assessments. Elopement drills were held each shift July 16 and 17, 2021 with appropriate staff response noted. Elopement drills will continue to be completed as per routine on varying shifts to ensure staff response is appropriate. The elopement binder was checked and found to be up to date and contained relevant information on residents currently at risk. The binder will be updated when/if there are changes noted to a current resident's behavior or a new admission who is at risk for unattended exit. The Executive Director or designee provided training beginning July 16 to interdisciplinary staff on elopement prevention and response to attempted or actual unattended exits from the facility. Staff were educated at the beginning of the shift or prior to working their next scheduled shift. The Executive Director has tracked training to ensure PRN staff receive education prior to working and	

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F 689	Continued From page 9 independent in wheelchair locomotion. R1 is an elopement risk as evidenced by hx [history] of attempts to leave the building unattended, wanders aimlessly, impaired safety awareness and disorientated to place d/t [due to] Alzheimer's dementia. Interventions included: "observe for comments about "finding the truck" as this may signal he will attempt to go into parking lot to look for his truck. Date initiated 07/08/2021; BEHAVIOR HISTORY: May try to leave facility unescorted (FYI), Redirect as necessary, approach resident from the front and talk to resident in a calm reassuring manner. R1 will wear wander guard (test functional status per protocol). Educate family/visitors to advise when leaving patient following visit, encourage socialization with others and provide recreational programming, Engage in activities/tasks to keep occupied. R1's Progress note dated 6/7/21, 10:03 a.m. indicated staff responded when hearing R1's alarm and found him in his bathroom on the toilets after self-transferring. The note indicated he had not used his call-light and, "has poor personal safety awareness and believes he is able to be independent in room ..." R1's Progress note dated 6/11/21, 10:30 p.m. indicated R1's "alarm was going off" and his wheelchair (W/C) was observed outside a public bathroom and R1 was "observed standing in the restroom." R1's Physician's Progress note by medical doctor (MD-D) on 6/29/2021 R1 was being seen for recertification of his nursing home stay. The note indicated he was suffering a lower respiratory	F 689	that new staff receive training during orientation. The Executive Director or designee is completing audits five times weekly for four weeks, then twice weekly for eight weeks to validate compliance with and knowledge of elopement guidelines. These audits were initiated July 18, 2021, and will continue for twelve weeks or longer based on review and recommendations of the facility quality assurance and performance improvement committee.	

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F 689	Continued From page 10	F 689		

infection at time of MD visit and that R1 was noted to have "Alzheimer's dementia requiring 24-hour supervision. He needs a lot of redirection and guidance as he tries to leave the building."

R1's Progress note dated 7/7/21, 7:30 p.m. indicated, "Resident escaped out the front door. The alarm did not go off. Staff was alerted that resident was outside. Staff went outside and brought him in and did head to toe assessment [sic] and found no injuries. Nurse notified family, DON and DR. Maintance [sic] came and checked alarm and new Wanderguard was put on resident.

According to a Nursing Home Incident Report Summary, date of incident 7/7/21, 7:15 p.m. a description of the incident was: "resident was observed outside of window in parking lot by window. Staff responded and escorted back into building. Upon returning to building, wander guard system alerted, upon exiting, between 7pm and 7:15 p.m., the wander system did not trigger." Action taken to protect the resident was listed as: "maintenance came to building and checked the wander system with multiple ankle bracelets. Replaced ankle bracelet and attached additional bracelet to frame of wheelchair. Both of which were validated as operational.

