P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically Submitted
July 15, 2022

Administrator
Olivia Restorative Care Center
1003 West Maple
Olivia, MN 56277

RE: CCN: 245290
Cycle Start Date: June 30, 2022

Dear Administrator:

On June 30, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 30, 2022, 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 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 July 30, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 30, 2022 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 30, 2022 (42 CFR 488.417 (b)).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require 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. <u>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.</u>

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 Sections 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, Olivia Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 30, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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, Licensing and Certification Program 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 30, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
July 15, 2022

Administrator
Olivia Restorative Care Center
1003 West Maple
Olivia, MN 56277

Re: State Nursing Home Licensing Orders
Event ID: 51XZ11

Dear Administrator:

The above facility was surveyed on June 28, 2022 through June 30, 2022 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING ______ B. WING ______	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE OLIVIA, MN 56277

(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 6/28/22, to 6/30/22, 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: H52902657C (MN84435), with a deficiency cited at F689. The survey resulted in an Immediate Jeopardy (IJ) at (F689). The IJ that began on 6/18/22, at 4:00 p.m., when R1 eloped from the facility, and the immediacy was removed on 6/30/22, at 1:53 p.m. when the facility implemented interventions to prevent potential for reoccurrence. The above findings constituted substandard quality of care, and an extended survey was conducted from 6/29/22 through 6/30/22. 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=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		7/22/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/22/2022

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 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, observation, and document review, the facility failed to provide adequate supervision despite being a known elopement risk, for 1 of 1 residents (R1) who left the facility, self-propelling in a wheelchair with the intent of returning to his home, over a mile away, with an air temperature at 90 degrees Fahrenheit (F). A stranger subsequently picked up R1 a few blocks away from the facility and brought him to R1's home in the community. This resulted in an immediate jeopardy (IJ) for R1 when, after he was returned to the facility on 6/18/22, the facility failed to place interventions that would prevent reoccurrence, placing R1 at risk for serious harm, injury, or death if he should elope again. The IJ began on 6/18/22, when the facility failed to place interventions to prevent R1 from eloping again and was identified on 6/29/22. The administrator and director of nursing (DON), were notified of the IJ on 6/29/22, at 4:28 p.m. The IJ was removed on 6/30/22, at 1:53 p.m. when the facility implemented interventions to prevent further elopements, but noncompliance remained at the lower scope and severity level 2, D, isolated scope, and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:	F 689	On 6/29/22 a WanderGuard was replaced back on R1. R1's care plan was changed to reflect the use of the WanderGuard, and an elopement risk assessment was completed. Staff were educated on R1's updated care plan. R1 will continue to have 1 to 1 meetings with activities and social services, and will be offered group or individual outings twice weekly. To prevent further incidents to all other potential residents, all WanderGuards will be checked by the nurse on each shift. All residents with an elopement risk have it reflected in their care plan. All WanderGuards are checked on each shift and all staff were re-educated on the elopement policy and the use of WanderGuards. A root cause analysis was completed for R1's elopement incident. The cause was determined to be a failure in following the manufacture instructions to have the WanderGuard checked daily. The daily checks of the WanderGuard's manufactured instructions were implemented, with the charge nurse checking them once on each shift. The	

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F 689	Continued From page 2	F 689		

R1's facesheet printed on 6/28/22, included a diagnoses of adjustment disorder with mixed disturbance of emotions and conduct, heart disease, high blood pressure, heart failure (when the heart doesn't pump as well as it should), and depression.

R1's quarterly Minimum Data Set (MDS) dated 4/15/22, indicated R1 was cognitively intact, had clear speech, was understood and could understand. R1 was independent in moving about on the unit in his wheelchair but required supervision off the unit. Walking occurred only once or twice during the MDS assessment period. In addition, the MDS indicated a wander/elopement alarm was not used.

R1's plan of care printed on 6/28/22, did not identify elopement as a focus area of concern.

R1's Elopement Risk Evaluation, dated 4/15/22, indicated R1 had a score of seven indicating he was at risk for elopement. The score was based upon the following seven parameters:
1. Ability to self-propel wheelchair
2. Habit/history of wandering or attempts to leave the building
3. Exhibited agitated behavior
4. Asked to go home
5. Had a psychiatric diagnosis
6. Family had voiced concerns that R1 may have a tendency to wander or elope
7. Taking medication which may cause confusion
An intervention checked off on the elopement risk evaluation form included, "exit alarm" which, according to the director of nursing (DON) during an interview on 6/29/22, at 9:15 a.m., meant a WanderGuard bracelet (a device worn by

Provider's Plan of Correction (F 689):

WanderGuard check was added to the TAR to be signed off by the nurse. Further, staff were reeducated on our elopement policy and R1's care plan.

The DON or designee will complete audits on the WanderGuard checks. Audits on WanderGuards were completed daily for 2 weeks then randomly and will remain on the TAR for the nurse to check each shift. Results of the audits will be brought to QAPI for discussion and review.

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F 689	Continued From page 3	F 689		

Continued From page 3

residents, who when in the vicinity of an exit door, the door automatically locks preventing the resident from leaving unattended). According to the elopement risk evaluation form, a WanderGuard was in use at that time, 4/15/22.

