

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 3, 2021

Administrator Mn Veterans Home Fergus Falls 1821 North Park Fergus Falls, MN 56537

RE: CCN: 245636 Cycle Start Date: November 18, 2020

Dear Administrator:

On January 19, 2021, we notified you a remedy was imposed. On January 19, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 15, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective February 3, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 7, 2020, 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 February 3, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 15, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.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, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 7, 2020

Administrator Mn Veterans Home Fergus Falls 1821 North Park Fergus Falls, MN 56537

RE: CCN: 245636 Cycle Start Date: November 18, 2020

Dear Administrator:

On November 18, 2020, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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.

Mn Veterans Home Fergus Falls December 7, 2020 Page 2

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:

Jen Bahr, RN, Unit Supervisor Bemidji District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, MN 56601-2933 Email: Jennifer.bahr@state.mn.us Office: (218) 308-2104 Mobile: (218) 368-3683

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

Mn Veterans Home Fergus Falls December 7, 2020 Page 3

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 February 18, 2021 (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 May 18, 2021 (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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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.

Mn Veterans Home Fergus Falls December 7, 2020 Page 4 Feel free to contact me if you have questions.

Sincerely,

5 6

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S | | |
|---|------------------------------------|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE 5 | SURVEY | |
| A. BUILDING | (X3) DATE SURVEY COMPLETED C | |
| | 8/2020 | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | 0,2020 | |
| MN VETERANS HOME FERGUS FALLS 1821 NORTH PARK FERGUS FALLS, MN 56537 | | |
| (X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)PREFIX TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 INITIAL COMMENTS F 000 | | |
| On 11/17/20, through 11/18/20, an abbreviated survey was completed at your facility to conduct a complaint(s) investigation(s). Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) were found to be | | |
| substantiated: H5636005C (MN67072) with deficiencies cited at F689 H5636006C (MN66934) with deficiencies cited at F689 | | |
| As a result of the investigation a related deficiency was cited at F610. | | |
| The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. | | |
| Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 610 Investigate/Prevent/Correct Alleged Violation F 610 SS=D CFR(s): 483.12(c)(2)-(4) | 1/15/21 | |
| §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: | | |
| §483.12(c)(2) Have evidence that all alleged | | |
| | X6) DATE | |

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.

PRINTED: 12/31/2020

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | F | FORM A | 12/31/2020 APPROVED 0938-0391 |
|-------------------------------|---|---|-------------------|-----|---|--|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION (X | (X3) DATE SURVEY COMPLETED | |
| | | 245636 | B. WING | | | C 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MN VETERANS HOME FERGUS FALLS | | | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 610 | violations are thorod §483.12(c)(3) Preven neglect, exploitation investigation is in prevent \$483.12(c)(4) Repo- investigations to the designated represent accordance with Stat Survey Agency, with incident, and if the a appropriate correction This REQUIREMENT by: Based on interview facility failed to ensu- care following an el- investigated to prev- elopement for 1 of 2 the building without Findings include: R2's admission Min 9/2/20, indicated R2 impairment and req and ambulation. The wandering behavior or intrude on others dementia R2's initial report to 11/3/20, identified a potential neglect of elopement from the p.m. R2 exited the breat report identified R2 | aghly investigated. ent further potential abuse, or mistreatment while the rogress. rt the results of all e administrator or his or her ntative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ve action must be taken. NT is not met as evidenced and document review, the ure allegations of neglect of opement were thoroughly ent further incidents of 2 residents (R2) who exited | F | 510 | F610 □ Investigate/Prevent/Correct Alleged Violation 1. Resident R2 had a new self-preservation assessment complet by 12/15/2020. Resident R2□s care p was updated with most current interventions to prevent wandering an redirect resident when resident has wandering tendencies. Park Street E2 was serviced by the vendor on 11/11/2020. Park Street Exit also had third alarm system installed by 11/20/2020. All incident reports create within the last 30 days will be reviewe the administrator to ensure investigat were complete and new interventions in place for the resident(s) involved, v applicable. 2. All residents have the potential to b affected. 3. Director of Nursing and Administra | plan nd to xit d a ed by tions s put when be | |

Facility ID: 00531

If continuation sheet Page 2 of 23

| | OF DEFICIENCIES | E & MEDICAID SERVICES | (X2) MI II T | | | OMB NO. 0938-039 (X3) DATE SURVEY | |
|--------------------------|---------------------|---|---------------------|----|---|--------------------------------------|---------------------------|
| | F CORRECTION | IDENTIFICATION NUMBER: | . , | | | | LETED |
| | | | A DOILDI | | | С | |
| | | 245636 | B. WING | | | 11/18/2020 | |
| NAME OF F | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | 321 NORTH PARK | | |
| MN VETE | RANS HOME FERG | US FALLS | | | ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETIO DATE |
| F 610 | Continued From p | age 2 | F 6′ | 10 | | | |
| | | and did not see a resident. | 10 | 10 | reviewed policy titled Vulnerable | | |
| | | ed into the parking lot and | | | Adult/Resident Protection Plan on | | |
| | | o report R2 was wandering in | | | 12/9/2020. Nursing staff were educate | ed | |
| | the parking lot. Th | ne wanderguard alarm did not | | | regarding policy titled Vulnerable | | |
| | | e exit alarm did. The facility | | | Adult/Resident Protection Plan by | | |
| | | guard alarm and identified R2's | | | 1/15/2021. Education included review | | |
| | | lant and the wanderguard | | | how to properly complete an incident | | |
| | | was functioning and they were | | | report in the electronic medical record | | |
| | | xited the building or why the em did not alert staff to R2 | | | system. This included a review of whe to document witness statements and I | | |
| | exiting the door. | | | | to document investigation of incident i | | |
| | oxiang the deer. | | | | the incident report including the need | | |
| | R2's investigative | report submitted to the SA on | | | document the reason for the incident a | | |
| | | the facility reviewed R2's care | | | action taken to prevent similar inciden | nt | |
| | | plan was followed. Further, the | | | from occurring. | | |
| | | eir policy and the policy was | | | | | |
| | | nanges were made to the facility | | | 4. Audits will be conducted weekly for | | |
| | | gation summary identified the | | | weeks by the Administrator or Designe | | |
| | | istered nurse] heard door alarm stated "E. Park St. Exit". | | | for up to 5 random completed incident reports per week to ensure that all | L | |
| | | irming door to check for | | | applicable portions of the incident repo | ort | |
| | | lents were noted to be outside | | | were completed. The incident reports | | |
| | | on received a call from the front | | | audited will also be audited to ensure | | |
| | | nurse who was in the front | | | a reason for the incident is identified in | n the | |
| | | h resident, [R2], outside in the | | | documentation and action taken to | | |
| | | N immediately attended to | | | prevent a similar incident from occurri | | |
| | | RN and other nurse were unable | | | Audit results will be reported to the Qu | | |
| | | [R2]. Unit Coordinator provided is able to direct him back | | | Assurance Committee for review at th | ie | |
| | | as escorted to his room safely. | | | next Quality Assurance meeting. | | |
| | | was going home to his | | | 5. 1/15/2021 | | |
| | | as redirected back into facility | | | | | |
| | | [R2's] daughter via phone and | | | | | |
| | she assisted to he | Ip redirect resident. Signs were | | | | | |
| | | st resident where his room is, | | | | | |
| | | park street corridors. Wander | | | | | |
| | | also tested to ensure working | | | | | |
| | | wears a wander guard due to cies. However, the door alarm | | | | | |

Facility ID: 00531

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| | | HAND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
|-------------------------------|--|--|--------------------|-----|--|-------------------|-------------------------------------|
| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ´ | | | (X3) DATE COMI | E SURVEY PLETED |
| | | 245636 | B. WING | i | | | C 18/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MN VETERANS HOME FERGUS FALLS | | | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 610 | that sounded was a anytime the door op device should have It is unknown how t wander guard equip located [R2] very qu and found to have r resident for further staff were identifed investigation. Action taken to prev subjected resident made to help orient was, Wander guard ensure working pro guard due to wande door alarm that sou that alarms anytime wander guard devic magnetic locks. It is got past the wande However, staff loca was assessed and will monitor residen concerns." The investigation di reasons for the alar they did to ensure t another resident was Further, the investig attempt to prevent f | age 3 a back up system that alarms pened. The wander guard a activated the magnetic locks. the resident got past the pped doors. However, staff uickly and he was assessed no injuries. Staff will monitor wandering concerns." Three to have contributed to the vent reoccurrence to the was identified as "Signs were tate resident to where his room d system was also tested to operly. Resident wore a wander ering tendencies. However, the unded was a back up system the door opened. The ce should have activated the s unknown how the resident r guard equipped doors. Ited Harold very quickly and he found to have no injuries. Staff at for further wandering id not identify causative rm not functioning and what the alarm would function if andered to the Park Street exit. gation did not identify R2 was ering and elopement behaviors ent centered interventions to further elopement attempts. | Fé | 510 | | | |

