DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 27, 2022

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: April 14, 2022

Dear Administrator:

On April 27, 2022, we notified you a remedy was imposed. On May 19, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 17, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 12, 2022 be discontinued as of May 17, 2022. (42 CFR 488.417 (b))

In our letter of April 27, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 14, 2022. 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 27, 2022

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: Reinspection Results
Event ID: IRGP12

Dear Administrator:

On May 19, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 14, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Submitted
April 27, 2022

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: April 14, 2022

Dear Administrator:

On April 14, 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 April 14, 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 May 12, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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 May 12, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 12, 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 14, 2022. This prohibition is not subject to appeal. 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.

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,</u>

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 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, Madison Healthcare Services is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 14, 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:

Nicole Osterloh, RN, Unit Supervisor

Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 October 14, 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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00329	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE SERVICES	900 SECOND AVENUE MADISON, MN 56256

(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	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: Surveyor: 34083 On 4/12/22 through 4/14/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your	2 000		

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2 000	Continued From page 1 electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5382046C (MN82119 & MN82332) with a licensing order issued at 0830. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 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: Surveyor: 34083 Based on observation, interview and document review, the facility failed to provide appropriate supervision and comprehensively assess exit seeking behaviors for 1 of 1 resident (R1). This resulted in an immediate jeopardy (IJ) when R1 was able to repeatedly exit the East door to the facility onto an unsafe walkway with stairs to one side and a sloped sidewalk to the other.	2 830	Corrected	5/17/22

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2 830	Continued From page 3 Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/8/22, identified R1 had severe cognitive impairment, and required supervision walking in R1's room, the corridor, and off the unit. R1 utilized a walker and was unsteady walking. R1 had not wandered during the assessment period however, she was identified to have a wander/elopement alarm and bed alarm placed. R1's diagnoses included non-traumatic brain dysfunction, Alzheimer's disease and dementia. R1's 9/23/21, Wandering Assessment indicated R1 was at high risk for elopement following an incident on 9/23/21. R1 was discovered across the parking lot and in front of the clinic portion of the hospital, (approximately 1/2 to 1 block form the entrance door). Interventions implemented at that time were to add a WanderGuard monitor on her right ankle. No further interventions were identified. No current or updated Wandering Assessments were noted in the medical record. R1's current, undated care plan, identified R1 was an elopement risk and had a history of attempts to leave the facility unattended with a history of impaired safety awareness. R1 had a Wander Guard monitor to her right ankle implemented on 9/23/21. On 3/25/22, staff updated her care plan to include 30-minute safety checks. There was no intervention related to the need for increased supervision when R1 continued her attempts to open the egress exit doors on the East and West end of the unit. R1's progress note dated 3/19/22, at 12:30 p.m. identified R1 attempted to exit through the West door by holding the egress release bar until the	2 830		

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2 830	Continued From page 4 door released. She was intercepted by an unidentified staff before she could exit the second door to a dirt area, which extended between a fence bordering the new construction and the building that extended to the street. Review of the 3/25/22, report submitted to the State Agency (SA) identified R1 was last seen sitting in the dining room at 9:40 a.m. At 9:45 a.m., staff were alerted R1 was outdoors by a visitor. The visitor reported the observation to an unidentified staff member. The door alarm system was sounding. R1 was seen outdoors by staff. Staff then retrieved R1 and she was brought back into the facility at approximately 9:50 a.m. The facility identified the alarms had sounded and staff were doing appropriate 1 hr checks at that time. Review of the 3/30/22, 5-day report to the SA identified staff were interviewed. 1 nurse aide (NA)-A stated they were down a hall, toileting another resident. NA-B reported they were on break at the time of the incident. Licensed practical nurse (LPN)-C reported she was returning from break at 9:45 a.m.. Registered nurse (RN)-A stated she was toileting a resident. NA-C reported she saw R1 in the East hallway at 9:45 a.m.. and verbally redirected R1 to turn around. NA-C did not ensure R1's safety and ensure she did not exit seek prior to entering another residents room to toilet a resident. NA-F stated she was in a resident's room and unable to hear the alarm. NA-E reported she heard the alarms and shut off the alarm. She had not seen any residents immediately in eyesight inside. The facility implemented staff to increase her safety checks from every hour to every 30 minutes, and review policies for elopement and alarm systems. Maintenance was to work on obtaining a method	2 830		