Discrepancies were noted in the facility documentation on whether R1 had or did not have a WanderGuard in place on 4/15/22. The MDS indicated he did not. Elopement Risk Evaluation indicated he did. The care plan did not mention a WanderGuard.

Physician orders for June 2022, indicated R1 could go on pass and/or LOA (leave of absence) with responsible a party and his medication.

A physician visit note dated 4/27/22, indicated R1 had been less agitated and understood he would be living at the facility long-term. R1 wanted to go out on pass and visit his wife and children. Family was concerned about his competency and his ability to make informed decisions. The physician indicated, he too, was very concerned about that as well. R1 had significant behaviors in the past including suicidal gesturing. The physician noted he would seek psychiatric input into his mental status.

A psychiatry note dated 4/28/22, indicated R1 was impulsive and his lack of insight extended to his desire to go home. A psychiatry note dated 5/31/22, indicated R1 lacked safety awareness, had short term memory impairment and impairment in concentration.

A progress note dated 6/17/22, indicated R1 was seen by a physician on routine rounds and R1 was upset and venting to the physician about

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F 689 Continued From page 4 F 689

wanting to go home and wanting all of his collections (coins and marbles) brought to the facility. The physician was informed that R1 never really slept and spent all day and night in his wheelchair with an occasional half hour in his recliner. The physician ordered Ativan (medication to relieve anxiety) to be administered one half hour before bedtime.

A progress note dated 6/18/22, at 6:33 p.m. indicated the facility received a call from family member (FM)-C who stated R1 arrived to his home in the community at 4:15 p.m. in his wheelchair. The DON was notified and staff were advised to call law enforcement to pick up R1 and return him to the facility. R1 returned at 4:50 p.m. and was assessed and no injuries were noted.

An incident report completed on 6/18/22, at 5:00 p.m. by the DON read: "On 6/18/22, at 4:15 PM, the charge nurse received a call from R1's wife. R1 had left the building in his wheelchair and gone home. Per the wife's explanation, he propelled his wheelchair part way and was picked up by a friend in a pick up [truck] and taken the rest of the way home. R1 informed staff, 'I wanted to go home.' 'I didn't do anything wrong.' The DON was called who advised charge nurse to immediately call 011 [911] and ask for police to go to the home address here in community and bring R1 back to the nursing home. No injuries. Alert and oriented. The incident report indicated there were no predisposing situational factors, including active exit seeker. R1 was upset because he wanted a young girl to give him a shower and was told she could not. He also "just wanted to go home" to get his marbles and coin collections. No witnesses were found. Following the incident, the DON, administrator, social services and R1's

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OLIVIA RESTORATIVE CARE CENTER	**1003 WEST MAPLE OLIVIA, MN 56277**

(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 689	Continued From page 5 physician were notified." During an interview on 6/28/22, at 2:11 p.m. trained medication aide (TMA)-B stated she was on duty when R1 eloped. TMA-B stated at about 3:00 p.m. on 6/18/22, R1 had been upset because he wanted a certain employee to give him a bath and that employee could not. According to TMA-B, the next thing she knew, FM-C called the facility at approximately 4:15 p.m. to report R1 was at her house. TMA-B stated they were not aware R1 had left the building, adding that R1 had gone out an exit door between his room and the nurses station without telling anyone. TMA-B did not know if R1 was an elopement risk, stating it was not uncommon for R1 to self-propel outside in his wheelchair to sit for a bit. TMA-B stated R1 had a WanderGuard on his wheelchair for a while, but it had been removed and she did not know why. During a telephone interview on 6/28/22, at 2:14 p.m. FM-C recalled the shock she felt when, "A guy showed up in the driveway in a black pick up. A guy got him [R1] out in his pick up and brought him up to the house in his wheelchair." FM-C stated she did know this man who told her R1 had been sitting on the road so he asked R1 if he needed help; R1 asked him to take him to his house. FM-C stated R1 was exhausted and it was hot that day, "I think he pushed himself in the wheelchair, self-propelling, that wears him out. Hotter than heck that day." FM-C didn't know how far R1 got before the man picked him up, adding, "we live clear across down." FM-C stated when she told the man R1 wasn't supposed to be here, he exited real quick. FM-C stated, R1, "Flew in here and was looking for something. Money. He doesn't understand it's not safe to take everything	F 689		

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	245290	A. BUILDING ______ B. WING ______	C 06/30/2022