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| STATEMEN | F OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPLE CONSTRUCTION | (X3) DA | D. 0938-039 TE SURVEY |
|--------------------------|--|---|---------------------|---|---------|---------------------------|
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | IG | CO | MPLETED |
| | | 245636 | B. WING _ | | 11 | C / 18/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MN VETI | ERANS HOME FERG | US FALLS | | 1821 NORTH PARK FERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY) | ULD BE | (X5) COMPLETIO DATE |
| F 610 | Continued From pa not received. | age 4 | F 61 | 10 | | |
| | administrator state building the facility The investigation in alarms and wander administrator state was not like a fall in always related to w were functioning. reason was determ would find it on the determined the res IDT would look at t memory unit was n keep any further in review as the infor investigation and II doors on the wings with magnetic locks had the Ademco sy would still have to determine why it w silenced behind the had not altered the of all residents was sounded, and a res trigger the alarm, fa accounted for. The facility policy re following regarding of the agency that to (mistreatment, neg injuries of unknown misappropriation of thoroughly investig | a 11/18/20, at 12:15 p.m. the d when a resident exits the completes an investigation. Included checking the door r guards for function. The d an elopement investigation investigation, because it was whether the alarms or doors The administrator stated if a nined for the elopement you incident reports or if it was ident was wandering more the hat to see if placement on the eeded. The facility did not vestigation documents to mation was in the five day DT notes. Further, the double had the wander guard system s. The exit doors of the facility ystem alert in place. The staff respond to the exit alarm and as sounding, but the alarm was e nurses station. The facility ir policy to ensure verification s completed when an alarm sident was not identified to to ensure all residents were evised 2/23/17, identified the investigation: "it is the policy reports of "abuse" lect, or abuse, including n source, exploitation and f property) are promptly and ated. The investigation is the v to determine what happened. | | | | |

Facility ID: 00531

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| TATEMEN | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | · · · | TE SURVEY MPLETED | |
|--------------------------|---|---|---------------------|--|--------|---------------------------|--|
| | | 245636 | B. WING | | 11 | C 11/18/2020 | |
| | PROVIDER OR SUPPLIER | JS FALLS | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 821 NORTH PARK ERGUS FALLS, MN 56537 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE | (X5) COMPLETIO DATE | |
| | All staff will coopera assure the resident designated facility p investigation immer how to complete an of abuse, injuries o seclusion and misa policy did not identi investigation regard neglect of care; how results of the invest tied to the report; N document resident the investigation; m identify and implem for the resident invest investigative notes appropriate state an reporting. Free of Accident Ha CFR(s): 483.25(d)(§483.25(d) Accident The facility must en §483.25(d)(2)Each supervision and as accidents. This REQUIREMENT | ate during the investigation to t is fully protected. The bersonnel will begin the diately. The policy identified n investigation for allegations f unknown source, involuntary uppropriation of property. The fy how to conduct an ding incidents of potential wever, the policy identified tigation would be recorded and Nursing and/or designee will 's behaviors and environmental e of the incident, as well as of resident's behavior during ursing and/or designee would nent appropriate interventions olved, all other residents and p-occurrence The follow-up would be submitted to the gency following state policy for azards/Supervision/Devices 1)(2) | F 610 | F689 	Free of Accident Hazards/Supervision/Devices | | 1/15/21 | |

Facility ID: 00531

If continuation sheet Page 6 of 23

| | OF DEFICIENCIES | & MEDICAID SERVICES | (X2) MI II TI | PLE CONSTRUCTION | OMB NO. | E SURVEY | |
|--------------------------|----------------------------------|--|---------------------|--|----------------------------------|---------------------------|--|
| | OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | | | | PLETED | |
| | | | / | | | С | |
| | | 245636 | B. WING | | | 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | | | |
| | | | | 1821 NORTH PARK | | | |
| | ERANS HOME FERGU | JS FALLS | | FERGUS FALLS, MN 56537 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETIO DATE | |
| F 689 | Continued From pa | ae 6 | F 68 | 9 | | | |
| | • | arm while exiting the building. | 1 00 | 1. Resident R1, R2, R3, | and R4 had a | | |
| | | lity failed to comprehensively | | new self-preservation as | | | |
| | assess for and dev | elop person centered | | completed by 12/15/2020 | | | |
| | interventions to red | | | R2, R3, and R4⊡s care µ | | | |
| | | ent for 4 of 4 residents (R2, | | updated with most curren | | | |
| | | ed who had previously exited I not sustain any injury | | prevent wandering and to when resident has wand | | | |
| | the building and did | | | Park Street Exit was service | | | |
| | Findings include: | | | vendor by 11/11/2020. P | | | |
| | 5 | | | also had a third alarm sy | | | |
| | | r on 11/17/20, at 1:00 p.m. | | 11/20/2020. All residents | | | |
| | | erved and each wing had | | risk for wandering/eloper | | | |
| | | a wanderguard system on each he east wing and the memory | | new self-preservation as completed as well as car | | | |
| | | vere separated by a small | | reviewed/updated to ens | | | |
| | | it doors on either side. One | | interventions are in place | | | |
| | | an outside fenced courtyard. | | • | | | |
| | | oor opened to the facility | | 2. All residents have the | potential to be | | |
| | across the road. Th | nd neighboring houses lined his exit door was called the | | affected. | | | |
| | | Both exit doors had alarms on | | 3. Director of Nursing an | | | |
| | | exit doors did not have ns. The doors on both units | | reviewed policy titled Vul Adult/Resident Protection | | | |
| | | m the nurses station of the | | 12/9/2020. Facility emerg | | | |
| | | re units. The director of | | section titled Elopement/ | | | |
| | nursing (DON) stat | ed the wanderguard alarms | | was reviewed and revise | | | |
| | | e double doors of each wing | | Nursing and Administrate | | | |
| | | aced on the facility exit doors | | Facility policy titled Wand | | | |
| | wander guard syste | c locking system used by the | | and Door Alarm System and revised by Director of | | | |
| | wanuer guaru syste | 5111. | | Administrator on 12/9/20 | | | |
| | R2's admission Mir | nimum Data Set (MDS) dated | | forms were created. For | | | |
| | 9/2/20, indicated R | 2 had minimal cognitive | | cause analysis post elop | | | |
| | | uired supervision with transfer | | seeking will be used afte | | | |
| | | he MDS identified R2 exhibited | | significant exit seeking b | | | |
| | | rs that did not place him at risk | | how the incident occurre | | | |
| | dementia. | s. R2 had a diagnosis of | | prevented and to ensure documentation is complete | | | |
| | domontu. | | | resident care area exit d | | | |

Facility ID: 00531

If continuation sheet Page 7 of 23

| (X3) DATE SUF COMPLETI C 11/18/20 | ED |
|--|-----------------------------|
| | 020 |
| | 2020 |
| 1 1710/2 | |
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Facility ID: 00531

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| | | I AND HUMAN SERVICES | | | | FORM | : 12/31/2020 APPROVED . 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | | E CONSTRUCTION | (X3) DAT CON | E SURVEY IPLETED |
| | | 245636 | B. WING | | | | C 18/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | I | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MN VETERANS HOME FERGUS FALLS | | | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
| | | | | | ř | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 689 | Continued From pa | ae 8 | F | 689 | | | |
| | remained the rest of | - | | 03 | | | |
| | | | | | 5. 1/15/2021 | | |
| | seeking behaviors. of the building as he reoriented R2. R2 to exit for 30 to 45 r went to his room. | m. R2 was exhibiting exit R2 asked staff how to get out e wanted to go home. Staff continued to search for a door minutes. R2 settled down and | | | | | |
| | | 5 a.m. R2 was asking for his d to get out of the facility. He good response. | | | | | |
| | - 10/23/20, at 3:06 room on the east w | p.m. R2 was moved to a new ing of the facility. | | | | | |
| | p.m. indicated staff alarm go off. The r alarmed door and o and/or outside of th seen. The respond alarm. Later, the re- telephone call indic R2 outside of the fa- nurse went out to a building. They were third staff member back into the facility R2's daughter was Signs were made to room was. The war ensure it was worki the facility through to Street exit. | report dated 11/3/20, at 12:15 heard the facility exit door esponding nurse went to the checked for residents near ne door. No residents were ling nurse then cleared the esponding nurse received a ating another nurse had found acility in the parking lot. The assist R2 back into the e unable to redirect R2 and a was called to assist. The s were able to redirect R2 y and back to his room safely. called to help redirect R2. o assist R2 with where his nder guard was checked to ng properly. R2 had exited the exit door named the Park | | | | | |
| | | e was added to the facility d 11/3/20, which indicated R2 | | | | | |