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2 830	Continued From page 5 to increase the loudness of the alarms so they could be heard in resident rooms. There was no indication the facility identified staff failed to provide appropriate supervision upon seeing R1 wandering with potential exit-seeking behaviors, nor was it identified staff were re-educated to immediately check all doors and ensure all residents were accounted for, prior to turning off any alarm. There was also no indication the facility identified the need for increased supervision when R1 would exhibit potential exit seeking behaviors to prevent future occurrences. Review of the 3/25/22, video footage of the incident identified at the recorded time of 9:47 a.m., R1 was seen walking quickly with no staff in attendance towards the East exit door. At 9:48 a.m., R1 was observed to have pushed buttons on the keypad and pressed the door release bar repeatedly, and finally held the egress door push button bar until the egress door released and R1 was able to open the door. R1 then held the door open, pulled her walker through the door and exited the hallway into the entry way between the inner and outer doors. NA-A responded to the alarm at 9:49 a.m. and looked around the inside area of the door. NA-A did not open the outer door to look outside. At 9:54 a.m. registered nurse (RN)-A responded, opened the door, looked into the entry way between the 2 doors, and returned to hallway by the nurses station. RN-A failed to check outside the outer door to see if a resident had actually exited the building. At 9:53 a.m. NA-A and NA-B were seen rushing out the outer door and returned with R1. Review of an additional incident report submitted to the SA on 4/1/22, identified R1 had once again exited the facility out of the East door at 4:45 p.m.. She was last checked at 4:39 p.m. and was	2 830		

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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
2 830	Continued From page 6 noted to be in the dining room by LPN-A. NA-C and NA-J heard the alarm but were assisting another resident in their room. After finishing assisting that resident, both NAs went outside and located R1. R1 was then escorted back inside the facility. R1 commented to staff, "I will get out again and you won't catch me next time." R1 was to have 1:1 supervision until further notice. Review of the 4/1/22, video footage identified at 4:46 p.m., R1 was noted to be walking rapidly with her walker in the hallway towards the East door. No staff were visible in the hallway. R1 repeated the same actions as she attempted to open the door on the 3/25/22, incident and exited through the door at 4:47 p.m. NA-C and NA-F responded to the alarm for the East door and exited the building to find R1. At 4:50 p.m. NA-C and NA-F returned through the East door with R1. R1 pulled her walker away from the two NAs and walked rapidly toward the nursing station. R1's progress notes from 4/1/22 through 4/9/22 made no mention R1 was on a 1:1 with staff or how staff were tracking and ensuring a 1:1 actually occurred. Review of the 4/5/22, 5 day report submitted to the SA identified 7 staff were interviewed. 6 staff were in other residents' rooms and not able to monitor R1's whereabouts, and 1 staff was on break. The report identified the care plan was to be revised to show 1:1 supervision was to occur until the alarm volume annunciator was to be installed. The facility noted R1 had exited the facility 1 week prior at a different time. There was no mention staff analyzed R1's exit seeking behaviors to look for patterns or trends to help identify when those behaviors were likely to	2 830		

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2 830	Continued From page 7 occur. Review of R1's care plan identified staff had not updated R1's care plan on 4/1/22, to show she required 1:1 continuous supervision. On 4/4/22, a revision was made noting a care conference was to be set up with family and R1's MD to discuss different placement options. There was no indication staff were educated R1 was to have continuous 1:1, the care plan was updated with that plan, or how the facility was ensuring continuous 1:1 actually occurred. There was no mention a comprehensive assessment or root cause analysis was completed to determine if 1:1 supervision was attainable, or if the facility looked for patterns of exit seeking behaviors to identify when those behaviors were likely to occur or when R1 would need increased supervision. R1's progress note dated 4/7/22, at 1:36 p.m. identified a care conference was held with R1's spouse and children, the assistant director of nursing (ADON), and MD to discuss possible options of different placement and potential safety measures for R1. The family members were resistant to transferring R1 to a different facility, as R1's spouse was tentatively able to visit daily wanted to keep her in the facility. There was no mention staff had analyzed R1's behaviors to identify when she was most likely to have exit seeking behaviors, or what they would do if all staff were busy and unable to respond to behaviors to prevent R1 from exiting in the future. Observations on 4/12/22 at 10:15 a.m. of R1 identified she was in her room lying in bed. Later at 12:00 p.m., R1 was observed eating her noon meal in the dining room. Interview on 4/12/22, at 10:51 a.m. LPN-A stated	2 830		

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2 830	Continued From page 8 she was working on 4/1/22, and was at the nursing station when R1 was standing by the East doorway. LPN-A left the nursing station to assist a different resident who was standing up from his wheelchair and assisted that resident to their room. LPN-A heard the door alarm sound at the East door. LPN-A observed 2 staff members running toward the door, and upon their return to the area, LPN-A was informed R1 had gone out the East door. LPN-A interviewed staff on duty who reported to her they did not hear the alarm as they were in other residents' rooms. The DON requested 1:1 monitoring of R1 until the new annunciator bells were installed on 4/8/22. Education was provided to staff following the 4/1/22, incident which included when R1 was in the hall, staff were to monitor her location, offer snacks, coffee, and possibly sit with her until she was ready to return to her room. R1's family was to be notified so they could come visit and assist staff with monitoring R1's location. LPN-A agreed she had not correctly identified R1 as exit seeking that day when R1 was staying by the East door just prior to the incident. LPN agreed she should not have left R1 alone or should have called for assistance so another staff could have supervised R1 preventing her from leaving the facility into an unsafe area outside the East door. Interview on 4/12/22, at 11:28 a.m., with NA-B stated she was working on 3/25/22 and 4/1/22. NA-B identified on 3/25/22 and 4/1/22, R1 pushed the bar on the door until it released, and she went out both inner and outer East doors. On: 1) 3/25/22, staff received education on WanderGuard door alarms in addition to the outside door alarms, how to reset the alarms, and the procedure for retrieving a resident and immediately reporting the incident to nursing staff. 2) 4/1/22, NA-B and NA-H were in another	2 830		