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F 689	Continued From page 6 valuable to the nursing home, that's mainly what he wanted when he came home, he wanted to look at his marble collection." FM-C stated she thought the time was about 6:00 p.m., but was not sure. FM-C stated R1 had lived at the facility since 2/3/22, and had not tried to go home before. When asked if R1 had an alarm bracelet on is body or wheelchair, FM-C stated no, "they put one on and he cut it off," adding, if R1 wants something bad enough, he will do it. According to FM-C, she was at the facility the evening of 6/17/22, for beer and brat night when R1 told her he cut off his WanderGuard bracelet. FM-C stated she didn't know what to believe because R1 fibs a lot, so she didn't report this to the staff. According to website www.accuweather.com, the temperature in the community on the afternoon of 6/18/22, was 93 degrees F. During an interview on 6/28/22, at 3:38 p.m. the DON stated on 6/18/22, a Saturday afternoon, the charge nurse called her to report that FM-C called the facility to inform them R1 was at her home. The DON advised staff to call 911 to have law enforcement pick him up and return him to the facility. The DON then called the administrator and social services and called back to the facility to talk to staff. Fifteen minute checks were initiated. The DON stated the investigation started on Monday 6/20/22, when a regional consultant (RC)-D and vice president of clinical services (VPCS)-E arrived to the facility. The investigation included a care conference with R1, FM-C, and other family members. According to the DON, the family stated they were expecting it [elopement] to happen sooner because R1 called them and threaten it all the time. The DON stated R1 was not unhappy at the facility; he just wanted to go home and get his coin and marble collections.	F 689		

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According to the DON, the investigation included talking to R1, the staff and a resident who R1 followed out the side door on the day of he elopement. The DON stated R1 had a WanderGuard bracelet on until 6/18/22, when unbeknownst to the facility, R1 cut it off. At that time, the facility was not conducting daily verification of WanderGuard bracelets on residents and therefore it went undetected. When asked if the facility had considered reapplying the WanderGuard bracelet following the elopement since R1 was assessed at being at risk for elopement, the DON stated they were told by RC-D and VPCS-E that R1's elopement was purposeful and this BIMS (brief interview for mental status) was 14 (indicating intact cognition), so a WanderGuard was not necessary. The DON stated following their investigation, RC-D and VPCS-E concluded the elopement was "not a true elopement" because R1 had a purpose and knew where he was going. During this interview, the administrator joined the conversation and stated she understood from the investigation that a WanderGuard was not necessary because R1 left the facility purposefully and knew where he was going, and for those reasons it was deemed not an elopement.

During the same interview, at 4:00 p.m., the DON placed a phone call to VPCS-E who stated, "We're not calling it an elopement. He knew what he was doing. He planned to leave. It was safe for him to leave the facility unsupervised - he's his own person and his BIMS is 14." VPCS-E stated a WanderGuard was not appropriate for R1, adding, "He's a guy I would let sign out and go. He collects stuff and wanted to go home and see it." VPCS-E stated R1 had the capability to cut

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the WanderGuard bracelet off and therefore it would not be effective. VPCS-E stated the facility implemented one to one activities with R1 which was more proactive and they educated R1; "He's his own person." VPCS-E stated they "Reviewed R1's behaviors, he rolls away, gets mad, that's why we added impulsiveness to his care plan." The facility did not require residents to sign out when going outside to enjoy the weather.

During an interview on 6/28/22, at 5:06 p.m., the DON stated WanderGuard's were implemented at the facility in April 2022 when they closed their secure unit. R1 had a WanderGuard bracelet placed on his wheelchair just prior to a 4/15/22, elopement risk evaluation, but according to the DON, the placement date was not documented. The DON identified the facility was not verifying placement of WanderGuard's on residents until after the elopement incident on 6/18/22. R1 cut the WanderGuard bracelet off his wheelchair around suppertime on 6/17/22, but staff were not aware of this.

During an interview on 6/28/22, at 5:16 p.m., social services (SS)-A, stated one to one's were implemented with R1 following the elopement, adding R1 was welcomed to come in and visit; "he talks when he wants to talk." According to SS-A, the sessions were proactive...more apt to see if R1 had a specific need...able to gauge his compulsive behaviors and mood...intervene if needed.

During an interview on 6/28/22, at 5:20 p.m. activities director (AD)-A stated one to one sessions with R1 occurred with SS-A and staff in the activities department. These sessions were not scheduled, they were informal and the

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frequency was not defined. AD-A stated R1 participated in activities offered by the activity department on a daily basis, including weekends, adding R1 was out of his room often attending activities.

During an interview and observation on 6/28/22, at 6:20 p.m. in his room, R1 stated, "That day I was going to go home and I didn't tell anyone. I just left." R1 stated it was 90 degrees and he only went two or three blocks, traveling on the street before a man picked him up. "I have no idea who it was." R1 stated he went home to get some of his collections [coins and marbles]. R1 stated he had a WanderGuard bracelet on his leg but cut it off, adding he borrowed a scissor "from the cart they put the pills on," then put the bracelet in a drawer. R1 opened a drawer underneath a closet and said, "It's gone, I gave it to them." R1 did not know what day it was when he cut off the bracelet, adding another one was put on, but later taken off by staff.

During an interview on 6/29/22, at 9:54 a.m. the DON stated when R1 returned after his elopement on 6/18/22, social services director (SS)-A instructed staff to apply a WanderGuard bracelet to R1, however, when the investigation started on 6/20/22, they were instructed by RC-D and VPCS-E to remove it as R1 didn't need it. The DON stated she dragged her feet in removing it, adding, "I didn't think it should be removed." On 6/23/22, RC-D saw the bracelet was still on R1 and again instructed her to remove it. The DON stated it was left on until 6/24/22. The DON stated R1 was still at risk for elopement risk, adding, "He said he won't, but if he gets upset, his M.O. (modus operandi) is to leave. This was his first time; but it's a possibility."

