Electronically delivered
December 10, 2021

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: CCN: 245548
Cycle Start Date: November 30, 2021

Dear Administrator:

On November 30, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On November 28, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's

administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Tuff Memorial Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 30, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

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

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00576	A. BUILDING: _____ B. WING _____	C 11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

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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 11/29/21 through 11/30/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5548020C (MN78745) (MN78849), however NO licensing orders were issued. 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		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 10, 2021

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

Re: Event ID: BJVL11

Dear Administrator:

The above facility survey was completed on November 30, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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F 000	INITIAL COMMENTS On 11/29/21 through 11/30/21, 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 requirements of 42 CFR Part 483, Subpart B, the 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 11/22/21, when facility failed to provide adequate supervison for R1 a known wanderer who was able to access a restricted area through the kitchen while in her wheelchair and fall down a stairwell resulting in subsequent fractures of left shoulder, wris, and 5 ribs including a laceration to left side of her head. The administrator was notified of the IJ for R1 on 11/30/21 at 2:15 p.m.. The IJ was removed on 11/28/21, prior to the survey when the facility took actions to correct the deficient practice. No extended survey was conducted. The following complaint was found to be SUBSTANTIATED: H5548020C (MN78745) (MN78849) with a deficiency cited at F689. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. NO plan of correction is required for a finding of past non-compliance. The facility is still required to acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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

Electronically Signed

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F 689	Continued From page 1 §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 interview and document review, the facility failed to provide adequate supervision for 1 of 1 wandering resident (R1), who accessed the kitchen area when staff left the door open and kitchen unattended, and fell down the back stairwell. This resulted in actual harm as R1 sustained fractures of her shoulder blade, wrist, 5 ribs, a laceration to the left side of her head and bleeding on her brain. The immediate jeopardy began on 11/22/21, when the facility failed to provide adequate supervision for R1 who was able to access a restricted area through the kitchen in her wheelchair and fell down a stairwell resulting in fractures of shoulder blade, wrist, and 5 ribs including a laceration to the left side of her head and was identified on 11/30/21. The administrator and DON were notified of the immediate jeopardy on 11/30/21 at 2:15 p.m. The immediate jeopardy was removed, and the deficient practice corrected on 11/28/21, prior to the start of the survey and was therefore Past Noncompliance. Findings include: Review of the 11/22/21 at 4:33 p.m., report to the State Agency (SA) identified R1 had entered the kitchen without being seen. The evening cook	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

was heading to the pantry and heard R1 around the corner in the stairwell. The cook went to investigate and saw R1 lying on the lower stairwell platform, 5 steps down. The cook proceeded to get help. The nurse called 911 and R1 was sent to emergency room for evaluation. Initial injuries identified were bruising to her forehead with an open area, and possible fracture of her arm and hip. R1 was alert and responded to prompts and was able to verbalize pain symptoms. The facilities 5-day summary identified all actions taken to prevent reoccurrence (as noted above).

R1's 6/1/21, Elopement report identified the front door Wander Guard alert sounded. R1 was observed to be across the driveway sitting on the grass in front of her wheelchair. R1 was still on facility grounds. Prior to R1 eloping out front door she was upset stating she wanted to take her cat home. R1 had been reminded her family would be coming to visit shortly. R1 had been assisted to her room shortly before she went out the door. R1 was confused and talked about going home multiple times during the day. The report provided identified R1's family member and physician had been notified. There was no mention any new interventions were implemented to protect R1 from harm.

R1's 8/31/21, quarterly Minimum Data Set (MDS) identified R1's had moderately impaired cognition and wandered daily. R1 was able to walk in the corridor with limited assistance and used a walker or wheelchair for locomotion. R1 had a bed alarm, chair alarm, and a wander/elopement alarm. R1 had a diagnosis of dementia.

R1's 6/8/21, Care Area Assessment (CAA)

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F 689	Continued From page 3	F 689		

identified R1 had behaviors symptoms of wandering 1 to 3 days during the assessment period. Staff were to ensure R1 was to safely wander through facility in her wheelchair. Staff were to redirect R1 and take back to her room to visit about her cat, her flowers, or the weather. R1 had a history of prior unsafe behavior of elopement by leaving the facility out the front door after attempting to return home.