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2 830	Continued From page 9	2 830		

resident's room with the door closed when they heard the East door alarm. NA-B remembered commenting to NA-H she thought it was R1 who had caused the alarm to sound. As soon as they were able to ensure the current resident's safety, they went to investigate the alarm. Another resident was standing in the hall and pointed to the exit door. NA-B and NA-H went outside the East outer door. NA-B recalled it was very windy that day. R1 was at the end of the ramp hunched forward over her walker with her shirt pulled over her head from the wind. Both NA's assisted R1 to pivot and turn around and go back up the ramp and into the building. NA-B noted R1 had difficulty with her balance in the wind and NA-B and NA-H walked on either side of her to assist as she walked back up the ramp into the building to prevent her from potentially falling over. R1 was upset at being brought back into the facility and when they were back in the building made the statement "I will get out again, and you won't catch me next time." R1 was to be placed on 1:1 supervision upon return to the building where it was to have continued until 4/8/22, when the new annunciators were installed as the facility felt louder alarms would alert staff to R1's exiting. R1 was reported to staff to be a high risk for elopement and staff were directed to monitor R1's location "if she wasn't in the dining room". NA-B was unaware if staff were to be in the dining room at all times while R1 was there. NA-B was unsure if staff were to provide increased supervision at times when R1's behaviors escalated to prevent R1 from exiting the building.

Interview on 4/12/22, at 12:01 p.m. with NA-G stated he was working on 4/1/22, when R1 exited the building, and the alarms sounded. NA-G did not check on the alarm, as he "thought it was from another resident" standing near the door. R1

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2 830	Continued From page 10	2 830		

was able to walk very quickly with her walker and her gait was steady. NA-G received education following the incident related to monitoring residents, how doors activated with release, and sounds that would indicate if the door was opened and a resident was outside the building. NA-G was unsure if staff were to provide increased supervision at times when R1's behaviors escalated to prevent R1 from exiting the building.

Interview on 4/12/22, at 12:14 p.m. family member (FM)-A stated R1 was initially admitted to the facility due to being up at night and wandering. FM-A received notification of the elopement incidents and was told a new alarm system was being installed. FM-A was unaware of any increased supervision required to prevent R1 from exiting the building.

Interview on 4/12/22, at 1:02 p.m. with NA-I identified staff were to provide 1:1 monitoring of R1 after the 4/1/22 incident. R1 repeatedly stated she wanted to go home and would often walk back and forth in the hall and then to her room. All staff were aware of the need to monitor R1's location. They were aware she frequently wandered in the halls and had exit seeking behaviors. NA-I was unaware if staff were to provide 1:1 supervision at times when R1's behaviors escalated showing exit seeking. NA-I indicated the louder alarms were to alert staff if R1 exited. There was no indication NA-I was trained to provide increased supervision at times when R1's behaviors escalated to prevent R1 from exiting the building.

During interview on 4/12/22, at 2:56 p.m. licensed social worker (LSW) stated a care conference was held on 4/7/22, with herself, R1's spouse,

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2 830	Continued From page 11 two daughters, ADON, and physician to discuss options for R1's safety. They discussed the possibility of the need to look for other placement if the facility was unable to keep R1 safe and in the building. LSW was not aware all staff were busy and not monitoring R1 when she exhibited exit seeking behaviors. Discussion of a transfer to a locked unit was suggested, but R1's spouse was not accepting of this option and stated if staff were able to hear the alarms "there should not be a problem". Interview on 4/12/22, at 3:50 p.m. with MD-A (who was also R1's medical doctor) identified he was aware of R1's elopements out of the facility. He agreed there was a safety concern. MD-A discussed the care conference with family on 4/7/22, but family preferred R1 remain at the facility. MD-A stated the louder alarm system would be effective in allowing staff to hear the alarms better, and possibly intervene, but it would not prevent R1 from exiting if she were unattended and could open the door. MD-A was not aware of comprehensive assessment having been completed to identify potential causative factors to determine the level of supervision R1 required when exit-seeking behaviors were occurring to prevent future elopements. During follow-up interview on 4/12/22 at 5:08 p.m., the DON identified she detailed the events of R1's elopement in the follow up reports to the SA, but did not complete additional comprehensive assessment or analysis of R1's exit-seeking behaviors to identify when R1 would require increased supervision to prevent future elopements from occurring. R1 "seemed to be aware of times when staff were busy". That was when she felt R1 was likely to attempt to leave the building. R1's statement about attempting to	2 830		