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F 689	Continued From page 10 The DON stated R1 had child-like behaviors, and gave an examples of one day when he crawled under the bed because he was mad and another day when he faked a seizure and was sent to the ER. "He gets mad and has no impulse control." During a telephone interview on 6/29/22, at 10:07 a.m. (FM)-H and (FM)-I stated they were aware of the incident and had been concerned after hearing about the elopement. FM-I stated the facility should, "get that WanderGuard back on R1's wheelchair." FM-I stated they were told by the facility that R1 was an adult and his own person, and could make decisions. In addition, FM-I stated the facility told them they couldn't imprison R1 and force him to do things. FM-H stated they did not know who picked up R1 and drove him to FM-C's home. The facility policy titled WanderGuard Policy dated 6/20/22, created in response to R1's elopement, indicated all staff would be aware of residents at risk of unsafe wandering and be aware of those who have a WanderGuard in place; staff would be educated on the use of WanderGuard's; nursing staff will check residents wearing a WanderGuard and document it on the TAR (treatment administration record). The policy provided guidance on want to do if the WanderGuard was not functioning properly. During a telephone interview on 6/29/22, at 3:07 p.m., medical doctor (MD)-G stated he R1 was probably cognitively intact, but lacked impulse control; "He gets mad and holds a grudge and acts out." MD-G acknowledged R1 lacked safety awareness and stated it was not safe for him to leave the facility on his own without supervision as he did on 6/18/22.	F 689		

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Interviews pertaining to R1's cognition and exit seeking behaviors:
--6/28/22, at 3:30 p.m., (TMA)-A stated R1 had not eloped before, adding R1 was smart, but very impulsive. R1 got mad if he didn't get his way... it's almost like attention seeking behavior.
--6/28/22, at 3:36 p.m., licensed practical nurse (LPN)-A stated R1 was a known elopement risk; he wanted to go home. "80% of the time, R1 makes good decisions and 20% of the time he did not. He gets mad and can't think clearly; makes poor decisions like leaving last weekend."
--6/29/22, at 11:58 a.m., (TMA)-C stated R1 had exit seeking behaviors, adding "we knew he wanted to go home." He liked to sit by the exit doors and watch the staff arrive to work.
--6/29/22, at 3:20 p.m., SS-A described R1's cognition as intact, however very impulsive when frustrated or things did not go his way, causing him to make poor decisions.

According to record review and interviews with the DON on 6/28/22, at 3:38 p.m. and on 6/29/22, at 9:54 a.m., and with SS-A on 6/28/22, at 5:16 p.m., the following actions were taken after R1's elopement:
--A WanderGuard bracelet was immediately placed on his chair on 6/18/22, and removed on 6/24/22.
--R1's elopement risk was reassessed on 6/20/22, and indicated a risk for elopement. The evaluation indicated a WanderGuard was not in use.
--Provided R1 one to one opportunities with the activities department staff and the SS in order decrease R1's compulsive behaviors by gauging R1's mood and allow opportunities for him to express concerns. The frequency was not

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defined.

During an interview on 6/29/22, at 5:58 p.m., the administrator stated she was out of town when R1 eloped. The DON made her aware of the elopement right away. The administrator directed her team to complete a vulnerable adult report to the State Agency, to put a WanderGuard on R1, and to start the investigation. Additionally, she informed her team that if they needed help, to reach out to the corporate nursing consultants. SS-A made the consultants aware of the elopement, "As a heads up." On 6/20/22, the consultants arrived to the facility to conduct the investigation. When asked why RC-D and VPCS-E directed the staff to remove the WanderGuard from R1 on 6/20/22, the administrator stated it was her understanding RC-D and VPCS-E determined R1 leaving the facility did not constitute an elopement. In addition, the consultants determined R1 left purposefully and knew where he was going, and therefore did not require a WanderGuard.

Facility policy titled WanderGuard Policy dated 6/20/22, created in response to R1's elopement, which indicated all staff would be aware of residents at risk of unsafe wandering and be aware of those who have a WanderGuard in place; staff would be educated on the use of WanderGuard's; nursing staff will check residents wearing a WanderGuard and document it on the TAR; and what to do if it's not functioning properly.

Facility policy titled Wandering and Elopement, with revised date of March 2019, indicated the facility would identify residents who are at risk of unsafe wandering and strive to prevent harm

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while maintaining the least restrictive environment for residents. If identified as a risk for wandering or elopement, the residents care plan would include strategies and interventions to maintain the resident's safety. The policy did not include characteristics or behaviors to for staff to monitor that may indicate a resident had intent to leave the facility.

This was verified by observation, interview and record review. The facility reassessed R1's elopement risk, provided R1 with a WanderGuard bracelet, added interventions to R1's care plan, implemented a policy of verifying placement of WanderGuard bracelets on residents twice a day and documenting it, implemented audits of WanderGuard's for all eight residents who have a WanderGuard and provided all staff with re-education on elopement.