R1's 9/14/21, Elopement Assessment identified R1 attempted to elope monthly. R1 had not had any successful elopement attempts off campus. R1 had impaired cognition and a diagnosis of dementia. R1 displayed wandering and exit seeking behaviors. R1 verbalized a desire to go home and look for people.

R1's current, undated care plan identified R1 was forgetful, had impaired safety awareness, wandered in her wheelchair looking for family and had wanted to go home. Staff were to disguise exits, use stop signs on front exit door, northeast door, and the northwest door. Staff were to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. R1 had worked at a hardware store and staff were to visit with her about her past work. Staff were to monitor her whereabouts every 2 hours and document her location. If staff were unable to locate R1, staff were to notify the charge nurse immediately. R1's triggers for wandering and elopement behavior were wanting to go home and looking for family. R1's behaviors could be de-escalated by letting R1 know what time family would be coming, remind her they knew where she was, and show R1 her room with her name outside of it. R1 had a WanderGuard applied to

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F 689	Continued From page 4	F 689		

her wheelchair and used a tabs alarm to alert staff if she attempted to stand on her own. R1 had a fall risk related to history of falls, unsteady gait, and unaware of safety needs. Staff were to anticipate her needs, have call light within reach, alarm on bed and in her wheelchair, ensure she had appropriate footwear on and encourage her to participate in restorative therapy along with activities.

R1's progress notes identified staff documented on:
1) 6/1/21, the facility front door wander-guard alert sounded. R1 was observed across the driveway sitting on the grass in front of the wheelchair. R1 had been upset prior to the incident and stated she wanted to take her cat home.
2) 6/2/21, R1 attempted to leave the facility after supper.
3) 7/20/21, R1 attempted to exit facility 2 times. R1 had been looking for a way to get out of the building and go home.
4) 8/2/21, R1 had been wandering in the hallway all day. Staff noted R1 fell in her bathroom. Staff were to remind R1 to wait for help. Staff were to ensure they stayed with R1 when toileting.
5) 10/19/21, R1 was noted to be in the hallway trying to find a door to go home.
6) 11/21/21, R1 fell out of her wheelchair while in dining room by the table. Staff noted they were unable to intervene before she fell to the floor.
7) 11/22/21, R1 had fallen down stairwell in restricted area, was sent to emergency room for evaluation and admitted to the hospital.
8) 11/30/21, R1 was re-admitted to facility with bilateral splints extending from hands to below her elbows. Multiple bruises were noted. She had sutures to left forehead, and had orders for

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F 689	Continued From page 5	F 689		

hospice and pain management. R1 was currently bedridden with interventions in place.

Observation and interview on 11/29/21 at 1:00 p.m., of the kitchen doors with the dietary manager (DM) identified the door which led into the dishwashing room was shut but not locked, however staff were just inside the door. All remaining kitchen doors not immediately attended were confirmed to be locked. The DM identified R1 had gone through door A. Door A was open as the cook had been in and out during coffee time assisting residents after BINGO. R1 was able to wheel herself into the kitchen through door A, then through door-B and down the hallway before entering door-D which led to the outside directly in front of exit door was an open stairwell to the left. The staircase was observed to have 5 steps leading down to a platform with additional steps leading down to the basement area. DM revealed door-D had no lock and had been left open during the loading of meals into the van for delivery to the another facility building. The DM confirmed door-D was not to be left open a any time. R1 was in her wheelchair and had gone through door-D. It was assumed R1 attempted to open the locked outside door. Staff felt when R1 was unsuccessful, she likely tried to turn around and fell down the open stairwell. Cook (C)-A was on the way to the pantry when she heard an alarm and went to investigate. C-A found R1 with part of her body on the platform and the rest on the steps. C-A came running out and summoned assistance. One of the nurses called 911 and the ambulance arrived. The DM confirmed R1 was an exit seeker. Staff had to redirect her often.

