DEPARTMENT OF HEALTH

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 Therefore, the NATCEP prohibition is rescinded.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

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.

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

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245636	A. BUILDING _____ B. WING _____	C 11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	**1821 NORTH PARK FERGUS FALLS, MN 56537**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 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 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §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	F 610		1/15/21

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

Electronically Signed | 12/16/2020

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F 610	Continued From page 1 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of neglect of care following an elopement were thoroughly investigated to prevent further incidents of elopement for 1 of 2 residents (R2) who exited the building without supervision. Findings include: R2's admission Minimum Data Set (MDS) dated 9/2/20, indicated R2 had minimal cognitive impairment and required supervision with transfer and ambulation. The MDS identified R2 exhibited wandering behaviors that did not place him at risk or intrude on others. R2 had a diagnosis of dementia R2's initial report to the State Agency (SA) dated 11/3/20, identified a report was submitted for potential neglect of care related to R2's elopement from the facility on 11/3/20, at 12:15 p.m. R2 exited the building, without injury. The report identified R2 exited the building through the Park Street exit door. The alarm sounded. A	F 610	F610 □ Investigate/Prevent/Correct Alleged Violation 1. Resident R2 had a new self-preservation assessment completed by 12/15/2020. Resident R2□s care plan was updated with most current interventions to prevent wandering and to redirect resident when resident has wandering tendencies. Park Street Exit was serviced by the vendor on 11/11/2020. Park Street Exit also had a third alarm system installed by 11/20/2020. All incident reports created within the last 30 days will be reviewed by the administrator to ensure investigations were complete and new interventions put in place for the resident(s) involved, when applicable. 2. All residents have the potential to be affected. 3. Director of Nursing and Administrator	

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F 610	Continued From page 2 nurse responded and did not see a resident. Another nurse pulled into the parking lot and called the facility to report R2 was wandering in the parking lot. The wanderguard alarm did not sound; however the exit alarm did. The facility tested the wanderguard alarm and identified R2's wanderguard pendant and the wanderguard alarm on the door was functioning and they were not sure why R2 exited the building or why the wanderguard system did not alert staff to R2 exiting the door. R2's investigative report submitted to the SA on 11/9/20, identified the facility reviewed R2's care plan and the care plan was followed. Further, the facility reviewed their policy and the policy was followed and no changes were made to the facility policy. The investigation summary identified the following " RN [registered nurse] heard door alarm ringing and alarm stated "E. Park St. Exit". RN went to the alarming door to check for residents. No residents were noted to be outside by the RN. RN soon received a call from the front office that another nurse who was in the front parking lot was with resident, [R2], outside in the front parking lot. RN immediately attended to resident outside. RN and other nurse were unable to initially redirect [R2]. Unit Coordinator provided assistance and was able to direct him back inside. Resident was escorted to his room safely. [R2] stated that he was going home to his "barracks." [R2] was redirected back into facility safely. RN notified [R2's] daughter via phone and she assisted to help redirect resident. Signs were made to help assist resident where his room is, and to not exit the park street corridors. Wander guard system was also tested to ensure working properly. Resident wears a wander guard due to wandering tendencies. However, the door alarm	F 610	reviewed policy titled Vulnerable Adult/Resident Protection Plan on 12/9/2020. Nursing staff were educated regarding policy titled Vulnerable Adult/Resident Protection Plan by 1/15/2021. Education included review of how to properly complete an incident report in the electronic medical record system. This included a review of where to document witness statements and how to document investigation of incident in the incident report including the need to document the reason for the incident and action taken to prevent similar incident from occurring. 4. Audits will be conducted weekly for 4 weeks by the Administrator or Designee for up to 5 random completed incident reports per week to ensure that all applicable portions of the incident report were completed. The incident reports audited will also be audited to ensure that a reason for the incident is identified in the documentation and action taken to prevent a similar incident from occurring. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 1/15/2021	

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F 610	Continued From page 3	F 610		

that sounded was a back up system that alarms anytime the door opened. The wander guard device should have activated the magnetic locks. It is unknown how the resident got past the wander guard equipped doors. However, staff located [R2] very quickly and he was assessed and found to have no injuries. Staff will monitor resident for further wandering concerns." Three staff were identifed to have contributed to the investigation.

Action taken to prevent reoccurrence to the subjected resident was identified as "Signs were made to help orientate resident to where his room was, Wander guard system was also tested to ensure working properly. Resident wore a wander guard due to wandering tendencies. However, the door alarm that sounded was a back up system that alarms anytime the door opened. The wander guard device should have activated the magnetic locks. It is unknown how the resident got past the wander guard equipped doors. However, staff located Harold very quickly and he was assessed and found to have no injuries. Staff will monitor resident for further wandering concerns."