A request was made for the facility investigation and evaluation of R1's 7/7/21 elopement incident. A document was provided titled Critical Event Analysis and Action Plan Worksheet signed on 7/8/21. The document indicated facility concentrated on the malfunction of the alarm, but failed to explore any issues related to supervision of R1 on the evening of 7/7/21 or interventions

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F 689	Continued From page 11 provided aside from the Wanderguard on that evening. The document indicated actions to take in relation to monitoring Wanderguard tags for placement and function, but stated only that nurses would be educated about that action. The document failed to include any all staff education or update to R1's care plan aside from the Wanderguard. A Wandering Risk Assessment was completed by the facility on 7/8/21 with a score of "moderate risk for wandering" and no listed score for elopement risk. The assessment tool failed to identify that R1 made multiple attempts to leave the facility or that he had succeeded in leaving on 7/7/21, although it continued to identify a care plan focus area of elopement. A previous Wandering Risk Assessment completed on 3/1/21 resulted in an identical score with no comment on R1's attempts to leave the facility. On 7/15/21, 9:15 a.m. R1 was observed to be leaving the dining area of the facility independently and moving towards the main entrance of the facility. R1 was observed to have Wanderguard tag attached to the right side of his W/C and wearing one on his left ankle. A staff person approached and said to R1, "we can ' t go in there right now, how about you stay out here with us." R1 asked, "where can I go then?" Staff brought him to watch television about 10 feet from where he had been previously. On 7/15/21, 10:05 a.m. R1 was observed to have moved from the television area to the beginning of the West Wing of the building, about 20 feet from the main entrance. He was unable or did not respond to any questions at that time.	F 689		

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F 689	Continued From page 12 On 7/15/21, 10:45 a.m. R1 was observed to have moved from the West Wing across the front lobby area to sit in a small hallway 20-30 feet from the main entrance and was napping in his chair. According to an interview on 7/15/21, at 12:12 p.m. a licensed practical nurse (LPN-A) stated on 7/7/21, R1 was sitting in the start of the East Wing headed away from the lobby. LPN-A stated it was a busy time of the shift and she was on her way to assist a different resident at about 7:00 p.m. Shortly afterwards she stated staff were alerted by a resident that they had seen R1 outside of the facility. LPN-A reported she immediately went to get him, and he was found in the parking lot approximately 200 feet from the entrance. R1 had moved along the driveway the direction delivery trucks go, but had turned up into a small parking area where the facility bus is parked. When questioned by LPN-A about his reason for being outside, R1 replied, "I was trying to get on the bus." LPN-A stated the Wanderguard alarm system had not sounded when R1 left the building, but did sound when R1 was assisted back in through the front entrance. LPN-A stated it was important to check the function of the Wanderguard tag, and it should be checked every shift; however, prior to the 7/7/21 incident they had not been checking it that often, nor were they documenting when they did check them. LPN-A said in her estimation R1 would attempt to get out the front entrance daily, and there were times when she was working that they would hear the front alarm sound multiple times during a shift when R1 would attempt to leave. According to an interview 7/15/21, 12:20 p.m. a family member (FM-B) stated about R1, "he's like	F 689		

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F 689	Continued From page 13 an escape artist." During an interview 7/16/21, 11:40 a.m. LPN-B stated she was aware of R1's elopement risk, but was unsure of any new interventions to keep him safe, first saying they may have moved him to a different room, then added she remembered he was now wearing two alarm tags instead of one. She stated she had not received any recent training related to elopements, but usually only works every other weekend. She stated she thought they were to check the Wanderguard alarms daily and that this was not a new practice. According to an interview 7/16/21, 11:42 a.m. a nursing assistant (NA-A) said she was aware that someone in the building had recently eloped but did not know any specifics. NA-A said she had not had any training on elopement since she had been in orientation (May 2020), and stated a resident who eloped from the building was at risk of being out in the street and getting hit by a car or of having a fall. NA-A said it was important for them to know where residents were at all times. NA-A reported that she was not a regularly scheduled employee, but worked on-call. According to an interview 7/16/21, 11:50 a.m. a registered nurse (RN-A) stated she worked at two other facilities and had training on what to do in case of elopement at those facilities, and thought she had training here after an elopement sometime in the past year, but she was unsure of the date. RN-A said nurses were to check to be sure the resident's Wanderguard tags were in place, but said they had not been checking the function of the tags to sound the alarm.	F 689		