The immediate jeopardy that began on 6/18/22, was removed on 6/29/22, when R1 had a WanderGuard bracelet placed on his ankle; his plan of care was updated to reflect the use of the WanderGuard; staff were educated on R1's plan of care, and a comprehensive reassessment of R1's elopement risk was completed. Interventions to reduce the risk of elopement included: one to one opportunities with activities staff and social services to identify and decreased impulsive behavior to elope; group and individual outings would be offered to R1's twice weekly. The facility also conducted audits on residents with WanderGuard's daily for two weeks and verification would occur on the TAR for the charge nurse to check each shift. All nursing staff not yet educated on the use of WanderGuard's and the elopement policy were educated. Noncompliance remained at the lower scope and

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F 689	Continued From page 14 severity level of level, D, isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 689		

Minnesota Department of Health

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2 000	Initial Comments	2 000		

*****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 6/28/22, to 6/30/22, 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.

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52902657C (MN84435) with a licensing order issued at 4658.0520 subp. 1. 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, observation, and document review, the facility failed to provide adequate supervision despite being a known elopement risk, for 1 of 1 residents (R1) who left the facility, self-propelling in a wheelchair with the intent of returning to his home, over a mile away, with an air temperature at 90 degrees Fahrenheit (F). A stranger subsequently picked up R1 a few blocks away from the facility and brought him to R1's home in the community. This resulted in an immediate jeopardy (IJ) for R1 when, after he was returned to the facility on 6/18/22, the facility failed to place interventions that would prevent	2 830	On 6/29/22 a WanderGuard was replaced back on R1. R1's care plan was changed to reflect the use of the WanderGuard, and an elopement risk assessment was completed. Staff were educated on R1's updated care plan. R1 will continue to have 1 to 1 meetings with activities and social services, and will be offered group or individual outings twice weekly. To prevent further incidents to all other potential residents, all WanderGuards will be checked by the nurse on each shift. All	7/22/22

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reoccurrence, placing R1 at risk for serious harm, injury, or death if he should elope again.

The IJ began on 6/18/22, when the facility failed to place interventions to prevent R1 from eloping again and was identified on 6/29/22. The administrator and director of nursing (DON), were notified of the IJ on 6/29/22, at 4:28 p.m. The IJ was removed on 6/30/22, at 1:53 p.m. when the facility implemented interventions to prevent further elopements, but noncompliance remained at the lower scope and severity level 2, D, isolated scope, and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R1's facesheet printed on 6/28/22, included a diagnoses of adjustment disorder with mixed disturbance of emotions and conduct, heart disease, high blood pressure, heart failure (when the heart doesn't pump as well as it should), and depression.

R1's quarterly Minimum Data Set (MDS) dated 4/15/22, indicated R1 was cognitively intact, had clear speech, was understood and could understand. R1 was independent in moving about on the unit in his wheelchair but required supervision off the unit. Walking occurred only once or twice during the MDS assessment period. In addition, the MDS indicated a wander/elopement alarm was not used.

R1's plan of care printed on 6/28/22, did not identify elopement as a focus area of concern.

R1's Elopement Risk Evaluation, dated 4/15/22, indicated R1 had a score of seven indicating he

2 830

residents with an elopement risk have it reflected in their care plan. All WanderGuards are checked on each shift and all staff were re-educated on the elopement policy and the use of WanderGuards.

A root cause analysis was completed for R1's elopement incident. The cause was determined to be a failure in following the manufacture instructions to have the WanderGuard checked daily. The daily checks of the WanderGuard's manufactured instructions were implemented, with the charge nurse checking them once on each shift. The WanderGuard check was added to the TAR to be signed off by the nurse. Further, staff were reeducated on our elopement policy and R1's care plan.

The DON or designee will complete audits on the WanderGuard checks. Audits on WanderGuards were completed daily for 2 weeks then randomly and will remain on the TAR for the nurse to check each shift. Results of the audits will be brought to QAPI for discussion and review.

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was at risk for elopement. The score was based upon the following seven parameters:
1. Ability to self-propel wheelchair
2. Habit/history of wandering or attempts to leave the building
3. Exhibited agitated behavior
4. Asked to go home
5. Had a psychiatric diagnosis
6. Family had voiced concerns that R1 may have a tendency to wander or elope
7. Taking medication which may cause confusion
An intervention checked off on the elopement risk evaluation form included, "exit alarm" which, according to the director of nursing (DON) during an interview on 6/29/22, at 9:15 a.m., meant a WanderGuard bracelet (a device worn by residents, who when in the vicinity of an exit door, the door automatically locks preventing the resident from leaving unattended). According to the elopement risk evaluation form, a WanderGuard was in use at that time, 4/15/22.

Discrepancies were noted in the facility documentation on whether R1 had or did not have a WanderGuard in place on 4/15/22. The MDS indicated he did not. Elopement Risk Evaluation indicated he did. The care plan did not mention a WanderGuard.

Physician orders for June 2022, indicated R1 could go on pass and/or LOA (leave of absence) with responsible a party and his medication.