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| | | HAND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
|-------------------------------|--|--|---------------------|----|--|------------------|-------------------------------------|
| STATEMEN | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245636 | B. WING | | | | C 18/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MN VETERANS HOME FERGUS FALLS | | | | | 321 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | had dementia and where he was at. F he was confused. H attempts to exit the independently with confused with direct in common areas a name. Staff would guide R2 in right dir R2's medical record comprehensively re address the ongoin continued wanderin several statements Further, R2 was no 11/3/20, elopement circumstances surr with potential causa effort to reduce the R2's care plan revis at risk for elopement Interventions includ safe in the facility, down when he tried encourage him to v him when he made him to his room and escort for all outside R2's risk for elopen Although, R2 had a the facility, R2's inte unchanged. During observation was seated in a cha east lobby area with | was often confused as to R2 was easily redirected when He had made no further | F 6 | 89 | | | |

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| | TH AND HUMAN SERVICES RE & MEDICAID SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | 245636 | B. WING | | | | C 18/2020 |
| NAME OF PROVIDER OR SUPPLIE | R | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MN VETERANS HOME FERGUS FALLS | | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
| PREFIX (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 Continued From sleeping. | page 10 | F 6 | 89 | | | |
| walker, stood up hall in the direction unidentified nurse nurse verbally did the room with his and started to an than which the number of the opposite wing able to redirect Ferrer verbal redirection. On 11/18/20, at a -A was interviewed the exit door alar panel was check exit. RN-A stated exit door and loo see anyone arou would alarm from through them but when they alarm resident. She ret cleared the alarm duties. RN-A stated head count to en inside the buildin full resident cour at risk to elope a building. Further resident with a w because the war About 5 minutes RN-A stated she nurse in the park | awoke and reached for his and started walking down the on of his room. R2 asked an e where his room was and the ected R2 down the east hall to name on the door. R2 turned abulate toward the opposite hall urse had directed him. R2 stated hat door, referring to a door on g. The unidentified nurse was 2 back to his own unit with and walked him to his room. 1:40 a.m. registered nurse (RN) ed and explained she had heard m go off and when the alarm ed, it was flashing Park Street d she immediately went to the ked around outside but could not nd. RN-A stated the exit doors a staff or maintenance going staff still checked the exits ed to be sure it had not been a urned to the nursing station and and returned to her work ed she did not initiate a facility sure all residents were safely g. They would not typically do a t, but they would check for those nd make sure they were in the she did not think it was a anderguard that set off the alarm, received a telephone call from a ing lot who indicated R2 was thing lot. RN-A stated she | | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ì í | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245636 | B. WING | | | C 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| MN VETERANS HOME FERGUS FALLS | | | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | Continued From par immediately went of back into the buildin needed to call for ful R2 back into the fact When interviewed of RN-B stated the ex- sometimes alarm b them off. When an would call the nurse sounding and have triggered the alarm from the unit nurse, RN-B stated if no re alarmed, the staff we that were at risk for During interview on nursing assistant (N sounded staff would and look for resider by the exit door, the sure their wanderer indicated they would count. R1's quarterly MDS had severe cognitive supervision with tra MDS identified R1 M Diagnoses included dementia. R1's Self Preservate 10/15/20, identified wandering. The IDT | age 11 but to the lot to try to bring R2 ng. R2 was resistive and urther staff assistance to bring cility. In 11/18/20, at 11:58 a.m. it door alarms would because the wind would set exit door alarm sounded, she e on unit where the alarm was her check to see what had . When she got the all clear , she would clear the alarm. esident was seen when a door would check on the residents elopement. 11/18/20, at 11:56 a.m. NA)-B stated if an alarm d check the alarming exit door nts. If no residents were seen e staff would check and make rs were around. NA-B d not do a full resident head 6 dated 10/21/20, identified R1 re impairment and required insfers and ambulation. The had wandering behaviors. d Parkinson's disease and tion assessment dated d R1 was at moderate risk for | p | 589 | | | |
| | and staff was not to | b leave R1 unattended when r medical appointments. No | | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | | E CONSTRUCTION | (X3) DATI COM | E SURVEY PLETED |
| | | 245636 | B. WING | | | C 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| | ERANS HOME FERGU | JS FALLS | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 689 | Continued From pa | ige 12 | F6 | 689 | | | |
| | further interventions implemented. | s were identified or | | | | | |
| | R1's progress notes 11/17/20, identified | s from 7/21/20, through the following: | | | | | |
| | seeking behaviors. | .m. R1 was exhibiting exit R1 attempted to exit the courtyard doors. The staff s bedroom. | | | | | |
| | behaviors through of the unit. R1 was | .m. R1 exhibited wandering out both north and south sides difficult to redirect and staff rmine what R1 was searching | | | | | |
| | behaviors through o | .m. R1 exhibited wandering out the shift. Distraction was and when it was, the ed briefly. | | | | | |
| | assessment was co was at moderate ris recommended to co guard and to accom appointments. Not identified or implem for elopement even September 2020, ic | p.m. a Self Preservation ompleted and indicated R1 sk for wandering. The IDT ontinue use of the wander npany R1 to all outside further interventions were nented to reduce the chances a though progress notes in dentified R1 was wandering a not always effective. | | | | | |
| | R1. A search was of call to all staff was of search for R1. The from a neighboring | .m. staff were unable to locate conducted of the unit. A radio made to alert all staff to facility received a phone call home owner reporting R1 was The facility staff retrieved R1 | | | | | |

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| | | HAND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
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| STATEMEN | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` í | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245636 | B. WING _ | | | | C 18/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| MN VET | ERANS HOME FERGU | JS FALLS | | | 21 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | from their front doo why he had exited t day (OD) indicated sounded to alert sta The staff checked a the doors did lock a yellow as it was sup encouraged to be even whereabouts closed through the exit doo - 11/13/20, at 11:27 completed. R1 cort and the facility wou goals and intervent was completed. During observation was wandering abo was pleasant, how communicate effect other resident room redirection to the da timely and R1 was R1's medical record comprehensibly rea address the ongoin continued wanderin several statements Further, R1 was no 11/7/20, elopement circumstances surr with potential causa effort to reduce the R1's care plan revie had severe cognitiv | or. R1 was unable to indicate the facility. The officer of the no alarms or code yellow had aff of R1's exit from the facility. all the exit doors with R1 and and the alarm did sound code pposed to. Staff were extra diligent and monitor R1's ly. R2 had exited the facility or named the Park Street exit. 7 a.m. R1 had a quarterly MDS tinued to wander frequently ild continue the current focus, tions. No further assessment on 11/17/20, at 2:08 p.m. R1 but the memory care unit. R1 | F 68 | 89 | | | |