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F 689	Continued From page 14 During an interview 7/16/21, 12:33 the DON described the facilities education and training program, stating they used an on-line education system called Relias and all staff received a monthly assignment to complete; however, she was unsure if the Relias training included any content about elopement. DON also said she was unsure if part time staff completed their assigned training. DON said the facility provided elopement drills. DON said they tried to have the elopement drills done on a variety of shifts and that all frontline staff were expected to participate in those drills. DON also stated they had a "communication sheets" that would provide information to staff on any changes in facility and information such as recent elopement, and that it was the responsibility of all nursing staff to read those if they had not been working recently. DON stated they had initiated training following R1's elopement on 7/7/21 although indicated some front line may not have received the training. According to an interview 7/16/21, 1:35 p.m. the administrator stated an expectation for all staff, from all departments to have been re-trained on elopement whenever a resident left the building unescorted. Administrator stated that training should include a review of the facility policy and procedures as well as training on how to check Wanderguard tag placement and how to replace them if needed. Administrator confirmed this day he was just now training LPN-B, NA-A and RN-A on the policy and procedures of elopement. He said, "yes, this was the first time those staff had been here for a while so I was talking to them about elopement and eye-protection. I guess they hadn't been in the building since the previous concern [R1's elopement]." When asked	F 689		

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F 689	Continued From page 15 why he was completing the education now the administrator stated, he needed to make sure he gave the elopement education to dietary staff and therapy staff. The administrator confirmed that he had not yet done so and said, "our first priority is for care staff as they have the most interaction." The administrator confirmed the facility had been performing elopement drills and stated an expectation for all staff in the building to be involved in a drill when it was being performed. He stated all staff from all shifts should receive training and feel comfortable in the expected response. The administrator reviewed documentation of a facility drill held 5/19/21 and confirmed that the participants, the maintenance director, DON, MDS-C, social worker and a therapy staff were not front line staff, and the document did not indicate all staff in the facility had participated in the drill. A request was made for documentation of completed training related to R1's 7/7/21 elopement. On 7/15/21 a document was received titled training log/in-service-date of training 7/9/21. Content "check placement of Wanderguard." The objective was listed as, "nursing staff are to check placement of Wanderguard's each shift and document on TAR [treatment administration record]." No further education information was provided, and the sheet was signed by the DON and four nurses, and one trained medication aid. No NAs were listed, no other department staff had signed attendance. On 7/16/21 the document was provided again in the afternoon and at that time had three additional nurses and three NAs added to the training list.	F 689		

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F 689	Continued From page 16 A request was made for evidence of staff completion of Relias training modules; however, the DON stated on 7/16/21 that their Relias modules did not contain content on elopement. Policy titled, North Shore Healthcare, Elopement dated 7/7/2015. The policy purpose was listed as "to safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. Elopement drill will be held quarterly." The document indicated that once a patient/resident was located a head to toe assessments should be done and the social service designee should assess for emotional distress. Furthermore, the document indicated the resident should be provided one to one supervision until further arrangements could be made to ensure the resident's safety. The immediate jeopardy that began on 7/7/21 was removed on 7/19/21 when it could be verified the facility had implemented an appropriate removal plan including re-assessment of R1's elopement risk, a review of policies and re-education to all staff on the elopement policy, the initiation of, and continued plan for elopement drills and audits of resident wandering risk assessment and care plans. Additionally, a Quality Assurance committee met to discuss and review the plan on 7/17/21.	F 689		

Electronically delivered
August 4, 2021

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

Re: State Nursing Home Licensing Orders
Event ID: YBPQ11

Dear Administrator:

The above facility was surveyed on July 15, 2021 through July 19, 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 7/15/21-7/19/21, 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	2 000		

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(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) COMPLETE DATE
2 000	Continued From page 1 be completed. The following complaints were found to be SUBSTANTIATED: H5270026C (MN00074610) H5270027C (MN00074620) 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	2 000		