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2 830	Continued From page 12 leave again was concerning. Measures to keep R1 safe included redirection by offering food and drink, use of a WanderGuard device, and 30-minute safety checks. After 4/1/22, when R1 was restless and wandering, R1's spouse was to be contacted to come and sit with her. There was no documentation provided to support current 30-minute safety checks were being completed or if staff identified the need to provide 1:1 supervision at times when R1's behaviors would increase. The DON felt R1 was not an appropriate placement at the facility due to safety concerns and her repeated attempts to exit. The DON elaborated a locked unit might be more appropriate placement, but the family did not want R1 transferred out of town. The DON agreed the facility had no method to monitor 30-minute checks were occurring, effective, or had directed staff when they would need to provide 1:1 direct supervision when R1's behaviors escalated to prevent future elopements. During interview on 4/13/22 at 10:11 a.m., NA-C identified R1 was very mobile, able to self-transfer, and was able to ambulate quickly using her walker. NA-C observed R1 attempting to exit by going to the exit doors, and pushing on the locking bar, but she was able to intervene before R1 actually got the door open. R1 asked NA-C how to leave, stating she wanted to go home. NA-C stated redirection was successful short term, but R1 continued to repeat the behavior. NA-C was unaware if staff needed to provide increased supervision between 30-minute checks when R1 was exhibiting increased exit-seeking behavior. During interview on 4/13/22 at 10:48 a.m., NA-A stated she was aware R1 made repeated	2 830		

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2 830	Continued From page 13 attempts to leave the building and following the recent elopements. NA-A "did not feel comfortable" R1 was not going to try and exit the building again. R1 had repeatedly voiced to NA-A of her intent to leave the facility and go home. NA-A reported she had since observed R1 attempt to open the exit door by pushing the release bar at different times, but the alarm had sounded, and staff were able to intervene before she was able to open the door. NA-A was unaware of any needed increased supervision to prevent exiting from occurring. Observation on 4/13/22 at 11:00 a.m., of R1 identified she was seated at the table in the dining room having tea. At 11:30 a.m., R1 ambulated independently back to her room, and was observed to undress in front of her window with opened curtains. Staff were notified by this surveyor to provide assistance to R1 and provide for her privacy. Observation on 4/13/22, at 2:00 p.m. with the DON of the East door exit identified a ramp was on one side, and several steep steps to the other. The ramp extended from the East door with a partial railing on the hill side of the ramp that extended only halfway along the hill. Review of the October 2021, Elopement Policy directed the admitting nurse to complete the Safety Risk Assessment and identify potential elopement and/or wandering behaviors and develop a specific plan of care for each resident. A Root Cause Analysis/Comprehensive assessment was to be completed following an elopement to identify what measures needed to be implemented. SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 14 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		

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F 000	INITIAL COMMENTS Surveyor: 34083 On 4/12/22 through 4/14/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 3/25/22, when R1 exited the building and was observed outside by a visitor. Staff were notified and R1 was returned to the building. R1 was not comprehensively reassessed at that time to determine causative factors, needed interventions, or was provided appropriate supervision when exhibiting those behaviors to prevent R1 from further attempts to exit the building to return home. On 4/1/22 at 1:45 p.m., R1 exited the building again to the same unsafe area on campus after exhibiting exit-seeking behavior. The administrator and director of nursing (DON) were notified of the IJ on 4/13/22 at 2:58 p.m.. The IJ was removed on 4/14/22, at 12:46 p.m.. The above findings constituted Substandard Quality of Care and an extended survey was conducted from 4/13/22 through 4/14/22. The following complaints was found to be SUBSTANTIATED: H5382046C (MN82119 & MN82332), with a deficiency cited at F689. The facility's plan of correction (POC) will serve	F 000		

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

Electronically Signed — 04/29/2022

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 000	Continued From page 1 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 34083 Based on observation, interview and document review, the facility failed to provide appropriate supervision and comprehensively assess exit seeking behaviors for 1 of 1 resident (R1). This resulted in an immediate jeopardy (IJ) when R1 was able to repeatedly exit the East door to the facility onto an unsafe walkway with stairs to one side and a sloped sidewalk to the other. The IJ began on 3/25/22, when R1 exited the building and was observed outside by a visitor.	F 689	R1 is an 85 year old female resident of MHS that eloped on 3/25/2022 and 4/01/2022 with no injury. The root cause of R1's elopements is that she wants to go home and demonstrates this by exit seeking and stating to staff "I want to go home". 1. Corrective action will be accomplished for R1 who was found to have been affected by the deficient practice of failing to provide appropriate supervision and comprehensively assessing exit seeking	5/17/22

