Electronically Delivered
November 29, 2021

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: CCN: 245399
Cycle Start Date: October 12, 2021

Dear Administrator:

On October 12, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have 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

Electronically delivered
November 1, 2021

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: CCN: 245399
Cycle Start Date: October 12, 2021

Dear Administrator:

On October 12, 2021, a survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 12, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 12, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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
	245399	A. BUILDING _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(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 10/07/21 through 10/12/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints was found to be SUBSTANTIATED: H5399052C (MN76265) with deficiency cited at F689 The following complaint was found to be UNSUBSTANTIATED H5399053C (MN77242) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		11/22/21

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

Electronically Signed | 11/09/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess and develop interventions to reduce the risk of elopement for 1 of 1 residents (R1) reviewed who displayed exit seeking behaviors and had sustained previous elopements without harm. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/27/21, identified R1 had moderate cognitive impairment and was independent with locomotion on and off the unit. Further, the MDS identified R1 displayed no wandering behaviors. R1's initial Elopement Risk Assessment completed 4/30/21, indicated he had no actual risk of an elopement and no potential risk of an elopement. R1's Elopement Risk Assessment completed on 7/27/21, indicated R1 had potential to learn door codes, opens outside exit doors, observant of staff, will attempt to exit when staff is not in close proximity and had a history of exit seeking behavior. In addition the assessment indicated a roam guard placed, resident attempted to leave the facility due to desiring to move to another place to live and sits outside to read and staff check on him frequently. The Assessment that was completed under the section "Causes of Elopement or Wandering" was not completed and was left blank. R1's care plan dated 8/4/21, indicated R1 was at risk for elopement and a personal wandering	F 689	R1 was discharged to independent living on 9/22/21. All residents who leave facility independently are at risk for deficient practice. All residents who currently leave facility independently will be re-assessed. Care plans will be updated based on the results of the assessment and will include any restrictions/limitations residents may require for safety. Staff involved in the assessment completion where educated on the process for completing an assessment on 10/12/21. Staff will be trained on care plan interventions for residents who leave the facility independently. All of the IDT team and nursing staff were educated on 11/9/21. They will notify the case managers if they know a resident who goes out or leaves the property independently. Audits for assessment completion of residents leaving independently will be completed 1 time a week for 4 weeks then 2 times a month for a month and then 1 time a month thereafter. Audit reports will be brought to QAPI committee for review and further recommendations.	

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F 689	Continued From page 2	F 689		

monitor was placed and checks set up per facility standard. Although the Progress Notes by Resident (PDBR) indicated the WanderGuard was placed on 7/2/21, the elopement assessment was not completed until 7/27/21 and was not care planned until 8/4/21.

A PDBR note dated 7/01/21, written by the facility administrator indicated, "Writer spoke with resident today regarding intent to leave facility. Resident told writer that his van would not be here until at least Tuesday and that his plans to leave today had fallen apart. Writer discussed potential discharge locations from facility. Resident expressed interest in finding an apartment in Little Falls, MN. Resident stated he did not get the apartment in the county he wanted."

A PDBR note dated 7/02/21, indicated per request from administrator a WanderGuard was placed on residents wheelchair.

A facility reported incident dated 8/29/21, indicated R1 was deemed safe to go outside independently, and was safe to go to Burger King and the bank across the street from the facility and had a WanderGuard in place due to his forgetfulness in letting staff know he was going outside or leaving the facility. There report further indicated over the past few months his cognition declined and a new assessment needed to be completed as he was no longer safe for him to leave the facility and he refused cognitive testing with occupational therapy and he was moderately cognitively impaired. The report indicated on 8/29/21, at 8:00 a.m. he left out the front door and the wander guard sounded and he left the parking lot so staff called the police. The police located

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F 689	Continued From page 3	F 689		

him at Burger King eating and R1 returned to the facility at 10:15 a.m. At 11:00 a.m. the front door alarm went off again and staff watched him and attempted to encouraged him to come back but he continued to leave so the police were called again. R1 eventually came back with the police officer at 12:00 p.m. and then went to the emergency department and was diagnosed with a urinary tract infection.