A physician visit note dated 4/27/22, indicated R1 had been less agitated and understood he would be living at the facility long-term. R1 wanted to go out on pass and visit his wife and children. Family was concerned about his competency and his ability to make informed decisions. The physician indicated, he too, was very concerned about that

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2 830	Continued From page 5 as well. R1 had significant behaviors in the past including suicidal gesturing. The physician noted he would seek psychiatric input into his mental status. A psychiatry note dated 4/28/22, indicated R1 was impulsive and his lack of insight extended to his desire to go home. A psychiatry note dated 5/31/22, indicated R1 lacked safety awareness, had short term memory impairment and impairment in concentration. A progress note dated 6/17/22, indicated R1 was seen by a physician on routine rounds and R1 was upset and venting to the physician about wanting to go home and wanting all of his collections (coins and marbles) brought to the facility. The physician was informed that R1 never really slept and spent all day and night in his wheelchair with an occasional half hour in his recliner. The physician ordered Ativan (medication to relieve anxiety) to be administered one half hour before bedtime. A progress note dated 6/18/22, at 6:33 p.m. indicated the facility received a call from family member (FM)-C who stated R1 arrived to his home in the community at 4:15 p.m. in his wheelchair. The DON was notified and staff were advised to call law enforcement to pick up R1 and return him to the facility. R1 returned at 4:50 p.m. and was assessed and no injuries were noted. An incident report completed on 6/18/22, at 5:00 p.m. by the DON read: "On 6/18/22, at 4:15 PM, the charge nurse received a call from R1's wife. R1 had left the building in his wheelchair and gone home. Per the wife's explanation, he propelled his wheelchair part way and was picked up by a friend in a pick up [truck] and taken the	2 830		

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rest of the way home. R1 informed staff, 'I wanted to go home.' 'I didn't do anything wrong.' The DON was called who advised charge nurse to immediately call 011 [911] and ask for police to go to the home address here in community and bring R1 back to the nursing home. No injuries. Alert and oriented. The incident report indicated there were no predisposing situational factors, including active exit seeker. R1 was upset because he wanted a young girl to give him a shower and was told she could not. He also "just wanted to go home" to get his marbles and coin collections. No witnesses were found. Following the incident, the DON, administrator, social services and R1's physician were notified."

During an interview on 6/28/22, at 2:11 p.m. trained medication aide (TMA)-B stated she was on duty when R1 eloped. TMA-B stated at about 3:00 p.m. on 6/18/22, R1 had been upset because he wanted a certain employee to give him a bath and that employee could not. According to TMA-B, the next thing she knew, FM-C called the facility at approximately 4:15 p.m. to report R1 was at her house. TMA-B stated they were not aware R1 had left the building, adding that R1 had gone out an exit door between his room and the nurses station without telling anyone. TMA-B did not know if R1 was an elopement risk, stating it was not uncommon for R1 to self-propel outside in his wheelchair to sit for a bit. TMA-B stated R1 had a WanderGuard on his wheelchair for a while, but it had been removed and she did not know why.

During a telephone interview on 6/28/22, at 2:14 p.m. FM-C recalled the shock she felt when, "A guy showed up in the driveway in a black pick up. A guy got him [R1] out in his pick up and brought him up to the house in his wheelchair." FM-C

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2 830	Continued From page 7 stated she did know this man who told her R1 had been sitting on the road so he asked R1 if he needed help; R1 asked him to take him to his house. FM-C stated R1 was exhausted and it was hot that day, "I think he pushed himself in the wheelchair, self-propelling, that wears him out. Hotter than heck that day." FM-C didn't know how far R1 got before the man picked him up, adding, "we live clear across down." FM-C stated when she told the man R1 wasn't supposed to be here, he exited real quick. FM-C stated, R1, "Flew in here and was looking for something. Money. He doesn't understand it's not safe to take everything valuable to the nursing home, that's mainly what he wanted when he came home, he wanted to look at his marble collection." FM-C stated she thought the time was about 6:00 p.m., but was not sure. FM-C stated R1 had lived at the facility since 2/3/22, and had not tried to go home before. When asked if R1 had an alarm bracelet on is body or wheelchair, FM-C stated no, "they put one on and he cut it off," adding, if R1 wants something bad enough, he will do it. According to FM-C, she was at the facility the evening of 6/17/22, for beer and brat night when R1 told her he cut off his WanderGuard bracelet. FM-C stated she didn't know what to believe because R1 fibs a lot, so she didn't report this to the staff. According to website www.accuweather.com, the temperature in the community on the afternoon of 6/18/22, was 93 degrees F. During an interview on 6/28/22, at 3:38 p.m. the DON stated on 6/18/22, a Saturday afternoon, the charge nurse called her to report that FM-C called the facility to inform them R1 was at her home. The DON advised staff to call 911 to have law enforcement pick him up and return him to the facility. The DON then called the administrator and social services and called back to the facility	2 830		