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F 689	Continued From page 2 Staff were notified and R1 was returned to the building. R1 was not comprehensively re-assessed at that time to determine causative factors, needed interventions, or was provided appropriate supervision when exhibiting those behaviors to prevent R1 from further attempts to exit the building to return home. On 4/1/22, at 1:45 p.m., R1 exited the building again to the same unsafe area on campus after exhibiting exit-seeking behavior. The administrator and director of nursing (DON) were notified of the IJ on 4/13/22, at 2:58 p.m. The IJ was removed on 4/14/22, at 12:46 p.m., however, non-compliance remained at D-ISOLATED, no actual harm with potential for more than minimal harm. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/8/22, identified R1 had severe cognitive impairment, and required supervision walking in R1's room, the corridor, and off the unit. R1 utilized a walker and was unsteady walking. R1 had not wandered during the assessment period however, she was identified to have a wander/elopement alarm and bed alarm placed. R1's diagnoses included non-traumatic brain dysfunction, Alzheimer's disease and dementia. R1's 9/23/21, Wandering Assessment indicated R1 was at high risk for elopement following an incident on 9/23/21. R1 was discovered across the parking lot and in front of the clinic portion of the hospital, (approximately 1/2 to 1 block form the entrance door). Interventions implemented at that time were to add a WanderGuard monitor on her right ankle. No further interventions were identified. No current or updated Wandering Assessments were noted in the medical record.	F 689	behaviors by reviewing the Elopement policy and reviewing it monthly with staff at clinical staffing meetings. An RCA was done by the IDT and the following was noted to identify that the root cause was R1 has exit seeking behaviors and history of elopements as evidenced by her stating "I want to go home" or "How do I get out of here". The IDT consists of the DON, ADON, Activities Director, Dietary Manager, Maintenance Manager, Infection Preventionist, Chaplain, and Social worker. Interventions that will be immediately implemented will include when staff recognize that R1 is more agitated and pacing the hallways they will call R1's husband to visit her here at MHS. If he is not available to come to the facility staff will contact activity staff to do a one-on-one activity with R1. If activity staff are not available staff on the floor must increase supervision up to and including one on one supervision until her agitation passes or her exit seeking behaviors subside. These were implemented 4/13/22 and were entered in her plan of care 4/13/22. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by completing a wander risk assessment upon admission and when/if the resident exhibits exit seeking behaviors/wandering behaviors, identifying what could be causing them to want to exit the building or wander, and formulating interventions with the IDT, adding interventions to the care plan, and communicating those interventions to staff	

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F 689	Continued From page 3 R1's current, undated care plan, identified R1 was an elopement risk and had a history of attempts to leave the facility unattended with a history of impaired safety awareness. R1 had a Wander Guard monitor to her right ankle implemented on 9/23/21. On 3/25/22, staff updated her care plan to include 30-minute safety checks. There was no intervention related to the need for increased supervision when R1 continued her attempts to open the egress exit doors on the East and West end of the unit. R1's progress note dated 3/19/22, at 12:30 p.m. identified R1 attempted to exit through the West door by holding the egress release bar until the door released. She was intercepted by an unidentified staff before she could exit the second door to a dirt area, which extended between a fence bordering the new construction and the building that extended to the street. Review of the 3/25/22, report submitted to the State Agency (SA) identified R1 was last seen sitting in the dining room at 9:40 a.m. At 9:45 a.m., staff were alerted R1 was outdoors by a visitor. The visitor reported the observation to an unidentified staff member. The door alarm system was sounding. R1 was seen outdoors by staff. Staff then retrieved R1 and she was brought back into the facility at approximately 9:50 a.m. The facility identified the alarms had sounded and staff were doing appropriate 1 hr checks at that time. Review of the 3/30/22, 5-day report to the SA identified staff were interviewed. 1 nurse aide (NA)-A stated they were down a hall, toileting another resident. NA-B reported they were on	F 689	and family. 3. Staff have been educated on R1's new interventions and elopement policy has been reviewed with staff and will be reviewed monthly with staff at clinical staff meetings for 3 months and then as needed. Staff have been educated with the updated alarm system. Elopement and missing person drills will be conducted monthly at random times on all shifts. Will have staff sign off on Elopement/Missing Persons Drill Log form. 4. The facility will monitor its corrective actions by: DON or designee conducting audits of progress notes in the 24 hour report to ensure care plan interventions were implemented if R1 or other residents were displaying exit seeking or wandering behavior monthly for 3 months. Audits of 30 minute checks will be conducted weekly from the POC documentation for 3 months. The DON or designee will audit responsiveness of staff during elopement drills and provide feedback to staff monthly. All audits will be brought to and discussed at QAPI for the next 3 months and then as needed. 5. The deficiencies in F689 will be corrected by May 17, 2022 and staff will be educated by May 17, 2022.	

