Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 7, 2022

Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

RE: CCN: 245489
Cycle Start Date: July 18, 2022

Dear Administrator:

On August 29, 2022, we notified you a remedy was imposed. On October 4, 2022 the Minnesota Department(s) of Health and Public Safety 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 September 27, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 13, 2022 be discontinued as of September 27, 2022. (42 CFR 488.417 (b))

In our letter of August 1, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 13, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 27, 2022, therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered

October 7, 2022

Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

Re: Reinspection Results
Event ID: XPMH12

Dear Administrator:

On August 23, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 23, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
August 1, 2022

Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

RE: CCN: 245489
Cycle Start Date: July 18, 2022

Dear Administrator:

On July 18, 2022, 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"and/or an E 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 October 18, 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 January 18, 2023 (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,

Sarah Lane

Sarah Lane, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	C 07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/14/22 - 7/18/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54893229C (MN85019), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	Tag: F689 Free of	8/21/22

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

Electronically Signed — 08/04/2022

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

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F 689	Continued From page 1 review the facility failed to perform maintenance of the Guardian door security system per the manufacturers recommendations and failed to implement a clear process for reporting and documenting malfunctions of the system resulting in an elopement for 1 of 2 residents (R1) reviewed for elopement. Findings include: R1's Admission Record indicated he admitted to the facility on 6/17/21. R1's diagnosis included dementia, anxiety and depression. R1's significant change Minimum Data Set (MDS) dated 6/30/22, identified severe cognitive impairment and indicated he required assistance from one staff for ambulation. R1's care plan dated 6/30/22, indicated he was at risk for elopement related to impaired cognition, history of attempts to leave the facility unattended and impaired safety awareness. The care plan identified the use of a Wanderguard bracelet (device used to activate locks and/or alarms to prevent exiting) and directed staff to check placement and function per facility protocol. R1's Elopement Risk Assessment dated 6/30/22, indicated he ambulated with assistance, displayed impulsive behaviors and poor safety awareness. The assessment indicated he had been up walking independently on 6/26/22 and had a history of wandering/exit seeking. An undated, untitled "summary" of events indicated R1 left the building and was found by an off duty staff member on 7/11/22, at 5:36 p.m. Upon contacting nurse, he was escorted back to	F 689	Accidents/Hazards/Supervision/Devices Corrective action to resident found to be affected: Resident was moved to a locked unit for safety. How the facility identified other residents potential to be affected: All other residents that were at risk for elopement and not currently on a locked unit were put on increased safety checks until maintenance on the door is resolved and in working order. Measures put in place to ensure it will not recur: Education to nurses on the procedure for checking code alerts and reporting. Maintenance was updated/Educated on manufacturer's recommendations and checks initiated per manufacturer’s instructions. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: Nursing/Maintenance	

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F 689	Continued From page 2 the facility. R1 was last seen in his room at 5:06 p.m. by nursing. When found he stated he was going to Fargo. Due to elopement R1 was moved to secure memory care unit. When checking function of wanderguard it was noted doors were not functioning properly. Other resident wearing wanderguards placed on 30 minute checks until door is secure. R1's facility Progress Notes revealed the following: 6/18/22, Staff found R1 in the therapy dining room after supper banging his walker on the window sill. R1 stated he wanted to go for a walk outside. Staff assisted R1 back to his room. Later during the shift staff found R1 halfway down the hallway with no walker an no shoes. 6/26/22, After family member had left, R1 was out walking in the hallway. 7/11/22, R1 was moved to the secured unit of the facility. 15 minute locations checks were discontinued. Review of R1's Medication Administration Record (MAR) dated July 2022, indicated: Nurse/TMA (trained medication aide) to check if Wanderguard is working properly every day and evening shift. If not working you need to notify manager immediately. The MAR indicated "yes" every day and every shift with the exception of 7/8/22, which indicated no. During interview on 7/15/22, at 8:26 a.m. licensed practical nurse (LPN)-A stated she was aware R1 had eloped from the facility but was unsure which door he exited. LPN-A stated R1 had eloped from	F 689	Date of completion: August 21, 2022	