| STATEMEN | T OF DEFICIENCIES | K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DA |) <u>. 0938-039</u> TE SURVEY MPLETED | |
|--------------------------|--|---|----------------------|--|---------|---|--|
| | OF CORRECTION | 245636 | A. BUILDI B. WING | NG | | С | |
| NAME OF | PROVIDER OR SUPPLIER | 243030 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 0DE | | |
| | ERANS HOME FERG | JS FALLS | | 1821 NORTH PARK FERGUS FALLS, MN 56537 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETIO DATE | |
| F 689 | around the facility a Interventions direct verbalize his feeling [R1] entered other him to the day roor alarm pull stations, attempts to elope, and unit, escort to with identifying [R1 his right wrist. Inte elopement were da a successfully elop interventions remain During interview or stated when a code staff a resident with door) goes over the memory unit do no alarm sounded on the charge nurse w staff via their talkie it could not be hear LPN-A stated staff alarming door, to s and that most of th LPN-A stated the c code had never so facility on 11/7/20. trouble with the alar resident with a war long enough, the day resident could go th wander guard alarm yellow when R1 pa the exit door alarm R1 opened the faci she did not know w | and did go into other's spaces. sed the following: encourage to gs, intervene right away when resident rooms and redirect n, redirect away from fire redirect when making re-orientate him to his room all outside appointments along] had wander guard placed on rventions related to risk for ited 4/17/19. Although, R1 had ed from the facility, R1's | F 6 | 89 | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATI COM | E SURVEY PLETED |
| | | 245636 | B. WING | | | | C 18/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ERANS HOME FERGU | JS FALLS | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | × | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | Continued From pa | ge 15 | F 6 | 89 | | | |
| | happened the previ the facility. | ous week when R4 had exited | | | | | |
| | stated R1 must hav doors long enough NA-A indicated R1 try to exit the facility | 11/18/20, at 9:30 a.m. NA-A re been standing by the double for the alarm to disengage. did not seem to intentionally and staff tried to engage R1 r snacks when he was as effective. | | | | | |
| | had moderate cogn independent with tra MDS indicated R3 v | dated 8/11/20, indicated R3 itive impairment and was ansfer and ambulation. The was also independent with the unit. R3 had a diagnosis | | | | | |
| | | ers dated 4/21/20, identified R3 placed for decreased safety ndering. | | | | | |
| | 8/6/20, indicated R3 wandering. IDT rec continue use of the | ion assessment completed on 3 was at moderate risk for ommendations were to wander guard and not to be ng outside appointments. No s were identified or | | | | | |
| | R3's progress notes | s identified the following: | | | | | |
| | sounded. R3 had g street exit and was | a.m. a code yellow alert jotten outside from the Park redirected immediately back nder guard was tested and ˈly. | | | | | |
| | - 8/17/20, at 2:23 p. | m. a coed yellow alert | | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
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| STATEMEN | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | | (X3) DATE COM | E SURVEY PLETED |
| | | 245636 | B. WING | i | | | C 18/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ERANS HOME FERGU | JS FALLS | | | 1821 NORTH PARK FERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | sounded. An LPN f street exit, walking immediately returned The wander guard w - 9/4/20, at 12:56 p exit sounded. R3 w room on the memo back to the east win - 9/22/20, at 9:46 a. wing and was redired - 11/2/20, at 3:12 p. door open and wen R3 exit the Park Str redirect R3 back int combative and una the facility lawn, cro banging on window homes, with staff for R3 to return to the f R3's incident report 11/2/20, each ident confused. R3 had a would continue to n interventions were a reduce wandering a R3's medical record been comprehensit address the ongoin continued wanderin several statements There was no evide circumstances surr attempts, had been | found R3 outside the Park away from the building. R3 ed to the facility when called. was working properly. b.m. code yellow park street vas found coming out of a ry unit and was redirected ng and his room. .m. R3 was found on the west ected back to the east wing. .m. staff heard the east wing it to check it. Staff observed reet exit and attempted to to the facility. R3 was ble to redirect. R3 ran across based Park Street and began rs and doors of the neighboring bllowing. Staff eventually got facility. ts dated 7/24/20, 8/17/20, and ified R3 would become easily a wander guard on and staff | F | 589 | | | |

| | | HAND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | (X3) DATE COM | E SURVEY PLETED |
| | | 245636 | B. WING | | | C 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| | ERANS HOME FERGU | JS FALLS | | | 321 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | Continued From pa | ige 17 | F 6 | 89 | | | |
| | at risk for elopemen dementia. There w direct staff related t risk for elopement w Although R3 had a the facility, R3 had safety and preventie elopement. During observation wandered to the ea toward the double e Staff frequently red common lobby area -At 3:24 p.m. R3 ag wing. Staff frequen common lobby area | sed 9/1/20, indicated R3 was nt related to a diagnosis of vere no interventions listed to to his risk of elopement. The was identified on 4/21/20. successful elopement from no interventions listed for on of his identified risk for on 11/17/20, at 2:14 p.m. R3 ast hall wing, frequently going exit doors of the east wing. irected R3 back to the a. gain wandered to the east hall ntly redirected R3 back to the a and was able to divert R3's ersation and television in the | | | | | |
| | -At 3:40 p.m. R3 be staff member as sh entered a room, R3 follow the next staff | egan following an unidentified he made rounds. When she b would pause and immediately f member to be near them. | | | | | |
| | the east hall wing. approached R3 and meal choices with F | egan to follow a resident down An unidentified staff member d began discussing the supper R3. R3 followed the staff wing into the lobby area. | | | | | |
| | stated when a code go to the door and l the nurse all clear. | 11/18/20, at 11:56 a.m. NA-B e yellow sounded, staff would look for residents and then tell NA-B indicated R3 was or a walk when going up and | | | | | |

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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
| | | 245636 | B. WING | i | | 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ERANS HOME FERGU | JS FALLS | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
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| F 689 | Continued From pa | ige 18 | F€ | 689 | | | |
| | snack and the news as a diversion. NA- | she would usually give him a spaper or turn on the television -B indicated she thought R3 wife, when walking up and | | | | | |
| | had severe cognitiv independent with tra | lated 8/20/20, indicated R4 ve impairment and was ansfer and ambulation, supervision on and off the unit. of dementia. | | | | | |
| | 10/15/20, indicated wandering. IDT reconstruction of the | tion assessment completed on R4 was a moderate risk for commendations were to wander guard and not to be ing outside appointments. No s were identified or | | | | | |
| | R4's progress note | (s) identified the following: | | | | | |
| | off, when memory of phone call from the staff indicated R4 h | p.m. a code yellow was going care unit staff received a east wing staff. East wing ad been found outside of the aff had responded promptly at back to his unit. | | | | | |
| | alarm was going off alarm promptly. Sta facility and promptly the wanderguard ward determined to be ward concluded R4 had s | p.m. indicated the code yellow f and staff responded to the aff found R4 outside of the y returned him to his room. as checked on his return and orking properly. The staff stood near the door long to disengage, thus allowing he doors. | | | | | |

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| STATEMEN | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | | (X3) DATE SURVEY COMPLETED | |
| | | 245636 | B. WING | i | | C 11/18/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| MN VET | ERANS HOME FERGU | JS FALLS | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | R4's care plan revis was at risk for elope wandering and dem staff to make [R4] ff facility, encourage ff available, wander g for all outside appor related to risk for el Although, R4 had a on 10/29/20, R4's in unchanged. R4's medical record been comprehensit address the ongoin continued wanderin several statements There was no evide circumstances sum attempts had been for possible contribut During interview on stated if an outside could not determine check their wander there. RN-B indicat do a head count, es stated there were s exit alarm on them stated if a coor (wanderguard alarm show on the system staff did not see that | sed on 9/2/20, indicated R4 ement related to his history of nentia. The care plan directed eel secure and safe in the family participation when guard placement and an escort intments. Interventions lopement were dated 9/2/20. a successful exited the facility interventions remained d lacked evidence R4 had bly reassessed to identify and og risk of elopement despite ng behaviors and having and/or attempts to elope. ence R4's wandering, nor the ounding the elopement accounted for and assessed uting factors and solutions. a 11/18/20, at 12:48 p.m. RN-B door alarm sounded and they e the cause, the staff would ers and make sure they were ted sometimes the staff would specially if it was winter. RN-B to few doors that just had the that it wasn't a problem. RN-B problem was the exit door nd memory unit doors. a 11/18/20, at 10:28 a.m. the | F | 589 | | | |

If continuation sheet Page 20 of 23

| | | I AND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|------------------|-------------------------------------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ``` | | | (X3) DATE COM | E SURVEY PLETED |
| | | 245636 | B. WING | | | | C 18/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ERANS HOME FERGU | JS FALLS | | | 821 NORTH PARK FERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | the unit. If the resi were to bring the re- assess for injury and was functioning pro- determine why the interviews and round to determine if the re- more related to the behavior. Incident re- meetings. The DO had been reviewed guard alarm and the not sounded. The re- were checked within facility and both alar when checked. The why either alarm dia The DON stated the memory unit double on the double doors attempting to leave come and check the The DON stated so by the wander guar lock would disenga however the alarm facility used the Sel for wanderguard us quarterly and as ne facility's compreher During interview on administrator stated was not like a fall in | dent was found outside, staff desident back into the facility, id assure the wander guard operly. They would try to resident left with staff ids on the unit. They would try resident was exit seeking or resident's dementia or a eports were reviewed at daily N identified R1's elopement and she was told the wander e Ademco system alarm had DON indicated both alarms in minutes of R1's return to the rms were working properly b DON stated she did not know d not sound in that instance. ey did place furniture near the e doors and a do not enter sign is to distract R1 from until the alarm company could e alarm system the next day. metimes a resident will stand d doors long enough that the ge as a safety feature, would still sound. Further, the f Preservation form to assess the forms were filled out eded, that form was the | F | 589 | | | |