A St. Gabriel's Emergency Department provider note dated 8/29/21, indicated R1 arrived by ambulance and was diagnosed with dementia with behavioral disturbance. The report indicated he was seen for a urinary tract infection and was sent home with an order for Bactrim (antibiotic) and to increase fluids.

During interview on 10/7/21, at 4:00 p.m. director of nursing (DON) stated the causes on the elopement assessment should be filled out by the nurse case managers and both of them are new to their positions and might not have been trained to fill them out correctly. The DON stated she will make sure to educate them on making sure to fill that portion out on the assessment. In a further interview at 4:10 p.m. the DON stated R1 was assessed and approved to go to the bank a cross the street and to go to Burger King next door until he was diagnosed with Shingles (infection caused by the varicella-zoster virus, which is the same virus that causes chickenpox) and he was told he needed to stay in his room to prevent spreading the virus and he became very upset and refused to stay in his room. The DON stated R1 was so upset on 8/27/21, he left the facility and went to the bank and they were unable to stop him so they called his niece who was his power of attorney. The DON stated he was

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F 689	Continued From page 4	F 689		

aggressive and the police were called and eventually returned him to the facility. The DON stated she did not report the incident to the state agency since she felt it was not an elopement because she knew R1 was going to the bank. He did go the the emergency room on that Sunday and the physician stated his shingles were scabbed over and he no longer needed to stay in his room. The DON stated the resident had since discharged from the nursing home.

During interview on 10/08/21, at 9:00 a.m. physical therapist assistant (PTA)-A stated she is the therapy manager and worked with R1 a couple times when he first admitted and the certified occupational therapist (COTA)-A attempted to do some cognitive testing but R1 refused. The PTA-A stated she never assessed R1 as safe to leave the building and never would have agreed for him to cross highway 27 which is a busy highway in front of the nursing home in which he would have to cross to get to the bank.

During interview on 10/08/21, at 12:53 p.m. family member (FM)-A stated she is the power of attorney for R1 and never once agreed for him to leave the facility alone and could only leave the facility if someone was with him. FM-A added, "When [R1] went to the bank on 8/27/21, he attempted to withdrawal $10,000 so the bank called me and asked if it would be ok and I told them no and allowed them to give him $200. He also eloped twice that weekend and the police were called, I was furious. The police wanted me to come get him. That is why I had him in the nursing home!" FM-A stated she worried about him crossing the highway and knows he was not always using the stop light and would just cross the street right in front of the nursing home.

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F 689	Continued From page 5	F 689		

During interview on 10/08/21, at 6:45 p.m. Police Officer (PO) stated he was involved with the incident at the bank on 8/27/21, stated R1 was verbally and physically abusive with the bank staff and he removed R1 from the bank and wheeled him back to the nursing home. He also stated he was called again that Sunday and found R1 at Burger King eating and brought him back to the nursing home and a ambulance was called because he was so upset the facility wanted him to stay in his room due to his shingles and he didn't believe he had them, so he wanted to be checked out.

During interview on 10/11/21, at 2:34 p.m. previous social worker (SW)-A stated R1 would go to the bank himself and FM-A would also take him into the community while he was at the facility. SW-A stated the activity director (AD) assessed R1 to go out into the community alone and in fact the AD was a certified occupational therapist (COTA).

During interview on 10/11/21, at 2:41 p.m. AD stated she is the director of activities and never assessed R1 to be safe to leave the facility independently. The AD stated she and the unit case manager tried to stop R1 earlier in August 2021 from leaving the facility to go to the bank and was told by SW-A stated that R1 was safe to leave the facility alone. AD stated maybe the SW-A was confused and thought I assessed him because I have a degree in COTA but I did not assess him to leave alone.