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2 830	Continued From page 8 to talk to staff. Fifteen minute checks were initiated. The DON stated the investigation started on Monday 6/20/22, when a regional consultant (RC)-D and vice president of clinical services (VPCS)-E arrived to the facility. The investigation included a care conference with R1, FM-C, and other family members. According to the DON, the family stated they were expecting it [elopement] to happen sooner because R1 called them and threaten it all the time. The DON stated R1 was not unhappy at the facility; he just wanted to go home and get his coin and marble collections. According to the DON, the investigation included talking to R1, the staff and a resident who R1 followed out the side door on the day of he elopement. The DON stated R1 had a WanderGuard bracelet on until 6/18/22, when unbeknownst to the facility, R1 cut it off. At that time, the facility was not conducting daily verification of WanderGuard bracelets on residents and therefore it went undetected. When asked if the facility had considered reapplying the WanderGuard bracelet following the elopement since R1 was assessed at being at risk for elopement, the DON stated they were told by RC-D and VPCS-E that R1's elopement was purposeful and this BIMS (brief interview for mental status) was 14 (indicating intact cognition), so a WanderGuard was not necessary. The DON stated following their investigation, RC-D and VPCS-E concluded the elopement was "not a true elopement" because R1 had a purpose and knew where he was going. During this interview, the administrator joined the conversation and stated she understood from the investigation that a WanderGuard was not necessary because R1 left the facility purposefully and knew where he was going, and for those reasons it was deemed not an elopement.	2 830		

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During the same interview, at 4:00 p.m., the DON placed a phone call to VPCS-E who stated, "We're not calling it an elopement. He knew what he was doing. He planned to leave. It was safe for him to leave the facility unsupervised - he's his own person and his BIMS is 14." VPCS-E stated a WanderGuard was not appropriate for R1, adding, "He's a guy I would let sign out and go. He collects stuff and wanted to go home and see it." VPCS-E stated R1 had the capability to cut the WanderGuard bracelet off and therefore it would not be effective. VPCS-E stated the facility implemented one to one activities with R1 which was more proactive and they educated R1; "He's his own person." VPCS-E stated they "Reviewed R1's behaviors, he rolls away, gets mad, that's why we added impulsiveness to his care plan." The facility did not require residents to sign out when going outside to enjoy the weather.

During an interview on 6/28/22, at 5:06 p.m., the DON stated WanderGuard's were implemented at the facility in April 2022 when they closed their secure unit. R1 had a WanderGuard bracelet placed on his wheelchair just prior to a 4/15/22, elopement risk evaluation, but according to the DON, the placement date was not documented. The DON identified the facility was not verifying placement of WanderGuard's on residents until after the elopement incident on 6/18/22. R1 cut the WanderGuard bracelet off his wheelchair around suppertime on 6/17/22, but staff were not aware of this.

During an interview on 6/28/22, at 5:16 p.m., social services (SS)-A, stated one to one's were implemented with R1 following the elopement, adding R1 was welcomed to come in and visit; "he talks when he wants to talk." According to

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SS-A, the sessions were proactive...more apt to see if R1 had a specific need...able to gauge his compulsive behaviors and mood...intervene if needed.

During an interview on 6/28/22, at 5:20 p.m. activities director (AD)-A stated one to one sessions with R1 occurred with SS-A and staff in the activities department. These sessions were not scheduled, they were informal and the frequency was not defined. AD-A stated R1 participated in activities offered by the activity department on a daily basis, including weekends, adding R1 was out of his room often attending activities.

During an interview and observation on 6/28/22, at 6:20 p.m. in his room, R1 stated, "That day I was going to go home and I didn't tell anyone. I just left." R1 stated it was 90 degrees and he only went two or three blocks, traveling on the street before a man picked him up. "I have no idea who it was." R1 stated he went home to get some of his collections [coins and marbles]. R1 stated he had a WanderGuard bracelet on his leg but cut it off, adding he borrowed a scissor "from the cart they put the pills on," then put the bracelet in a drawer. R1 opened a drawer underneath a closet and said, "It's gone, I gave it to them." R1 did not know what day it was when he cut off the bracelet, adding another one was put on, but later taken off by staff.

During an interview on 6/29/22, at 9:54 a.m. the DON stated when R1 returned after his elopement on 6/18/22, social services director (SS)-A instructed staff to apply a WanderGuard bracelet to R1, however, when the investigation started on 6/20/22, they were instructed by RC-D and VPCS-E to remove it as R1 didn't need it.

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The DON stated she dragged her feet in removing it, adding, "I didn't think it should be removed." On 6/23/22, RC-D saw the bracelet was still on R1 and again instructed her to remove it. The DON stated it was left on until 6/24/22. The DON stated R1 was still at risk for elopement risk, adding, "He said he won't, but if he gets upset, his M.O. (modus operandi) is to leave. This was his first time; but it's a possibility." The DON stated R1 had child-like behaviors, and gave an examples of one day when he crawled under the bed because he was mad and another day when he faked a seizure and was sent to the ER. "He gets mad and has no impulse control."

During a telephone interview on 6/29/22, at 10:07 a.m. (FM)-H and (FM)-I stated they were aware of the incident and had been concerned after hearing about the elopement. FM-I stated the facility should, "get that WanderGuard back on R1's wheelchair." FM-I stated they were told by the facility that R1 was an adult and his own person, and could make decisions. In addition, FM-I stated the facility told them they couldn't imprison R1 and force him to do things. FM-H stated they did not know who picked up R1 and drove him to FM-C's home.