If continuation sheet Page 21 of 23

| | | HAND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-------------------|-------------------------------------|
| STATEMEN | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE COMI | E SURVEY PLETED |
| | | 245636 | B. WING | | | | C 18/2020 |
| NAME OF | PROVIDER OR SUPPLIER | • | | | TREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| | ERANS HOME FERGU | JS FALLS | | | 821 NORTH PARK ERGUS FALLS, MN 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | were functioning. T reason was determ would find it on the determined the resi IDT would look at th memory unit was n stated the double d wander guard syste exit doors of the face alert in place. The s respond to the exit was sounding, but t the nurses station. the facility had rece alarm" and intended exit door, as that exit door the residents of frequently. This alar east wing and the n the staff to physical alarm. The facility as the staff had not planned to train sta end of the following stated it was not the resident head coun however it would not the policy. The facility's policy and Door Alarm Sy 3/19, indicated a re would be determine assessment and if wander guard would during a resident's identified, a wander would be reviewed | age 21 The administrator stated if a lined for the elopement you incident reports or if it was ident was wandering more the hat to see if placement on the eeded. The administrator loors on the wings had the em with magnetic locks. The cility had the Ademco system staff would still have to alarm and determine why it the alarm was silenced behind The administrator indicated ently purchased a "screech d to install it on the Park Street kit door was identified as the were able to exit more rm would be heard on both the nemory unit and would require ly go to the door to disable the had not installed the alarm yet, t been trained on it, but iff and place the alarm by the g week. The administrator e facility's policy to do a tt if an alarm sounded; ot be a bad idea to add that to titled Wander Management stem with revision date of sident's risk for wandering ed during pre-admission a need was determined, a d be placed. If at any time stay, a wander risk was r guard may be placed. This quarterly and as needed. The Park Street exit door did not | F | 589 | | | |

If continuation sheet Page 22 of 23

| | | AND HUMAN SERVICES | | | | FORM | 12/31/2020 APPROVED 0938-0391 |
|-------------------------------|--|--|---------------------|--|---------------|------------------------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C | |
| | | 245636 | B. WING | | | | , 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | L | | STREET ADDRESS, CITY, STATE, Z | | | |
| MN VETERANS HOME FERGUS FALLS | | | | 1821 NORTH PARK FERGUS FALLS, MN 56537 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD E | | (X5) COMPLETION DATE |
| F 689 | have a magnetic loc the wander guard s would have to pass connected to the sy immediately before staff were responsi alarm immediately. determined which r their current locatio a resident exited th | inge 22 ck and was not connected to system because a resident through a door that is system with a magnetic lock reaching this exit door. All ble to respond to a sounding Upon each alarm, it must be esident set off the alarm and n before the alarm is reset. If e building, the resident will be ected back into the building. | F 68 | | | | |

Facility ID: 00531



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 7, 2020

Administrator Mn Veterans Home Fergus Falls 1821 North Park Fergus Falls, MN 56537

Re: State Nursing Home Licensing Orders Event ID: HORH11

Dear Administrator:

The above facility was surveyed on November 17, 2020 through November 18, 2020 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 <u>only a suggestion</u> 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.

Mn Veterans Home Fergus Falls December 7, 2020 Page 2

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

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:

Jen Bahr, RN, Unit Supervisor Bemidji District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, MN 56601-2933 Email: Jennifer.bahr@state.mn.us Office: (218) 308-2104 Mobile: (218) 368-3683

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us cc: Licensing and Certification File

| Minnesota Department o | f Health | | | |
|---|--|-------------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | 00531 | B. WING | | C 11/18/2020 |
| NAME OF PROVIDER OR SUPPL | IER STREET A | DDRESS, CITY, | STATE, ZIP CODE | |
| MN VETERANS HOME FE | RGUS FALLS | RTH PARK 5 FALLS, MN | 56537 | |
| PREFIX (EACH DEFICI | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY) | D BE COMPLETE |
| 2 000 Initial Commen | S | 2 000 | | |
| ***** | TENTION***** | | | |
| NH LICENSI | NG CORRECTION ORDER | | | |
| 144A.10, this compursuant to a surfound that the component of the end of the | with Minnesota Statute, section prrection order has been issued urvey. If, upon reinspection, it is eficiency or deficiencies cited orrected, a fine for each violation hall be assessed in accordance of fines promulgated by rule of Department of Health. If whether a violation has been res compliance with all the rule provided at the tag I Rule number indicated below. Intains several items, failure to of the items will be considered nee. Lack of compliance upon th any item of multi-part rule will ressment of a fine even if the item d during the initial inspection was | | | |
| that may result orders provided the Department | st a hearing on any assessments from non-compliance with these that a written request is made to within 15 days of receipt of a sment for non-compliance. | | | |
| was conducted licensure. The f issued. Please correction that | ENTS: d 11/18/20, an abbreviated survey to determine compliance for state ollowing correction orders are indicate in your electronic plan of you have reviewed these orders, date when they will be completed | | | |
| ////////////////////////////////////// | OVIDER/SUPPLIER REPRESENTATIVE'S SI | GNATURE | TITLE | (X6) DATE |

Electronically Signed

6899

If continuation sheet 1 of 20

PRINTED: 12/31/2020 FORM APPROVED

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED C | | |
|--|---|--|-----------------|--|--------------------------------|--------|
| | | 00531 | B. WING | | - 11/1 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| MN VETI | ERANS HOME FERGU | JS FALLS | RTH PARK | 56537 | | |
| (X4) ID | SUMMARY STA | | ID | PROVIDER'S PLAN OF (| CORRECTION | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ON SHOULD BE HE APPROPRIATE | COMPLE |
| 2 000 | Continued From pa | Continued From page 1 | | | | |
| The following complaint(s) substantiated: H5636005C (MN67072) C issued at MN Rule 4658.0 H5636006C (MN66934) C issued at MN Rule 4658.0 You have agreed to partic receipt of State licensure of the Minnesota Departmen Informational Bulletin 14-C http://www.health.state.mr obul.htm. State licensing of 2567, under the Minnesota licensing order statute(s) B electronically. Although no necessary for State Statut the word "Corrected" in the You must then indicate on licensure process, under t date, the date your orders to electronically submitting | | 2072) Correction order(s) 4658.0520 subp.1 9934) Correction order(s) 4658.0520 subp.1 o participate in the electronic nsure orders consistent with artment of Health | | | | |
| | Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule found o the "Summary State column, and replac the correction order the findings, which statute after the state | nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left Prefix Tag". The state out of compliance is listed in ement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met Following the surveyors | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED C | | |
|---|--|---|-----------------------|---|-------|-------------------------|
| | | 00531 | B. WING | | 11/1 | 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| MN VETE | ERANS HOME FERGU | IS FALLS | RTH PARK FALLS, MN | 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLET DATE |
| 2 000 | Continued From pa | ge 2 | 2 000 | | | |
| | Correction" and the | "Time Period for Correction". | | | | |
| | FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE | RD THE HEADING OF THE J, WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. | | | | |
| | PLAN OF CORREC | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF TE STATUTES/RULES. | | | | |
| 2 830 | MN Rule 4658.0520 Proper Nursing Car |) Subp. 1 Adequate and re; General | 2 830 | | | 1/15/21 |
| | receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t | general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed. | | | | |
| | by: Based on observati review, the facility fa were accounted for sounded the exit ala In addition, the facil | ent is not met as evidenced on, interview and document ailed to ensure all residents after 1 of 4 residents (R2) arm while exiting the building. ity failed to comprehensively elop person centered uce the risk of | | corrected | | |

HORH11

If continuation sheet 3 of 20

PRINTED: 12/31/2020 FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED C | | | |
|---|---|---|---|--|---|----------------------|--|
| | | 00531 | B. WING | | | 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, S ⁻ RTH PARK | TATE, ZIP CODE | | | |
| | ERANS HOME FERG | US FALLS | FALLS, MN 5 | 56537 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE COM THE APPROPRIATE D | (X5) IPLET ATE | |
| 2 830 | Continued From pa | age 3 | 2 830 | | | | |
| | wandering/elopement for 4 of 4 residents (R2, R1, R3, R4) reviewed who had previously exited the building and did not sustain any injury. | | | | | | |
| | Findings include: | | | | | | |
| | each wing was obs double doors with a of the doorways. T unit double doors w room with glass ex exit door opened to The opposite exit d campus, a road, ar across the road. Th Park Street exit. E them, however, the wanderguard alarm were not visible fro east or memory ca nursing (DON) stat were located on the and could not be pl | Ir on 11/17/20, at 1:00 p.m. berved and each wing had a wanderguard system on each the east wing and the memory vere separated by a small it doors on either side. One o an outside fenced courtyard. loor opened to the facility nd neighboring houses lined his exit door was called the Both exit doors had alarms on e exit doors did not have hs. The doors on both units m the nurses station of the re units. The director of ed the wanderguard alarms e double doors of each wing laced on the facility exit doors c locking system used by the em. | | | | | |
| | 9/2/20, indicated R impairment and rec and ambulation. T wandering behavio | nimum Data Set (MDS) dated 2 had minimal cognitive quired supervision with transfer he MDS identified R2 exhibited rs that did not place him at risk s. R2 had a diagnosis of | l l | | | | |
| | identified risk factor elopement. The for that included the fo | reservation assessment form rs for wandering and rm used a check list system Illowing information: level of ors, recent experiences such | | | | | |