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2 000	Continued From page 2 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 prevent an elopement and provide safety for 1 or 2 residents (R1) identified at risk for elopement who successfully eloped from the building and was found outside. This deficient practices resulted in immediate jeopardy for R1. The IJ began on 7/7/21 at 7:00 p.m. when R1 exited the building and staff were unaware until	2 830	See Plan of correction in F689.	8/13/21

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2 830	Continued From page 3 staff saw R1 through a window and alerted staff of R1 being outside. The IJ was identified on 7/16/21 and the administrator and director of nursing (DON) were notified of the immediate jeopardy at 2:23 p.m. on 7/16/21. The IJ was removed on 7/19/21, but noncompliance remained at the lower scope and severity level of D, isolated with the potential to cause more than minimal harm. Findings include: R1's Admission Record, included diagnosis of Alzheimer's disease, anxiety, disorder,bilateral osteoarthritis of knee (bony degeneration of both knee joints) and type 2 Diabetes Mellitus. R1's care plan dated 8/30/19 with revision, for self-care deficit r/t [related to] cognitive deficits, impaired mobility as evidenced by R1 reliance on staff to assist with bathing, grooming and dressing. Intervention included R1 was independent in wheelchair locomotion. R1 is an elopement risk as evidenced by hx [history] of attempts to leave the building unattended, wanders aimlessly, impaired safety awareness and disorientated to place d/t [due to] Alzheimer's dementia. Interventions included: "observe for comments about "finding the truck" as this may signal he will attempt to go into parking lot to look for his truck. Date initiated 07/08/2021; BEHAVIOR HISTORY: May try to leave facility unescorted (FYI), Redirect as necessary, approach resident from the front and talk to resident in a calm reassuring manner. R1 will wear wander guard (test functional status per protocol). Educate family/visitors to advise when leaving patient following visit, encourage socialization with others and provide recreational	2 830		

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2 830	Continued From page 4 programming, Engage in activities/tasks to keep occupied. R1's Progress note dated 6/7/21, 10:03 a.m. indicated staff responded when hearing R1's alarm and found him in his bathroom on the toilets after self-transferring. The note indicated he had not used his call-light and, "has poor personal safety awareness and believes he is able to be independent in room ..." R1's Progress note dated 6/11/21, 10:30 p.m. indicated R1's "alarm was going off" and his wheelchair (W/C) was observed outside a public bathroom and R1 was "observed standing in the restroom." R1's Physician's Progress note by medical doctor (MD-D) on 6/29/2021 R1 was being seen for recertification of his nursing home stay. The note indicated he was suffering a lower respiratory infection at time of MD visit and that R1 was noted to have "Alzheimer's dementia requiring 24-hour supervision. He needs a lot of redirection and guidance as he tries to leave the building." R1's Progress note dated 7/7/21, 7:30 p.m. indicated, "Resident escaped out the front door. The alarm did not go off. Staff was alerted that resident was outside. Staff went outside and brought him in and did head to toe assessment [sic] and found no injuries. Nurse notified family, DON and DR. Maintance [sic] came and checked alarm and new Wanderguard was put on resident. According to a Nursing Home Incident Report Summary, date of incident 7/7/21, 7:15 p.m. a description of the incident was: "resident was	2 830		