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F 689	Continued From page 3 the facility one other time and a Wanderguard had been placed. LPN-A stated the Wanderguard was checked for functioning by taking a resident over to a door. LPN-A stated she typically checked the nearest door. During an interview on 7/15/22 at 9:26 a.m. maintenance technician (MT)-A reviewed the maintenance logs and did not find evidence the malfunction had been reported. MT-A stated he tested all of the doors in the facility once per month. MT-A said he got a transmitter from a nurse to test the doors. MT-A stated he was not aware the doors had not been working. On 7/15/22, at 11:16 a.m. the administrator stated after R1 eloped from the facility the nurse on duty tested the doors and discovered while the Wanderguard device was working the front entry door was not functioning properly. The administrator stated the front door was back in working order the following day. On 7/15/22, at 11:30 a.m. during a tour, the administrator had a transmitter in her hand. While approaching the front door, the Wanderguard did not activate properly and the front entry doors slid open. A second door leading outside off the transitional care unit was tested. When the transmitter was near the door the light came on but the door still opened. On 7/18/22, at 11:09 a.m. RN-B stated when checking Wanderguard function she took residents on the unit to the administrative entrance because it was the closest door. RN-B stated that entrance was always locked so it would not work anyway. RN-B stated she had never tested any of the other doors.	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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F 689	Continued From page 4 On 7/18/22, at 11:13 a.m. RN-C stated she had checked the main entry door that morning and it did not function properly. On 7/18/22, at 11:30 a.m. the director of nursing (DON) stated the staff should be checking the main entry door regardless of what unit the resident was on. The DON stated there was no formal training on the process for checking Wanderguard function and said the nurses trained during orientation with another staff. On 7/18/22, at 11:42 a.m. the maintenance director (MD) stated the Wanderguard system was checked every month. The MD stated "we grab a pendant every month and go to a door and make sure they are locking." He stated MT-A checks the doors and said "he probably just holds it in his hand and walks through." On 7/18/22, at 12:54 p.m. RN-A acknowledged she had marked "yes" in the MAR for Wanderguard function. RN-A stated she checked yes to indicate she checked the Wanderguard, not yes that it was working. On 7/18/22, at 1:35 p.m. the DON confirmed the yes/no in the MAR pertained to whether the device was functioning or not. On 7/18/22, at 3:08 p.m. the DON confirmed staff continued to indicated proper Wanderguard functioning even though the door continued to malfunction. The DON stated staff were charting "yes" because while the door did not work the device was still functioning. On 7/18/22, at 3:20 p.m. the MD stated he was	F 689		

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F 689	Continued From page 5 not aware of the recommendations for testing the system and said, "we just test them monthly." Review of the Guardian user manual dated 10/28/13,Section II testing, indicated the following: Recommended Weekly Testing, Testing Wandering Patient Monitoring with Lock. - Patient Escort Feature Test: Enter the monitoring zone with a transmitter on your ankle. The red LED will turn on and the door will quietly lock. A facility policy related to checking proper functioning of the Wanderguard device was requested but not received.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2022

Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

Re: State Nursing Home Licensing Orders
Event ID: XPMH11

Dear Administrator:

The above facility was surveyed on July 14, 2022 through July 18, 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:

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

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

Please feel free to call me with any questions.

Sarah Lane

Sarah Lane, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00013	A. BUILDING: _____ B. WING _____	C 07/18/2022

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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/14/22 - 7/18/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00013	A. BUILDING: _____ B. WING _____	C 07/18/2022

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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54893229C (MN85019) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00013	A. BUILDING: _____ B. WING _____	C 07/18/2022

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to perform maintenance of the Guardian door security system per the manufacturers recommendations and failed to implement a clear process for reporting and documenting malfunctions of the system resulting in an elopement for 1 of 2 residents (R1) reviewed for elopement. Findings include:	2 830	corrected	8/21/22

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2 830	Continued From page 3 R1's Admission Record indicated he admitted to the facility on 6/17/21. R1's diagnosis included dementia, anxiety and depression. R1's significant change Minimum Data Set (MDS) dated 6/30/22, identified severe cognitive impairment and indicated he required assistance from one staff for ambulation. R1's care plan dated 6/30/22, indicated he was at risk for elopement related to impaired cognition, history of attempts to leave the facility unattended and impaired safety awareness. The care plan identified the use of a Wanderguard bracelet (device used to activate locks and/or alarms to prevent exiting) and directed staff to check placement and function per facility protocol. R1's Elopement Risk Assessment dated 6/30/22, indicated he ambulated with assistance, displayed impulsive behaviors and poor safety awareness. The assessment indicated he had been up walking independently on 6/26/22 and had a history of wandering/exit seeking. An undated, untitled "summary" of events indicated R1 left the building and was found by an off duty staff member on 7/11/22, at 5:36 p.m. Upon contacting nurse, he was escorted back to the facility. R1 was last seen in his room at 5:06 p.m. by nursing. When found he stated he was going to Fargo. Due to elopement R1 was moved to secure memory care unit. When checking function of wanderguard it was noted doors were not functioning properly. Other resident wearing wanderguards placed on 30 minute checks until door is secure. R1's facility Progress Notes revealed the following:	2 830		