The facility policy titled WanderGuard Policy dated 6/20/22, created in response to R1's elopement, indicated all staff would be aware of residents at risk of unsafe wandering and be aware of those who have a WanderGuard in place; staff would be educated on the use of WanderGuard's; nursing staff will check residents wearing a WanderGuard and document it on the TAR (treatment administration record). The policy provided guidance on want to do if the WanderGuard was not functioning properly.

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During a telephone interview on 6/29/22, at 3:07 p.m., medical doctor (MD)-G stated he R1 was probably cognitively intact, but lacked impulse control; "He gets mad and holds a grudge and acts out." MD-G acknowledged R1 lacked safety awareness and stated it was not safe for him to leave the facility on his own without supervision as he did on 6/18/22.

Interviews pertaining to R1's cognition and exit seeking behaviors:
--6/28/22, at 3:30 p.m., (TMA)-A stated R1 had not eloped before, adding R1 was smart, but very impulsive. R1 got mad if he didn't get his way... it's almost like attention seeking behavior.
--6/28/22, at 3:36 p.m., licensed practical nurse (LPN)-A stated R1 was a known elopement risk; he wanted to go home. "80% of the time, R1 makes good decisions and 20% of the time he did not. He gets mad and can't think clearly; makes poor decisions like leaving last weekend."
--6/29/22, at 11:58 a.m., (TMA)-C stated R1 had exit seeking behaviors, adding "we knew he wanted to go home." He liked to sit by the exit doors and watch the staff arrive to work.
--6/29/22, at 3:20 p.m., SS-A described R1's cognition as intact, however very impulsive when frustrated or things did not go his way, causing him to make poor decisions.

According to record review and interviews with the DON on 6/28/22, at 3:38 p.m. and on 6/29/22, at 9:54 a.m., and with SS-A on 6/28/22, at 5:16 p.m., the following actions were taken after R1's elopement:
--A WanderGuard bracelet was immediately placed on his chair on 6/18/22, and removed on 6/24/22.
--R1's elopement risk was reassessed on 6/20/22, and indicated a risk for elopement. The

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evaluation indicated a WanderGuard was not in use.
--Provided R1 one to one opportunities with the activities department staff and the SS in order decrease R1's compulsive behaviors by gauging R1's mood and allow opportunities for him to express concerns. The frequency was not defined.

During an interview on 6/29/22, at 5:58 p.m., the administrator stated she was out of town when R1 eloped. The DON made her aware of the elopement right away. The administrator directed her team to complete a vulnerable adult report to the State Agency, to put a WanderGuard on R1, and to start the investigation. Additionally, she informed her team that if they needed help, to reach out to the corporate nursing consultants. SS-A made the consultants aware of the elopement, "As a heads up." On 6/20/22, the consultants arrived to the facility to conduct the investigation. When asked why RC-D and VPCS-E directed the staff to remove the WanderGuard from R1 on 6/20/22, the administrator stated it was her understanding RC-D and VPCS-E determined R1 leaving the facility did not constitute an elopement. In addition, the consultants determined R1 left purposefully and knew where he was going, and therefore did not require a WanderGuard.

Facility policy titled WanderGuard Policy dated 6/20/22, created in response to R1's elopement, which indicated all staff would be aware of residents at risk of unsafe wandering and be aware of those who have a WanderGuard in place; staff would be educated on the use of WanderGuard's; nursing staff will check residents wearing a WanderGuard and document it on the TAR; and what to do if it's not functioning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00939	A. BUILDING: ______ B. WING ______	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	**1003 WEST MAPLE OLIVIA, MN 56277**

(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
2 830	Continued From page 14 properly. Facility policy titled Wandering and Elopement, with revised date of March 2019, indicated the facility would identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as a risk for wandering or elopement, the residents care plan would include strategies and interventions to maintain the resident's safety. The policy did not include characteristics or behaviors to for staff to monitor that may indicate a resident had intent to leave the facility. This was verified by observation, interview and record review. The facility reassessed R1's elopement risk, provided R1 with a WanderGuard bracelet, added interventions to R1's care plan, implemented a policy of verifying placement of WanderGuard bracelets on residents twice a day and documenting it, implemented audits of WanderGuard's for all eight residents who have a WanderGuard and provided all staff with re-education on elopement. The immediate jeopardy that began on 6/18/22, was removed on 6/29/22, when R1 had a WanderGuard bracelet placed on his ankle; his plan of care was updated to reflect the use of the WanderGuard; staff were educated on R1's plan of care, and a comprehensive reassessment of R1's elopement risk was completed. Interventions to reduce the risk of elopement included: one to one opportunities with activities staff and social services to identify and decreased impulsive behavior to elope; group and individual outings would be offered to R1's twice weekly. The facility also conducted audits on residents with WanderGuard's daily for two weeks and	2 830		

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2 830	Continued From page 15 verification would occur on the TAR for the charge nurse to check each shift. All nursing staff not yet educated on the use of WanderGuard's and the elopement policy were educated. Noncompliance remained at the lower scope and severity level of level, D, isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. 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		

Minnesota Department of Health

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