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break at the time of the incident. Licensed practical nurse (LPN)-C reported she was returning from break at 9:45 a.m.. Registered nurse (RN)-A stated she was toileting a resident. NA-C reported she saw R1 in the East hallway at 9:45 a.m.. and verbally redirected R1 to turn around. NA-C did not ensure R1's safety and ensure she did not exit seek prior to entering another residents room to toilet a resident. NA-F stated she was in a resident's room and unable to hear the alarm. NA-E reported she heard the alarms and shut off the alarm. She had not seen any residents immediately in eyesight inside. The facility implemented staff to increase her safety checks from every hour to every 30 minutes, and review policies for elopement and alarm systems. Maintenance was to work on obtaining a method to increase the loudness of the alarms so they could be heard in resident rooms. There was no indication the facility identified staff failed to provide appropriate supervision upon seeing R1 wandering with potential exit-seeking behaviors, nor was it identified staff were re-educated to immediately check all doors and ensure all residents were accounted for, prior to turning off any alarm. There was also no indication the facility identified the need for increased supervision when R1 would exhibit potential exit seeking behaviors to prevent future occurrences.

Review of the 3/25/22, video footage of the incident identified at the recorded time of 9:47 a.m., R1 was seen walking quickly with no staff in attendance towards the East exit door. At 9:48 a.m., R1 was observed to have pushed buttons on the keypad and pressed the door release bar repeatedly, and finally held the egress door push button bar until the egress door released and R1 was able to open the door. R1 then held the door

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open, pulled her walker through the door and exited the hallway into the entry way between the inner and outer doors. NA-A responded to the alarm at 9:49 a.m. and looked around the inside area of the door. NA-A did not open the outer door to look outside. At 9:54 a.m. registered nurse (RN)-A responded, opened the door, looked into the entry way between the 2 doors, and returned to hallway by the nurses station. RN-A failed to check outside the outer door to see if a resident had actually exited the building. At 9:53 a.m. NA-A and NA-B were seen rushing out the outer door and returned with R1.

Review of an additional incident report submitted to the SA on 4/1/22, identified R1 had once again exited the facility out of the East door at 4:45 p.m.. She was last checked at 4:39 p.m. and was noted to be in the dining room by LPN-A. NA-C and NA-J heard the alarm but were assisting another resident in their room. After finishing assisting that resident, both NAs went outside and located R1. R1 was then escorted back inside the facility. R1 commented to staff, "I will get out again and you won't catch me next time." R1 was to have 1:1 supervision until further notice.

Review of the 4/1/22, video footage identified at 4:46 p.m., R1 was noted to be walking rapidly with her walker in the hallway towards the East door. No staff were visible in the hallway. R1 repeated the same actions as she attempted to open the door on the 3/25/22, incident and exited through the door at 4:47 p.m. NA-C and NA-F responded to the alarm for the East door and exited the building to find R1. At 4:50 p.m. NA-C and NA-F returned through the East door with R1. R1 pulled her walker away from the two NAs and

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F 689	Continued From page 6 walked rapidly toward the nursing station. R1's progress notes from 4/1/22 through 4/9/22 made no mention R1 was on a 1:1 with staff or how staff were tracking and ensuring a 1:1 actually occurred. Review of the 4/5/22, 5 day report submitted to the SA identified 7 staff were interviewed. 6 staff were in other residents' rooms and not able to monitor R1's whereabouts, and 1 staff was on break. The report identified the care plan was to be revised to show 1:1 supervision was to occur until the alarm volume annunciator was to be installed. The facility noted R1 had exited the facility 1 week prior at a different time. There was no mention staff analyzed R1's exit seeking behaviors to look for patterns or trends to help identify when those behaviors were likely to occur. Review of R1's care plan identified staff had not updated R1's care plan on 4/1/22, to show she required 1:1 continuous supervision. On 4/4/22, a revision was made noting a care conference was to be set up with family and R1's MD to discuss different placement options. There was no indication staff were educated R1 was to have continuous 1:1, the care plan was updated with that plan, or how the facility was ensuring continuous 1:1 actually occurred. There was no mention a comprehensive assessment or root cause analysis was completed to determine if 1:1 supervision was attainable, or if the facility looked for patterns of exit seeking behaviors to identify when those behaviors were likely to occur or when R1 would need increased supervision. R1's progress note dated 4/7/22, at 1:36 p.m.	F 689		

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identified a care conference was held with R1's spouse and children, the assistant director of nursing (ADON), and MD to discuss possible options of different placement and potential safety measures for R1. The family members were resistant to transferring R1 to a different facility, as R1's spouse was tentatively able to visit daily wanted to keep her in the facility. There was no mention staff had analyzed R1's behaviors to identify when she was most likely to have exit seeking behaviors, or what they would do if all staff were busy and unable to respond to behaviors to prevent R1 from exiting in the future.