PRINTED: 12/31/2020 FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|--|----------------------------------|-------------------------------|--|
| | | 00531 | B. WING | | | C 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| | ERANS HOME FERGU | 1821 NO | RTH PARK | | | | |
| | ERANS HOWE FERG | FERGUS | FALLS, MN 5 | 56537 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 4 | 2 830 | | | | |
| | medications, histor risk factors, negativ home placement an recommendations. determined was no R2's Self Preservat 8/27/20, indicated F wandering. The for recommended the and to be accompa appointments. No identified or implem R2's progress note - 8/27/20, at 1:35 p the facility a minimu arrival. R2's daugh | placement of a wander guard inied to all outside further interventions were nented. (s) identified the following: .m. R2 had attempted to leave um of five times since his iter called and spoke with him | | | | | |
| | placed. - 9/4/20, at 5:33 a.r his suitcase. R2 st somewhere tomorr about his situation. | n down. A wander guard was n. R2 was awake and packing ated he was moving ow. R2 seemed confused When assisted, R2 did | | | | | |
| | seeking behaviors. and stated he was ambulated toward t | .m. R2 was exhibiting exit R2 had his luggage packed leaving. R2 was dressed and the exit doors. Staff was able to his room, where he of the night. | | | | | |
| | seeking behaviors. of the building as h | .m. R2 was exhibiting exit R2 asked staff how to get out e wanted to go home. Staff continued to search for a door | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED C | | |
|---|--|---|---------------------|--|----------------------------------|-------------------------|
| | | 00531 | B. WING | | 11/ | 18/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| MN VETI | ERANS HOME FERGU | IS FALLS | RTH PARK | 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | ge 5 | 2 830 | | | |
| | to exit for 30 to 45 r went to his room. | ninutes. R2 settled down and | | | | |
| | - 10/21/20, at 11:35 a.m. R2 was asking for his suitcase and wanted to get out of the facility. He was redirected with good response. | | | | | |
| | - 10/23/20, at 3:06 room on the east w | o.m. R2 was moved to a new ing of the facility. | | | | |
| | p.m. indicated staff alarm go off. The r alarmed door and c and/or outside of th seen. The respond alarm. Later, the re- telephone call indica R2 outside of the far nurse went out to a building. They were third staff member back into the facility R2's daughter was Signs were made to room was. The war ensure it was worki | report dated 11/3/20, at 12:15 heard the facility exit door esponding nurse went to the hecked for residents near e door. No residents were ing nurse then cleared the esponding nurse received a ating another nurse had found icility in the parking lot. The assist R2 back into the unable to redirect R2 and a was called to assist. The s were able to redirect R2 and back to his room safely. called to help redirect R2. o assist R2 with where his ider guard was checked to ng properly. R2 had exited he exit door named the Park | | | | |
| | incident report date had dementia and v where he was at. F he was confused. H attempts to exit the independently with | e was added to the facility d 11/3/20, which indicated R2 was often confused as to &2 was easily redirected when le had made no further facility. R2 walked a walker and became tions. Signs have been placed | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 11/18/2020 | |
|--------------------------|---|--|-------------------------|--|--|-------------------------|
| | | 00531 | B. WING | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| IN VETE | ERANS HOME FERGU | IS FALLS | RTH PARK FALLS, MN 5 | 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | ige 6 | 2 830 | | | |
| | | continue to monitor R2 and rection when confused. | | | | |
| | comprehensively re address the ongoin continued wanderir several statements Further, R2 was no 11/3/20, elopement circumstances surr with potential causa effort to reduce the R2's care plan revis at risk for elopement Interventions inclue safe in the facility, down when he tried encourage him to w him when he made him to his room and escort for all outsid R2's risk for elopement Although, R2 had a | d lacked evidence R2 was eassessed to identify and or grisk of elopement despite and/or attempts to elope. At reassessed following the t from the building including ounding the elopement along ative factors and patterns in an incidences of elopement. Sed 10/8/20, indicated R2 was nt related to dementia. Ided: make [R2] feel secure and call his daughter to calm him d to leave the facility, verbalize his feelings, redirect attempts to elope and reorien d unit and would require an e . Interventions related to nent were dated 10/8/20. A successful elopement from erventions remained | ł | | | |
| | was seated in a cha east lobby area with | on 11/17/20, at 2:22 p.m. R2 air with the television on in the h four other residents. R2 was ad a light coat on and was | | | | |
| | walker, stood up ar hall in the direction unidentified nurse v nurse verbally direct | woke and reached for his nd started walking down the of his room. R2 asked an where his room was and the cted R2 down the east hall to ame on the door. R2 turned | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 11/18/2020 | |
|---------------|--|--|---------------------------------|---|--|-----------------|
| | | 00531 | B. WING | | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | | |
| | ERANS HOME FERGU | JS FALLS | RTH PARK FALLS, MN 5 | 6537 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC) | HE APPROPRIATE | COMPLET DATE |
| 2 830 | Continued From pa | ige 7 | 2 830 | | | |
| | than which the nurshe would go out that the opposite wing. able to redirect R2 verbal redirection a On 11/18/20, at 11: -A was interviewed the exit door alarm panel was checked exit. RN-A stated se exit door and looke see anyone around would alarm from s through them but si when they alarmed resident. She return cleared the alarm a duties. RN-A stated head count to ensu inside the building. full resident count, at risk to elope and building. Further sh resident with a wan because the wande About 5 minutes aff RN-A stated she re nurse in the parking outside in the parking | ulate toward the opposite hall se had directed him. R2 stated at door, referring to a door on The unidentified nurse was back to his own unit with nd walked him to his room. 40 a.m. registered nurse (RN) and explained she had heard go off and when the alarm , it was flashing Park Street she immediately went to the d around outside but could not . RN-A stated the exit doors taff or maintenance going taff still checked the exits to be sure it had not been a hed to the nursing station and and returned to her work d she did not initiate a facility re all residents were safely They would not typically do a but they would check for those make sure they were in the he did not think it was a derguard that set off the alarm, received a telephone call from a g lot who indicated R2 was ng lot. RN-A stated she but to the lot to try to bring R2 ng. R2 was resistive and urther staff assistance to bring cility. Dn 11/18/20, at 11:58 a.m. it door alarms would because the wind would set | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
|---------------|--|---|-------------------------|--|-----------------|--------------------|
| | | | A. BUILDING: | | - c | |
| | | 00531 | B. WING | | | 0 18/2020 |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | ERANS HOME FERG | US FALLS | RTH PARK FALLS, MN 🖇 | 56537 | | |
| (X4) ID | SUMMARY STA | | | PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO ⊺ DEFICIENC | THE APPROPRIATE | COMPLET DATE |
| 2 830 | Continued From pa | age 8 | 2 830 | | | |
| | sounding and have triggered the alarm from the unit nurse RN-B stated if no re | e on unit where the alarm was her check to see what had . When she got the all clear , she would clear the alarm. esident was seen when a door yould check on the residents r elopement. | | | | |
| | nursing assistant (I sounded staff woul and look for resider by the exit door, the sure their wandered | a 11/18/20, at 11:56 a.m. NA)-B stated if an alarm d check the alarming exit door nts. If no residents were seen e staff would check and make rs were around. NA-B ld not do a full resident head | | | | |
| | had severe cognitive supervision with tra MDS identified R1 | S dated 10/21/20, identified R1 ve impairment and required ansfers and ambulation. The had wandering behaviors. d Parkinson's disease and | | | | |
| | 10/15/20, identified wandering. The ID recommendation to and staff was not to | o use of a wander guard alert o leave R1 unattended when r medical appointments. No | | | | |
| | R1's progress note 11/17/20, identified | s from 7/21/20, through the following: | | | | |
| | seeking behaviors. | .m. R1 was exhibiting exit R1 attempted to exit the courtyard doors. The staff s bedroom. | | | | |