During interview on 10/11/21, at 4:11 p.m. the facility nurse consultant stated the facility should have done a safe to leave facility assessment on

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F 689	Continued From page 6 R1 to determine if he was safe to leave the facility independently. The consultant stated the only document she could find was his elopement assessments. The facility Resident Assessment Templates indicated the following assessment only required if they apply for residents-Complete PRN (as needed) revised 1/25/19, Leaves facility independently (If goes outside or leaves the property alone). The facility Elopement policy revised 10/23/17, indicated any time a resident is identified at a risk for elopement a Comprehensive Elopement Assessment will be completed and a plan put into place, which will include the residents; cognitive status, ambulation and mobility status, history of wandering, supervision if required to leave the building, interventions in place to prevent the elopement.	F 689		

Electronically delivered
November 1, 2021

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

Re: State Nursing Home Licensing Orders
Event ID: 4JP911

Dear Administrator:

The above facility was surveyed on October 7, 2021 through October 12, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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
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	00382	A. BUILDING: _____ B. WING _____	C 10/12/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/07/21 through 10/12/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT compliance with the MN State Licensure. The following complaint was found to be	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H5399052C (MN76265), licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5399053C (MN77242) The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess and develop interventions to reduce the risk of elopement for 1 of 1 residents (R1) reviewed who	2 830	Corrected	11/22/21

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	00382	A. BUILDING: _____ B. WING _____	C 10/12/2021

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2 830	Continued From page 2 displayed exit seeking behaviors and had sustained previous elopements without harm. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/27/21, identified R1 had moderate cognitive impairment and was independent with locomotion on and off the unit. Further, the MDS identified R1 displayed no wandering behaviors. R1's initial Elopement Risk Assessment completed 4/30/21, indicated he had no actual risk of an elopement and no potential risk of an elopement. R1's Elopement Risk Assessment completed on 7/27/21, indicated R1 had potential to learn door codes, opens outside exit doors, observant of staff, will attempt to exit when staff is not in close proximity and had a history of exit seeking behavior. In addition the assessment indicated a roam guard placed, resident attempted to leave the facility due to desiring to move to another place to live and sits outside to read and staff check on him frequently. The Assessment that was completed under the section "Causes of Elopement or Wandering" was not completed and was left blank. R1's care plan dated 8/4/21, indicated R1 was at risk for elopement and a personal wandering monitor was placed and checks set up per facility standard. Although the Progress Notes by Resident (PDBR) indicated the WanderGuard was placed on 7/2/21, the elopement assessment was not completed until 7/27/21 and was not care planned until 8/4/21. A PDBR note dated 7/01/21, written by the facility	2 830		

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2 830	Continued From page 3 administrator indicated, "Writer spoke with resident today regarding intent to leave facility. Resident told writer that his van would not be here until at least Tuesday and that his plans to leave today had fallen apart. Writer discussed potential discharge locations from facility. Resident expressed interest in finding an apartment in Little Falls, MN. Resident stated he did not get the apartment in the county he wanted." A PDBR note dated 7/02/21, indicated per request from administrator a WanderGuard was placed on residents wheelchair. A facility reported incident dated 8/29/21, indicated R1 was deemed safe to go outside independently, and was safe to go to Burger King and the bank across the street from the facility and had a WanderGuard in place due to his forgetfulness in letting staff know he was going outside or leaving the facility. There report further indicated over the past few months his cognition declined and a new assessment needed to be completed as he was no longer safe for him to leave the facility and he refused cognitive testing with occupational therapy and he was moderately cognitively impaired. The report indicated on 8/29/21, at 8:00 a.m. he left out the front door and the wander guard sounded and he left the parking lot so staff called the police. The police located him at Burger King eating and R1 returned to the facility at 10:15 a.m. At 11:00 a.m. the front door alarm went off again and staff watched him and attempted to encouraged him to come back but he continued to leave so the police were called again. R1 eventually came back with the police officer at 12:00 p.m. and then went to the emergency department and was diagnosed with a urinary tract infection.	2 830		