Observations on 4/12/22 at 10:15 a.m. of R1 identified she was in her room lying in bed. Later at 12:00 p.m., R1 was observed eating her noon meal in the dining room.

Interview on 4/12/22, at 10:51 a.m. LPN-A stated she was working on 4/1/22, and was at the nursing station when R1 was standing by the East doorway. LPN-A left the nursing station to assist a different resident who was standing up from his wheelchair and assisted that resident to their room. LPN-A heard the door alarm sound at the East door. LPN-A observed 2 staff members running toward the door, and upon their return to the area, LPN-A was informed R1 had gone out the East door. LPN-A interviewed staff on duty who reported to her they did not hear the alarm as they were in other residents' rooms. The DON requested 1:1 monitoring of R1 until the new annunciator bells were installed on 4/8/22. Education was provided to staff following the 4/1/22, incident which included when R1 was in the hall, staff were to monitor her location, offer snacks, coffee, and possibly sit with her until she was ready to return to her room. R1's family was

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to be notified so they could come visit and assist staff with monitoring R1's location. LPN-A agreed she had not correctly identified R1 as exit seeking that day when R1 was staying by the East door just prior to the incident. LPN agreed she should not have left R1 alone or should have called for assistance so another staff could have supervised R1 preventing her from leaving the facility into an unsafe area outside the East door.

Interview on 4/12/22, at 11:28 a.m., with NA-B stated she was working on 3/25/22 and 4/1/22. NA-B identified on 3/25/22 and 4/1/22, R1 pushed the bar on the door until it released, and she went out both inner and outer East doors. On:
1) 3/25/22, staff received education on WanderGuard door alarms in addition to the outside door alarms, how to reset the alarms, and the procedure for retrieving a resident and immediately reporting the incident to nursing staff.
2) 4/1/22, NA-B and NA-H were in another resident's room with the door closed when they heard the East door alarm. NA-B remembered commenting to NA-H she thought it was R1 who had caused the alarm to sound. As soon as they were able to ensure the current resident's safety, they went to investigate the alarm. Another resident was standing in the hall and pointed to the exit door. NA-B and NA-H went outside the East outer door. NA-B recalled it was very windy that day. R1 was at the end of the ramp hunched forward over her walker with her shirt pulled over her head from the wind. Both NA's assisted R1 to pivot and turn around and go back up the ramp and into the building. NA-B noted R1 had difficulty with her balance in the wind and NA-B and NA-H walked on either side of her to assist as she walked back up the ramp into the building to prevent her from potentially falling over. R1 was

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upset at being brought back into the facility and when they were back in the building made the statement "I will get out again, and you won't catch me next time." R1 was to be placed on 1:1 supervision upon return to the building where it was to have continued until 4/8/22, when the new annunciators were installed as the facility felt louder alarms would alert staff to R1's exiting. R1 was reported to staff to be a high risk for elopement and staff were directed to monitor R1's location "if she wasn't in the dining room". NA-B was unaware if staff were to be in the dining room at all times while R1 was there. NA-B was unsure if staff were to provide increased supervision at times when R1's behaviors escalated to prevent R1 from exiting the building.

Interview on 4/12/22, at 12:01 p.m. with NA-G stated he was working on 4/1/22, when R1 exited the building, and the alarms sounded. NA-G did not check on the alarm, as he "thought it was from another resident" standing near the door. R1 was able to walk very quickly with her walker and her gait was steady. NA-G received education following the incident related to monitoring residents, how doors activated with release, and sounds that would indicate if the door was opened and a resident was outside the building. NA-G was unsure if staff were to provide increased supervision at times when R1's behaviors escalated to prevent R1 from exiting the building.

Interview on 4/12/22, at 12:14 p.m. family member (FM)-A stated R1 was initially admitted to the facility due to being up at night and wandering. FM-A received notification of the elopement incidents and was told a new alarm system was being installed. FM-A was unaware of

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any increased supervision required to prevent R1 from exiting the building.

Interview on 4/12/22, at 1:02 p.m. with NA-I identified staff were to provide 1:1 monitoring of R1 after the 4/1/22 incident. R1 repeatedly stated she wanted to go home and would often walk back and forth in the hall and then to her room. All staff were aware of the need to monitor R1's location. They were aware she frequently wandered in the halls and had exit seeking behaviors. NA-I was unaware if staff were to provide 1:1 supervision at times when R1's behaviors escalated showing exit seeking. NA-I indicated the louder alarms were to alert staff if R1 exited. There was no indication NA-I was trained to provide increased supervision at times when R1's behaviors escalated to prevent R1 from exiting the building.