| STATEMEN | ta Department of He | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | COMF | E SURVEY PLETED |
|--------------------------|--|--|-----------------------|---|------------|-------------------------|
| | | 00531 | B. WING | | 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| IN VETE | ERANS HOME FERGU | IS FALLS | RTH PARK FALLS, MN | 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | ge 9 | 2 830 | | | |
| | - 9/2/20, at 12:46 p.m. R1 exhibited wandering behaviors through out both north and south sides of the unit. R1 was difficult to redirect and staff was unable to determine what R1 was searching for. | | | | | |
| | - 9/22/20, at 9:32 p.m. R1 exhibited wandering behaviors through out the shift. Distraction was not always effective and when it was, the behavior only ceased briefly. | | | | | |
| | assessment was co was at moderate ris recommended to co guard and to accom appointments. No identified or implem for elopement even September 2020, id | b.m. a Self Preservation ompleted and indicated R1 sk for wandering. The IDT ontinue use of the wander appany R1 to all outside further interventions were nented to reduce the chances though progress notes in lentified R1 was wandering not always effective. | | | | |
| | R1. A search was of call to all staff was of search for R1. The from a neighboring at their front door. from their front doo why he had exited to day (OD) indicated sounded to alert sta | m. staff were unable to locate conducted of the unit. A radio made to alert all staff to facility received a phone call home owner reporting R1 was The facility staff retrieved R1 r. R1 was unable to indicate he facility. The officer of the no alarms or code yellow had aff of R1's exit from the facility. all the exit doors with R1 and | | | | |
| | the doors did lock a yellow as it was sup encouraged to be e whereabouts closel | and the exit doors with ren and and the alarm did sound code oposed to. Staff were xtra diligent and monitor R1's y. R2 had exited the facility or named the Park Street exit. | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
|--------------------------|---|---|---------------------------------|--|---|--|
| | | 00531 | B. WING | | 11/18/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | | |
| MN VETE | ERANS HOME FERGU | IS FALLS | RTH PARK FALLS, MN 5 | 6537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE COMPLE THE APPROPRIATE DATE | |
| 2 830 | 11/13/20, at 11:27 completed. R1 cont and the facility wou goals and intervent was completed. During observation was wandering above was pleasant, howe communicate effect other resident room redirection to the dat timely and R1 was R1's medical record comprehensibly real address the ongoin continued wanderin several statements Further, R1 was no 11/7/20, elopement circumstances surr with potential causa effort to reduce the | and/or attempts to elope. d lacked evidence R1 was assessed to identify and g risk of elopement despite ag behaviors and making and/or attempts to elope. t reassessed following the from the building including ounding the elopement. | 2 830 | | | |
| | had severe cognitiv for elopement relate around the facility a Interventions direct verbalize his feeling [R1] entered other n | ewed 11/10/20, identified R1 re impairment and was at risk ed to dementia. R1 wandered and did go into other's spaces. ed the following: encourage to gs, intervene right away when resident rooms and redirect n, redirect away from fire | | | | |
| | alarm pull stations, attempts to elope, r and unit, escort to a with identifying [R1] his right wrist. Inter elopement were da | redirect when making re-orientate him to his room all outside appointments along had wander guard placed on ventions related to risk for ted 4/17/19. Although, R1 had ed from the facility, R1's | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|---|--|-------------------------------|--|-----------------------------------|-------------------------|
| | | 00531 | B. WING | | | C 18/2020 |
| | PROVIDER OR SUPPLIER | | DDRESS, CITY, S | | 11/ | 10/2020 |
| | | 1821 NO | RTH PARK | TATE, ZIF GODE | | |
| IN VETE | RANS HOME FERG | US FALLS | FALLS, MN 5 | 6537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | age 11 | 2 830 | | | |
| | interventions remai | ined unchanged. | | | | |
| | stated when a code staff a resident with door) goes over the memory unit do not alarm sounded on t the charge nurse w staff via their talkies it could not be hear LPN-A stated staff alarming door, to s and that most of the LPN-A stated the c code had never sou facility on 11/7/20. trouble with the alar resident with a war long enough, the de resident could go th wander guard alarm yellow when R1 pa the exit door alarm R1 opened the faci she did not know w LPN-A stated she t happened the prev the facility. | a 11/18/20, at 8:25 a.m. LPN-A e yellow (an alert identifying to a wanderguard exited the e intercom, the staff on the t hear it. LPN-A indicated the the east and west wings and yould notify the memory unit s and the alarmed sounded as rd in the memory care wing. had to put in a code at the top the alarm from sounding e staff were aware of the code harge nurse had told her the unded when R1 exited the The facility had been having rm system before and if a ider guard stood by the door oor would unlock and the nrough. LPN-A verified the n should have sounded code ssed through them, as well as should have sounded when lity exit door. LPN-A stated thy both alarms did not sound. hought the same thing had ious week when R4 had exited | | | | |
| | stated R1 must hav doors long enough NA-A indicated R1 try to exit the facility | 11/18/20, at 9:30 a.m. NA-A ve been standing by the double for the alarm to disengage. did not seem to intentionally y and staff tried to engage R1 or snacks when he was vas effective. | | | | |
| | | dated 8/11/20, indicated R3 nitive impairment and was | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: _ | E CONSTRUCTION | COMF | E SURVEY PLETED | |
|--------------------------|--|---|-------------------------|---|---------------------------------|------------------------|--|
| | | 00531 | B. WING | | 11/ | 11/18/2020 | |
| AME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| IN VETE | ERANS HOME FERG | US FALLS | RTH PARK FALLS, MN १ | 56537 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC' | ION SHOULD BE HE APPROPRIATE | (X5) COMPLE DATE | |
| 2 830 | Continued From pa | age 12 | 2 830 | | | | |
| | MDS indicated R3 | ansfer and ambulation. The was also independent with the unit. R3 had a diagnosis | | | | | |
| | | ers dated 4/21/20, identified R3 I placed for decreased safety ndering. | 3 | | | | |
| | 8/6/20, indicated R wandering. IDT rec continue use of the | tion assessment completed on 3 was at moderate risk for commendations were to e wander guard and not to be ing outside appointments. No s were identified or | | | | | |
| | R3's progress note | s identified the following: | | | | | |
| | sounded. R3 had g street exit and was | a.m. a code yellow alert gotten outside from the Park redirected immediately back ander guard was tested and rly. | | | | | |
| | sounded. An LPN street exit, walking immediately returned | .m. a coed yellow alert found R3 outside the Park away from the building. R3 ed to the facility when called. was working properly. | | | | | |
| | exit sounded. R3 v | o.m. code yellow park street was found coming out of a ory unit and was redirected ng and his room. | | | | | |
| | , | .m. R3 was found on the west ected back to the east wing. | | | | | |
| | - 11/2/20, at 3:12 p | .m. staff heard the east wing | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | COM | E SURVEY PLETED C |
|--------------------------|---|--|---------------------|--|----------------------------------|-------------------------|
| | | 00531 | B. WING | | | 18/2020 |
| AME OF F | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| N VETE | ERANS HOME FERG | IS FALLS | RTH PARK | 56537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | age 13 | 2 830 | | | |
| | R3 exit the Park St redirect R3 back in combative and una the facility lawn, cro banging on window | at to check it. Staff observed reet exit and attempted to to the facility. R3 was able to redirect. R3 ran across possed Park Street and began and doors of the neighboring bollowing. Staff eventually got facility. | 1 | | | |
| | 11/2/20, each ident confused. R3 had would continue to r interventions were | ts dated 7/24/20, 8/17/20, and tified R3 would become easily a wander guard on and staff nonitor. No further added to R3's care plan to and elopement attempts. | | | | |
| | been comprehensil address the ongoin continued wanderin several statements There was no evide circumstances surr attempts, had been | d lacked evidence R3 had bly reassessed to identify and ag risk of elopement despite ng behaviors and having and/or attempts to elope. ence R3's wandering, nor the rounding the elopement accounted for and assessed uting factors and solutions. | | | | |
| | at risk for elopemen dementia. There w direct staff related t risk for elopement Although R3 had a the facility, R3 had | sed 9/1/20, indicated R3 was nt related to a diagnosis of vere no interventions listed to to his risk of elopement. The was identified on 4/21/20. successful elopement from no interventions listed for ton of his identified risk for | | | | |
| | wandered to the ea toward the double e | on 11/17/20, at 2:14 p.m. R3 ast hall wing, frequently going exit doors of the east wing. lirected R3 back to the | | | | |