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2 830	Continued From page 5 observed outside of window in parking lot by window. Staff responded and escorted back into building. Upon returning to building, wander guard system alerted, upon exiting, between 7pm and 7:15 p.m., the wander system did not trigger." Action taken to protect the resident was listed as: "maintenance came to building and checked the wander system with multiple ankle bracelets. Replaced ankle bracelet and attached additional bracelet to frame of wheelchair. Both of which were validated as operational. A request was made for the facility investigation and evaluation of R1's 7/7/21 elopement incident. A document was provided titled Critical Event Analysis and Action Plan Worksheet signed on 7/8/21. The document indicated facility concentrated on the malfunction of the alarm, but failed to explore any issues related to supervision of R1 on the evening of 7/7/21 or interventions provided aside from the Wanderguard on that evening. The document indicated actions to take in relation to monitoring Wanderguard tags for placement and function, but stated only that nurses would be educated about that action. The document failed to include any all staff education or update to R1's care plan aside from the Wanderguard. A Wandering Risk Assessment was completed by the facility on 7/8/21 with a score of "moderate risk for wandering" and no listed score for elopement risk. The assessment tool failed to identify that R1 made multiple attempts to leave the facility or that he had succeeded in leaving on 7/7/21, although it continued to identify a care plan focus area of elopement. A previous Wandering Risk Assessment completed on 3/1/21 resulted in an identical score with no comment on R1's attempts to leave the facility.	2 830		

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2 830	Continued From page 6 On 7/15/21, 9:15 a.m. R1 was observed to be leaving the dining area of the facility independently and moving towards the main entrance of the facility. R1 was observed to have Wanderguard tag attached to the right side of his W/C and wearing one on his left ankle. A staff person approached and said to R1, "we can ' t go in there right now, how about you stay out here with us." R1 asked, "where can I go then?" Staff brought him to watch television about 10 feet from where he had been previously. On 7/15/21, 10:05 a.m. R1 was observed to have moved from the television area to the beginning of the West Wing of the building, about 20 feet from the main entrance. He was unable or did not respond to any questions at that time. On 7/15/21, 10:45 a.m. R1 was observed to have moved from the West Wing across the front lobby area to sit in a small hallway 20-30 feet from the main entrance and was napping in his chair. According to an interview on 7/15/21, at 12:12 p.m. a licensed practical nurse (LPN-A) stated on 7/7/21, R1 was sitting in the start of the East Wing headed away from the lobby. LPN-A stated it was a busy time of the shift and she was on her way to assist a different resident at about 7:00 p.m. Shortly afterwards she stated staff were alerted by a resident that they had seen R1 outside of the facility. LPN-A reported she immediately went to get him, and he was found in the parking lot approximately 200 feet from the entrance. R1 had moved along the driveway the direction delivery trucks go, but had turned up into a small parking area where the facility bus is parked. When questioned by LPN-A about his	2 830		

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2 830	Continued From page 7	2 830		

reason for being outside, R1 replied, "I was trying to get on the bus." LPN-A stated the Wanderguard alarm system had not sounded when R1 left the building, but did sound when R1 was assisted back in through the front entrance. LPN-A stated it was important to check the function of the Wanderguard tag, and it should be checked every shift; however, prior to the 7/7/21 incident they had not been checking it that often, nor were they documenting when they did check them. LPN-A said in her estimation R1 would attempt to get out the front entrance daily, and there were times when she was working that they would hear the front alarm sound multiple times during a shift when R1 would attempt to leave.

According to an interview 7/15/21, 12:20 p.m. a family member (FM-B) stated about R1, "he's like an escape artist."

During an interview 7/16/21, 11:40 a.m. LPN-B stated she was aware of R1's elopement risk, but was unsure of any new interventions to keep him safe, first saying they may have moved him to a different room, then added she remembered he was now wearing two alarm tags instead of one. She stated she had not received any recent training related to elopements, but usually only works every other weekend. She stated she thought they were to check the Wanderguard alarms daily and that this was not a new practice.