During interview on 4/12/22, at 2:56 p.m. licensed social worker (LSW) stated a care conference was held on 4/7/22, with herself, R1's spouse, two daughters, ADON, and physician to discuss options for R1's safety. They discussed the possibility of the need to look for other placement if the facility was unable to keep R1 safe and in the building. LSW was not aware all staff were busy and not monitoring R1 when she exhibited exit seeking behaviors. Discussion of a transfer to a locked unit was suggested, but R1's spouse was not accepting of this option and stated if staff were able to hear the alarms "there should not be a problem".

Interview on 4/12/22, at 3:50 p.m. with MD-A (who was also R1's medical doctor) identified he was aware of R1's elopements out of the facility. He agreed there was a safety concern. MD-A

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discussed the care conference with family on 4/7/22, but family preferred R1 remain at the facility. MD-A stated the louder alarm system would be effective in allowing staff to hear the alarms better, and possibly intervene, but it would not prevent R1 from exiting if she were unattended and could open the door. MD-A was not aware of comprehensive assessment having been completed to identify potential causative factors to determine the level of supervision R1 required when exit-seeking behaviors were occurring to prevent future elopements.

During follow-up interview on 4/12/22 at 5:08 p.m., the DON identified she detailed the events of R1's elopement in the follow up reports to the SA, but did not complete additional comprehensive assessment or analysis of R1's exit-seeking behaviors to identify when R1 would require increased supervision to prevent future elopements from occurring. R1 "seemed to be aware of times when staff were busy". That was when she felt R1 was likely to attempt to leave the building. R1's statement about attempting to leave again was concerning. Measures to keep R1 safe included redirection by offering food and drink, use of a WanderGuard device, and 30-minute safety checks. After 4/1/22, when R1 was restless and wandering, R1's spouse was to be contacted to come and sit with her. There was no documentation provided to support current 30-minute safety checks were being completed or if staff identified the need to provide 1:1 supervision at times when R1's behaviors would increase. The DON felt R1 was not an appropriate placement at the facility due to safety concerns and her repeated attempts to exit. The DON elaborated a locked unit might be more appropriate placement, but the family did not

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want R1 transferred out of town. The DON agreed the facility had no method to monitor 30-minute checks were occurring, effective, or had directed staff when they would need to provide 1:1 direct supervision when R1's behaviors escalated to prevent future elopements.

During interview on 4/13/22 at 10:11 a.m., NA-C identified R1 was very mobile, able to self-transfer, and was able to ambulate quickly using her walker. NA-C observed R1 attempting to exit by going to the exit doors, and pushing on the locking bar, but she was able to intervene before R1 actually got the door open. R1 asked NA-C how to leave, stating she wanted to go home. NA-C stated redirection was successful short term, but R1 continued to repeat the behavior. NA-C was unaware if staff needed to provide increased supervision between 30-minute checks when R1 was exhibiting increased exit-seeking behavior.

During interview on 4/13/22 at 10:48 a.m., NA-A stated she was aware R1 made repeated attempts to leave the building and following the recent elopements. NA-A "did not feel comfortable" R1 was not going to try and exit the building again. R1 had repeatedly voiced to NA-A of her intent to leave the facility and go home. NA-A reported she had since observed R1 attempt to open the exit door by pushing the release bar at different times, but the alarm had sounded, and staff were able to intervene before she was able to open the door. NA-A was unaware of any needed increased supervision to prevent exiting from occurring.

Observation on 4/13/22 at 11:00 a.m., of R1

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identified she was seated at the table in the dining room having tea. At 11:30 a.m., R1 ambulated independently back to her room, and was observed to undress in front of her window with opened curtains. Staff were notified by this surveyor to provide assistance to R1 and provide for her privacy.

Observation on 4/13/22, at 2:00 p.m. with the DON of the East door exit identified a ramp was on one side, and several steep steps to the other. The ramp extended from the East door with a partial railing on the hill side of the ramp that extended only halfway along the hill.

Review of the October 2021, Elopement Policy directed the admitting nurse to complete the Safety Risk Assessment and identify potential elopement and/or wandering behaviors and develop a specific plan of care for each resident. A Root Cause Analysis/Comprehensive assessment was to be completed following an elopement to identify what measures needed to be implemented.

The IJ which began on 3/25/22, was removed on 4/14/22, at 12:46 p.m., when it could be verified through observation, interview and record review, the facility had educated all staff to recognize R1's triggers and behaviors of agitation, such as when she was observed pacing the hallways. Staff were to provide immediate supervision and contact R1's spouse to visit. If he was not available, activity staff were to be contacted to provide an activity for R1. If neither spouse of activity staff were available, staff were to provide increased supervision up to and including 1:1 supervision until R1's agitation passes or her exit seeking behaviors subsided. The care plan was

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F 689	Continued From page 14 updated to reflect those changes and R1 was comprehensively re-assessed.	F 689		

Electronically delivered
April 27, 2022

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: State Nursing Home Licensing Orders
Event ID: IRGP11

Dear Administrator:

The above facility was surveyed on April 12, 2022 through April 14, 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us