| STATEME | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|---|--|--------------------------------|-------------------------|--|
| | | 00531 | | | 11/18/2020 | | |
| NAME OF I | PROVIDER OR SUPPLIER | | DDRESS, CITY, S [.] RTH PARK | TATE, ZIP CODE | | | |
| IN VETI | ERANS HOME FERGU | IS FALLS | FALLS, MN 5 | 56537 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹ | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 14 | 2 830 | | | | |
| | common lobby area | a. | | | | | |
| | wing. Staff frequer common lobby area | gain wandered to the east hall htly redirected R3 back to the a and was able to divert R3's ersation and television in the | | | | | |
| | -At 3:40 p.m. R3 began following an unidentified staff member as she made rounds. When she entered a room, R3 would pause and immediately follow the next staff member to be near them. | | <i>y</i> | | | | |
| | the east hall wing. approached R3 and meal choices with I | egan to follow a resident down An unidentified staff member d began discussing the supper R3. R3 followed the staff wing into the lobby area. | | | | | |
| | stated when a code go to the door and the nurse all clear. usually just going fo down the halls and snack and the new as a diversion. NA | a 11/18/20, at 11:56 a.m. NA-B e yellow sounded, staff would look for residents and then tell NA-B indicated R3 was or a walk when going up and she would usually give him a spaper or turn on the televisior -B indicated she thought R3 wife, when walking up and | | | | | |
| | had severe cognitivi independent with tr | lated 8/20/20, indicated R4 /e impairment and was ansfer and ambulation, supervision on and off the unit. s of dementia. | | | | | |
| | 10/15/20, indicated wandering. IDT red | tion assessment completed on R4 was a moderate risk for commendations were to wander guard and not to be | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: _ | CONSTRUCTION | COM | E SURVEY PLETED C |
|--------------------------|---|--|---------------------------|---|--------------------------------|-------------------------|
| | | 00531 | B. WING | | 11/ | 18/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| IN VETE | ERANS HOME FERGU | JS FALLS | RTH PARK 5 FALLS, MN 5 | 6537 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | ige 15 | 2 830 | | | |
| | left unattended dur further intervention implemented. | ing outside appointments. No s were identified or | | | | |
| | R4's progress note | (s) identified the following: | | | | |
| | off, when memory of phone call from the staff indicated R4 h | p.m. a code yellow was going care unit staff received a e east wing staff. East wing had been found outside of the aff had responded promptly at back to his unit. | | | | |
| | alarm was going of alarm promptly. St facility and promptly the wanderguard w determined to be w concluded R4 had | p.m. indicated the code yellow f and staff responded to the aff found R4 outside of the y returned him to his room. as checked on his return and torking properly. The staff stood near the door long to disengage, thus allowing he doors. | | | | |
| | was at risk for elop wandering and den staff to make [R4] f facility, encourage available, wander g for all outside appo related to risk for el Although, R4 had a | sed on 9/2/20, indicated R4 ement related to his history of nentia. The care plan directed eel secure and safe in the family participation when juard placement and an escort intments. Interventions lopement were dated 9/2/20. a successful exited the facility interventions remained | | | | |
| | R4's medical record been comprehensil address the ongoin continued wanderir | d lacked evidence R4 had oly reassessed to identify and g risk of elopement despite ng behaviors and having and/or attempts to elope. | | | | |

| AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: _ | | COM | E SURVEY PLETED C |
|------------------------|---|---|-------------------------|--|----------------|-------------------------|
| | | 00531 | B. WING | | 11/18/2020 | |
| AME OF F | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| N VETE | ERANS HOME FERG | US FALLS | RTH PARK FALLS, MN 5 | 6537 | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLE DATE |
| 2 830 | Continued From pa | age 16 | 2 830 | | | |
| | circumstances sum attempts had been for possible contrib During interview or stated if an outside could not determin check their wander there. RN-B indica do a head count, e stated there were s exit alarm on them stated the only real between the east a When interviewed DON stated if a coo (wanderguard alarm show on the system | ence R4's wandering, nor the rounding the elopement accounted for and assessed outing factors and solutions. 11/18/20, at 12:48 p.m. RN-B door alarm sounded and they e the cause, the staff would rers and make sure they were ited sometimes the staff would specially if it was winter. RN-B so few doors that just had the that it wasn't a problem. RN-E l problem was the exit door and memory unit doors. on 11/18/20, at 10:28 a.m. the de yellow alarmed m), the resident's picture would n behind the nurse's station. If at resident at the exit, they | 3 | | | |
| | the unit. If the res were to bring the re assess for injury ar was functioning pro determine why the | o and look for the resident on ident was found outside, staff esident back into the facility, nd assure the wander guard operly. They would try to resident left with staff nds on the unit. They would try | , | | | |
| | more related to the behavior. Incident i meetings. The DC had been reviewed | resident was exit seeking or resident's dementia or a reports were reviewed at daily N identified R1's elopement and she was told the wander e Ademco system alarm had | | | | |
| | not sounded. The were checked with facility and both ala when checked. The | DON indicated both alarms in minutes of R1's return to the arms were working properly e DON stated she did not know d not sound in that instance. | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED C | |
|-------------------|-------------------------------------|--|---|--|------------------------------------|----------------|
| | | 00531 | B. WING | | 11/18/2020 | |
| AME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE, ZIP CODE | | |
| N VETE | ERANS HOME FERGU | JS FALLS | RTH PARK FALLS, MN 5 | 6537 | | |
| (X4) ID PREFIX | - | TEMENT OF DEFICIENCIES | ID PREFIX | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT | | (X5) COMPLE |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | DATE |
| 2 830 | Continued From pa | ige 17 | 2 830 | | | |
| | memory unit double | e doors and a do not enter sign | | | | |
| | | s to distract R1 from | | | | |
| | | until the alarm company could | | | | |
| | | e alarm system the next day. | | | | |
| | | metimes a resident will stand | | | | |
| | | d doors long enough that the | | | | |
| | • | ge as a safety feature, | | | | |
| | | would still sound. Further, the | | | | |
| | | If Preservation form to assess | | | | |
| | | se, the forms were filled out | | | | |
| | | eded, that form was the | | | | |
| | facility's compreher | nsive assessment. | | | | |
| | During interview on | 11/18/20, at 12:15 p.m. the | | | | |
| | | d when a resident exits the | | | | |
| | | completes an investigation. | | | | |
| | | cluded checking the door | | | | |
| | | guards for function. The | | | | |
| | | d an elopement investigation | | | | |
| | | vestigation, because it was | | | | |
| | | hether the alarms or doors | | | | |
| | • | The administrator stated if a | | | | |
| | | ined for the elopement you | | | | |
| | | incident reports or if it was | | | | |
| | | ident was wandering more the | | | | |
| | | hat to see if placement on the | | | | |
| | | eeded. The administrator | | | | |
| | | oors on the wings had the | | | | |
| | | em with magnetic locks. The cility had the Ademco system | | | | |
| | | staff would still have to | | | | |
| | | alarm and determine why it | | | | |
| | | the alarm was silenced behind | | | | |
| | | The administrator indicated | | | | |
| | | ently purchased a "screech | | | | |
| | | d to install it on the Park Street | | | | |
| | | kit door was identified as the | | | | |
| | | were able to exit more | | | | |
| | | rm would be heard on both the | | | | |
| | east wing and the r | | 1 | | | 1 |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00531 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | (X3) DATE SURVEY COMPLETED C | | | | | | |
|--|--|---|---------------------|--|----------------------------------|-------------------------|--|--|--|--|
| | | | | 11/1 | 8/2020 | | | | | |
| AME OF I | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | | | | | |
| MN VETERANS HOME FERGUS FALLS 1821 NORTH PARK FERGUS FALLS, MN 56537 | | | | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | | | | |
| 2 830 | Continued From page 18 | | 2 830 | | | | | | | |
| | alarm. The facility as the staff had not planned to train sta end of the following stated it was not the resident head coun however it would no the policy. The facility's policy and Door Alarm Sy 3/19, indicated a re would be determine assessment and if wander guard woul during a resident's identified, a wander would be reviewed policy indicted the F have a magnetic lo the wander guard s would have to pass connected to the sy immediately before staff were responsi alarm immediately. determined which r their current locatio a resident exited th assessed and redir SUGGESTED MET director of nursing of review applicable p resident's wandering | Ily go to the door to disable the had not installed the alarm yet, been trained on it, but ff and place the alarm by the gweek. The administrator e facility's policy to do a t if an alarm sounded; ot be a bad idea to add that to titled Wander Management stem with revision date of sident's risk for wandering ed during pre-admission a need was determined, a d be placed. If at any time stay, a wander risk was r guard may be placed. This quarterly and as needed. The Park Street exit door did not ck and was not connected to system because a resident to through a door that is ystem with a magnetic lock reaching this exit door. All ble to respond to a sounding Upon each alarm, it must be esident set off the alarm and in before the alarm is reset. If e building, the resident will be rected back into the building. THOD OF CORRECTION: The (DON), or designee, could olicies and procedures for ing and elopements; then revise re there was comprehensive | | | | | | | | |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00531 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|-------------------------------|---|---|--|--|--|
| | | B. WING | | | C 11/18/2020 | |
| | PROVIDER OR SUPPLIER | 1821 NO | DDRESS, CITY, ST RTH PARK 5 FALLS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | ON SHOULD BE COMPL HE APPROPRIATE DAT | |
| 2 830 | Continued From page 19 | | 2 830 | | | |
| | TIME PERIOD FOF (21) days. | R CORRECTION: Twenty-one | | | | |
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