Interview on 11/29/21 at 1:46 p.m., with C-A identified she had been the evening cook on

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F 689	Continued From page 6	F 689		

11/22/21. She had been assisting with serving coffee after BINGO in the dining room, which was also used for activities. Door-A was usually open when staff were serving residents. She went back into the kitchen and was on her way to the pantry across from door D to get more cups when she heard a beeping sound. C-A thought it was the back exit door alarm. When she entered through door-D, she saw R1 lying on the steps with her wheelchair on top of her. She ran for help and returned with the activity director (AD) who assisted her to get the wheelchair off of R1. Prior to the incident, she recalled R1 had been sitting at the table directly across the room from door-A. She did not see R1 leave the table or go towards the kitchen. R1 was known to "roam around" and somehow had gotten into the kitchen unobserved. Activity aid (AA)-B was also in dining room helping serve coffee. The activity director (AD) who had just finished BINGO, was not directly in the area of the dining room at the time of the incident, but was back by DM office. C-A confirmed R1 had went through door-A as she had left it open while she was going in and out of the kitchen. Since the incident, staff were to make sure all kitchen doors were shut and locked. Door-A could only be open during the 3 main mealtimes while staff were present.

Interview on 11/29/21 at 2:05 p.m., with the AD identified BINGO ended around 2:45 p.m.. At the time of the incident, she was standing in the doorway of the DM office talking to the DM when C-A ran out of the door yelling for help. She went to assist C-A while the DM found additional help and someone to call 911. She described R1's position as her bottom laying on the platform of the stairway and her head on the first step down from there. R1 was bleeding and had her

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F 689	Continued From page 7	F 689		

wheelchair on top of her. Once they got the wheelchair off R1, she was able to kneel on the steps and apply pressure to R1's head to stop the bleeding and support her with her body. Several other staff arrived and medical aid was provided while they waited for the ambulance. No staff had seen R1 enter the kitchen. She confirmed door-A was normally closed, but during coffee or activity time it was open. R1 would talk about leaving the facility but usually just looked out the window for her family's truck as they came daily to visit. The AD revealed if door-A had been closed "this would have never happened". The AD had re-educated activity staff after the incident to ensure no residents were left unattended in the dining room and that all kitchen doors were to be locked at all times unless during a meal service.

Interview on 11/29/21 at 2:48 p.m., with AA-C identified AA-C was assisting with BINGO prior to the incident. There were 3 other residents at that table and all had coffee and a snack. One of the residents had asked for a ride back to their room. There was another activity staff still in the dining room at the time when she left the dining room. At that time, R1 was still drinking her coffee when she left the dining room. As she was walking back into the dining room, the medication nurse asked her if she knew where R1 was. At that moment, the charge nurse, DON, and administrator were seen coming through the dining room and going into the kitchen. AA-C stated she thought she had only been away 5 minutes before returning to the dining room and since other staff were in the dining room at the time she left, she felt it was ok to leave. She did not coordinate with other staff to ensure someone supervised the remaining residents while other staff escorted residents back to their rooms. After

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	245548	A. BUILDING _____ B. WING _____	C 11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

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F 689	Continued From page 8	F 689		

the incident, she was re-educated the kitchen doors were to be closed and locked when kitchen staff were not present. No resident was to be left unsupervised in the dining room. She revealed prior to the incident, R1 was known to wheel herself around in her wheelchair throughout the facility. She had "no problems getting around".

Interview on 11/29/21 at 3:01 p.m. with AA-B related to the incident identified she was present in the dining room immediately prior to the incident. She did not see R1 leave the table. She was walking around the dining room handing out prizes and snack after BINGO. She had left the area for a short time to give a resident a ride back to their room and could not recall if she had seen R1 at the table or not. She confirmed she was retrained to kitchen door and supervision policies put into place after the incident. She revealed R1 was an exit seeker. She had to redirect her in the past before when she was attempting to exit seek.