According to an interview 7/16/21, 11:42 a.m. a nursing assistant (NA-A) said she was aware that someone in the building had recently eloped but did not know any specifics. NA-A said she had not had any training on elopement since she had been in orientation (May 2020), and stated a resident who eloped from the building was at risk

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2 830	Continued From page 8 of being out in the street and getting hit by a car or of having a fall. NA-A said it was important for them to know where residents were at all times. NA-A reported that she was not a regularly scheduled employee, but worked on-call. According to an interview 7/16/21, 11:50 a.m. a registered nurse (RN-A) stated she worked at two other facilities and had training on what to do in case of elopement at those facilities, and thought she had training here after an elopement sometime in the past year, but she was unsure of the date. RN-A said nurses were to check to be sure the resident's Wanderguard tags were in place, but said they had not been checking the function of the tags to sound the alarm. During an interview 7/16/21, 12:33 the DON described the facilities education and training program, stating they used an on-line education system called Relias and all staff received a monthly assignment to complete; however, she was unsure if the Relias training included any content about elopement. DON also said she was unsure if part time staff completed their assigned training. DON said the facility provided elopement drills. DON said they tried to have the elopement drills done on a variety of shifts and that all frontline staff were expected to participate in those drills. DON also stated they had a "communication sheets" that would provide information to staff on any changes in facility and information such as recent elopement, and that it was the responsibility of all nursing staff to read those if they had not been working recently. DON stated they had initiated training following R1's elopement on 7/7/21 although indicated some front line may not have received the training.	2 830		

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2 830	Continued From page 9 According to an interview 7/16/21, 1:35 p.m. the administrator stated an expectation for all staff, from all departments to have been re-trained on elopement whenever a resident left the building unescorted. Administrator stated that training should include a review of the facility policy and procedures as well as training on how to check Wanderguard tag placement and how to replace them if needed. Administrator confirmed this day he was just now training LPN-B, NA-A and RN-A on the policy and procedures of elopement. He said, "yes, this was the first time those staff had been here for a while so I was talking to them about elopement and eye-protection. I guess they hadn't been in the building since the previous concern [R1's elopement]." When asked why he was completing the education now the administrator stated, he needed to make sure he gave the elopement education to dietary staff and therapy staff. The administrator confirmed that he had not yet done so and said, "our first priority is for care staff as they have the most interaction." The administrator confirmed the facility had been performing elopement drills and stated an expectation for all staff in the building to be involved in a drill when it was being performed. He stated all staff from all shifts should receive training and feel comfortable in the expected response. The administrator reviewed documentation of a facility drill held 5/19/21 and confirmed that the participants, the maintenance director, DON, MDS-C, social worker and a therapy staff were not front line staff, and the document did not indicate all staff in the facility had participated in the drill. A request was made for documentation of completed training related to R1's 7/7/21 elopement. On 7/15/21 a document was received	2 830		

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2 830	Continued From page 10 titled training log/in-service-date of training 7/9/21. Content "check placement of Wanderguard." The objective was listed as, "nursing staff are to check placement of Wanderguard's each shift and document on TAR [treatment administration record]." No further education information was provided, and the sheet was signed by the DON and four nurses, and one trained medication aid. No NAs were listed, no other department staff had signed attendance. On 7/16/21 the document was provided again in the afternoon and at that time had three additional nurses and three NAs added to the training list. A request was made for evidence of staff completion of Relias training modules; however, the DON stated on 7/16/21 that their Relias modules did not contain content on elopement. Policy titled, North Shore Healthcare, Elopement dated 7/7/2015. The policy purpose was listed as "to safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. Elopement drill will be held quarterly." The document indicated that once a patient/resident was located a head to toe assessments should be done and the social service designee should assess for emotional distress. Furthermore, the document indicated the resident should be provided one to one supervision until further arrangements could be made to ensure the resident's safety. The immediate jeopardy that began on 7/7/21 was removed on 7/19/21 when it could be verified the facility had implemented an appropriate removal plan including	2 830		

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2 830	Continued From page 11 re-assessment of R1's elopement risk, a review of policies and re-education to all staff on the elopement policy, the initiation of, and continued plan for elopement drills and audits of resident wandering risk assessment and care plans. Additionally, a Quality Assurance committee met to discuss and review the plan on 7/17/21. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures for resident' elopements; then revise as needed to ensure the comprehensive assessment and care planning of such events; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		