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2 830	Continued From page 4 A St. Gabriel's Emergency Department provider note dated 8/29/21, indicated R1 arrived by ambulance and was diagnosed with dementia with behavioral disturbance. The report indicated he was seen for a urinary tract infection and was sent home with an order for Bactrim (antibiotic) and to increase fluids. During interview on 10/7/21, at 4:00 p.m. director of nursing (DON) stated the causes on the elopement assessment should be filled out by the nurse case managers and both of them are new to their positions and might not have been trained to fill them out correctly. The DON stated she will make sure to educate them on making sure to fill that portion out on the assessment. In a further interview at 4:10 p.m. the DON stated R1 was assessed and approved to go to the bank a cross the street and to go to Burger King next door until he was diagnosed with Shingles (infection caused by the varicella-zoster virus, which is the same virus that causes chickenpox) and he was told he needed to stay in his room to prevent spreading the virus and he became very upset and refused to stay in his room. The DON stated R1 was so upset on 8/27/21, he left the facility and went to the bank and they were unable to stop him so they called his niece who was his power of attorney. The DON stated he was aggressive and the police were called and eventually returned him to the facility. The DON stated she did not report the incident to the state agency since she felt it was not an elopement because she knew R1 was going to the bank. He did go the the emergency room on that Sunday and the physician stated his shingles were scabbed over and he no longer needed to stay in his room. The DON stated the resident had since discharged from the nursing home.	2 830		

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2 830	Continued From page 5 During interview on 10/08/21, at 9:00 a.m. physical therapist assistant (PTA)-A stated she is the therapy manager and worked with R1 a couple times when he first admitted and the certified occupational therapist (COTA)-A attempted to do some cognitive testing but R1 refused. The PTA-A stated she never assessed R1 as safe to leave the building and never would have agreed for him to cross highway 27 which is a busy highway in front of the nursing home in which he would have to cross to get to the bank. During interview on 10/08/21, at 12:53 p.m. family member (FM)-A stated she is the power of attorney for R1 and never once agreed for him to leave the facility alone and could only leave the facility if someone was with him. FM-A added, "When [R1] went to the bank on 8/27/21, he attempted to withdrawal $10,000 so the bank called me and asked if it would be ok and I told them no and allowed them to give him $200. He also eloped twice that weekend and the police were called, I was furious. The police wanted me to come get him. That is why I had him in the nursing home!" FM-A stated she worried about him crossing the highway and knows he was not always using the stop light and would just cross the street right in front of the nursing home. During interview on 10/08/21, at 6:45 p.m. Police Officer (PO) stated he was involved with the incident at the bank on 8/27/21, stated R1 was verbally and physically abusive with the bank staff and he removed R1 from the bank and wheeled him back to the nursing home. He also stated he was called again that Sunday and found R1 at Burger King eating and brought him back to the nursing home and a ambulance was called because he was so upset the facility wanted him	2 830		

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2 830	Continued From page 6	2 830		

to stay in his room due to his shingles and he didn't believe he had them, so he wanted to be checked out.

During interview on 10/11/21, at 2:34 p.m. previous social worker (SW)-A stated R1 would go to the bank himself and FM-A would also take him into the community while he was at the facility. SW-A stated the activity director (AD) assessed R1 to go out into the community alone and in fact the AD was a certified occupational therapist (COTA).

During interview on 10/11/21, at 2:41 p.m. AD stated she is the director of activities and never assessed R1 to be safe to leave the facility independently. The AD stated she and the unit case manager tried to stop R1 earlier in August 2021 from leaving the facility to go to the bank and was told by SW-A stated that R1 was safe to leave the facility alone. AD stated maybe the SW-A was confused and thought I assessed him because I have a degree in COTA but I did not assess him to leave alone.

During interview on 10/11/21, at 4:11 p.m. the facility nurse consultant stated the facility should have done a safe to leave facility assessment on R1 to determine if he was safe to leave the facility independently. The consultant stated the only document she could find was his elopement assessments.

The facility Resident Assessment Templates indicated the following assessment only required if they apply for residents-Complete PRN (as needed) revised 1/25/19, Leaves facility independently (If goes outside or leaves the property alone).

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2 830	Continued From page 7 The facility Elopement policy revised 10/23/17, indicated any time a resident is identified at a risk for elopement a Comprehensive Elopement Assessment will be completed and a plan put into place, which will include the residents; cognitive status, ambulation and mobility status, history of wandering, supervision if required to leave the building, interventions in place to prevent the elopement. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures regarding comprehensive elopement assessment; then educate staff on ensuring residents are assessed to be safe to leave the facility, and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		