Surveillance footage review and interview on 11/29/21 at 3:19 p.m., with the administrator identified video footage of the inside of the kitchen was reviewed. At 3:01 p.m., C-A was seen going in and out of the pantry in the back of the kitchen near door D. At 3:04 p.m., R1 wheeled down the kitchen hallway and turned to her right through door-D. No video footage was available of the back door after R1 went through door-D. At 3:05 p.m., C-A was seen walking in the hallway, paused for a second at the pantry door, then walked to door-D. Moments later, C-A was seen running back from door D. C-A and AD are seen running back and entering door-D. From 3:06 p.m. to 3:17 p.m., staff were observed assisting with R1's care until emergency medical

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F 689	Continued From page 9	F 689		

services arrived to take R1 via ambulance to the emergency room.

On 11/29/21 at 4:15 p.m., a call was placed to the medical director and a message left to return call. The medical director did not return the call at time of survey.

Interview on 11/29/21 at 4:32 p.m., with administrator identified some keypad locks were obtained last week at the local store. The store did not have enough locks at that time, so 3 doors (Door A, Door D and door F) were locked with the traditional key-type lock. The remaining keypads had been installed that morning of 11/29/21. Audits were to be done each day to ensure all kitchen access doors were secured so no residents would be able to access the restricted kitchen area. The administrator confirmed only 1 other resident had wandering and exit-seeking behaviors. The facility had already been in process of updating all alarm systems in the building. They were also installing the new WanderGuard system to the entire building. R1 had an elopement attempt at the beginning of June and set off the alarms but had not left the building that he was aware of.

Further, prior to R1's fall, door-A was typically left open when staff were serving meals or coffee. His investigation identified other staff were in the dining room at the time, but may have had their back turned to R1. She was able to slip through the door without being seen. The facility changed the process now after R1's fall and all doors to the kitchen will remain shut and locked except during the 3 main meals including being shut during snack and coffee time. R1 had 2-hour checks with the last time having occurred at 2:00

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F 689	Continued From page 10	F 689		

p.m., just before BINGO. R1 had her WanderGuard and tabs alarm on, however, the kitchen doors had no WanderGuard installed.

Observation on 11/29/21 at 5:00 p.m., of the dining room identified door-A was open with cook just inside of door plating food for staff to deliver to dining room. All other doors were locked.

Interview on 11/30/21 at 8:37 a.m., with trained medication aid (TMA)-A identified R1 got around good in her wheelchair, she did wander around the building. She identified that R1 had a wander guard on, and staff were to check on her every 2 hours. When R1 got into the kitchen it had been in between their 2-hour check times. She was unaware if R1 had ever tried to enter the kitchen before but did wander in that back dining room area a lot.

Interview on 11/30/21 at 8:40 a.m., with NA-A identified she had seen R1 go into the kitchen once before the incident, but she was easily redirected back out by staff. R1 usually wandered when there was down time between meals and activities. She said R1 "could be quick" in her wheelchair and moved fast throughout the facility. R1 had a tabs alarm and WanderGuard on her wheelchair as she was a fall risk and a high risk for elopement. She confirmed staff completed 2 our checks on R1's whereabouts each day.

Review of the 7/21/21, Elopement/Missing Resident policy identified residents will be assessed upon admission, with any significant change, quarterly, or after an elopement or attempted elopement to assess intervention needs. Residents who are high risk have been identified to require a WanderGuard and have

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F 689	Continued From page 11 staff checks at 15-minute intervals to reduce elopement risk. If a resident had no exit seeking for a 2-week time period, the resident may have checks slowly decreased in increments of 15 minutes but was to have no fewer checks than every 2 hours. There was no mention of a facility wide safety assessment of the physical environment to be performed. The past noncompliance immediate jeopardy began on 11/22/21. The immediate jeopardy was removed and the deficient practice corrected by 11/28/21, after the facility implemented a systemic plan that included the following actions: The facility conducted a root cause analysis and installed keypad locks on the dishwasher room door (door F), the door that enters the kitchen from the staff entry-way by the time clock (door E), and the back door that goes to the stairwell (door D). Additionally, the sliding door to the kitchen (door A) was to remain closed and locked except during the 3 meals when staff served food. At all other times, door A was to remain closed and locked. The cook on-duty was to audit all doors into the kitchen, 3 times per day and document the results of those audits. All staff were educated to the new processes outlined above, and to not leave any resident unsupervised in the dining room at any time.	F 689		