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2 830	Continued From page 4 6/18/22, Staff found R1 in the therapy dining room after supper banging his walker on the window sill. R1 stated he wanted to go for a walk outside. Staff assisted R1 back to his room. Later during the shift staff found R1 halfway down the hallway with no walker an no shoes. 6/26/22, After family member had left, R1 was out walking in the hallway. 7/11/22, R1 was moved to the secured unit of the facility. 15 minute locations checks were discontinued. Review of R1's Medication Administration Record (MAR) dated July 2022, indicated: Nurse/TMA (trained medication aide) to check if Wanderguard is working properly every day and evening shift. If not working you need to notify manager immediately. The MAR indicated "yes" every day and every shift with the exception of 7/8/22, which indicated no. During interview on 7/15/22, at 8:26 a.m. licensed practical nurse (LPN)-A stated she was aware R1 had eloped from the facility but was unsure which door he exited. LPN-A stated R1 had eloped from the facility one other time and a Wanderguard had been placed. LPN-A stated the Wanderguard was checked for functioning by taking a resident over to a door. LPN-A stated she typically checked the nearest door. During an interview on 7/15/22 at 9:26 a.m. maintenance technician (MT)-A reviewed the maintenance logs and did not find evidence the malfunction had been reported. MT-A stated he tested all of the doors in the facility once per month. MT-A said he got a transmitter from a	2 830		

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2 830	Continued From page 5 nurse to test the doors. MT-A stated he was not aware the doors had not been working. On 7/15/22, at 11:16 a.m. the administrator stated after R1 eloped from the facility the nurse on duty tested the doors and discovered while the Wanderguard device was working the front entry door was not functioning properly. The administrator stated the front door was back in working order the following day. On 7/15/22, at 11:30 a.m. during a tour, the administrator had a transmitter in her hand. While approaching the front door, the Wanderguard did not activate properly and the front entry doors slid open. A second door leading outside off the transitional care unit was tested. When the transmitter was near the door the light came on but the door still opened. On 7/18/22, at 11:09 a.m. RN-B stated when checking Wanderguard function she took residents on the unit to the administrative entrance because it was the closest door. RN-B stated that entrance was always locked so it would not work anyway. RN-B stated she had never tested any of the other doors. On 7/18/22, at 11:13 a.m. RN-C stated she had checked the main entry door that morning and it did not function properly. On 7/18/22, at 11:30 a.m. the director of nursing (DON) stated the staff should be checking the main entry door regardless of what unit the resident was on. The DON stated there was no formal training on the process for checking Wanderguard function and said the nurses trained during orientation with another staff.	2 830		

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2 830	Continued From page 6 On 7/18/22, at 11:42 a.m. the maintenance director (MD) stated the Wanderguard system was checked every month. The MD stated "we grab a pendant every month and go to a door and make sure they are locking." He stated MT-A checks the doors and said "he probably just holds it in his hand and walks through." On 7/18/22, at 12:54 p.m. RN-A acknowledged she had marked "yes" in the MAR for Wanderguard function. RN-A stated she checked yes to indicate she checked the Wanderguard, not yes that it was working. On 7/18/22, at 1:35 p.m. the DON confirmed the yes/no in the MAR pertained to whether the device was functioning or not. On 7/18/22, at 3:08 p.m. the DON confirmed staff continued to indicated proper Wanderguard functioning even though the door continued to malfunction. The DON stated staff were charting "yes" because while the door did not work the device was still functioning. On 7/18/22, at 3:20 p.m. the MD stated he was not aware of the recommendations for testing the system and said, "we just test them monthly." Review of the Guardian user manual dated 10/28/13,Section II testing, indicated the following: Recommended Weekly Testing, Testing Wandering Patient Monitoring with Lock. - Patient Escort Feature Test: Enter the monitoring zone with a transmitter on your ankle. The red LED will turn on and the door will quietly lock. A facility policy related to checking proper	2 830		

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2 830	Continued From page 7 functioning of the Wanderguard device was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to checking proper functioning of the Wanderguard system and proper training related to documentation and reporting of malfunctions. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		