The investigation did not identify causative reasons for the alarm not functioning and what they did to ensure the alarm would function if another resident wandered to the Park Street exit. Further, the investigation did not identify R2 was assessed for wandering and elopement behaviors to implement resident centered interventions to attempt to prevent further elopement attempts.

Notes regarding the internal investigation ie...actual staff interviews obtained and details on what was investigated were requested and were

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F 610	Continued From page 4	F 610		

not received.

During interview on 11/18/20, at 12:15 p.m. the administrator stated when a resident exits the building the facility completes an investigation. The investigation included checking the door alarms and wander guards for function. The administrator stated an elopement investigation was not like a fall investigation, because it was always related to whether the alarms or doors were functioning. The administrator stated if a reason was determined for the elopement you would find it on the incident reports or if it was determined the resident was wandering more the IDT would look at that to see if placement on the memory unit was needed. The facility did not keep any further investigation documents to review as the information was in the five day investigation and IDT notes. Further, the double doors on the wings had the wander guard system with magnetic locks. The exit doors of the facility had the Ademco system alert in place. The staff would still have to respond to the exit alarm and determine why it was sounding, but the alarm was silenced behind the nurses station. The facility had not altered their policy to ensure verification of all residents was completed when an alarm sounded, and a resident was not identified to trigger the alarm, to ensure all residents were accounted for.

The facility policy revised 2/23/17, identified the following regarding investigation: "it is the policy of the agency that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. The investigation is the process used to try to determine what happened.

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F 610	Continued From page 5 All staff will cooperate during the investigation to assure the resident is fully protected. The designated facility personnel will begin the investigation immediately. The policy identified how to complete an investigation for allegations of abuse, injuries of unknown source, involuntary seclusion and misappropriation of property. The policy did not identify how to conduct an investigation regarding incidents of potential neglect of care; however, the policy identified results of the investigation would be recorded and tied to the report ; Nursing and/or designee will document resident's behaviors and environmental concerns at the time of the incident, as well as observations made of resident's behavior during the investigation; nursing and/or designee would identify and implement appropriate interventions for the resident involved, all other residents and to prevent future co-occurrence The follow-up investigative notes would be submitted to the appropriate state agency following state policy for reporting.	F 610		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all residents were accounted for after 1 of 4 residents (R2)	F 689	F689 □ Free of Accident Hazards/Supervision/Devices	1/15/21

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F 689	Continued From page 6 sounded the exit alarm while exiting the building. In addition, the facility failed to comprehensively assess for and develop person centered interventions to reduce the risk of 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: During a facility tour on 11/17/20, at 1:00 p.m. each wing was observed and each wing had double doors with a wanderguard system on each of the doorways. The east wing and the memory unit double doors were separated by a small room with glass exit doors on either side. One exit door opened to an outside fenced courtyard. The opposite exit door opened to the facility campus, a road, and neighboring houses lined across the road. This exit door was called the Park Street exit. Both exit doors had alarms on them, however, the exit doors did not have wanderguard alarms. The doors on both units were not visible from the nurses station of the east or memory care units. The director of nursing (DON) stated the wanderguard alarms were located on the double doors of each wing and could not be placed on the facility exit doors due to the magnetic locking system used by the wander guard system. R2's admission Minimum Data Set (MDS) dated 9/2/20, indicated R2 had minimal cognitive impairment and required supervision with transfer and ambulation. The MDS identified R2 exhibited wandering behaviors that did not place him at risk or intrude on others. R2 had a diagnosis of dementia.	F 689	1. Resident R1, R2, R3, and R4 had a new self-preservation assessment completed by 12/15/2020. Resident R1, R2, R3, and R4□s care plans were updated with most current interventions to prevent wandering and to redirect resident when resident has wandering tendencies. Park Street Exit was serviced by the vendor by 11/11/2020. Park Street Exit also had a third alarm system installed by 11/20/2020. All residents deemed to be at risk for wandering/elopement will have new self-preservation assessment completed as well as care plans reviewed/updated to ensure appropriate interventions are in place. 2. All residents have the potential to be affected. 3. Director of Nursing and Administrator reviewed policy titled Vulnerable Adult/Resident Protection Plan on 12/9/2020. Facility emergency plan section titled Elopement/Missing resident was reviewed and revised by Director of Nursing and Administrator on 12/9/2020. Facility policy titled Wander Management and Door Alarm System was reviewed and revised by Director of Nursing and Administrator on 12/9/2020. Two new forms were created. Form titled root cause analysis post elopement/exit seeking will be used after an elopement or significant exit seeking behavior to identify how the incident occurred, how it can be prevented and to ensure follow up documentation is completed. Form titled resident care area exit door alarm	

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F 689	Continued From page 7 The facility's Self Preservation assessment form identified risk factors for wandering and elopement. The form used a check list system that included the following information: level of orientation, behaviors, recent experiences such as room change, level of mobility, diagnoses, medications, history of wandering, safety factors, risk factors, negative feelings related to nursing home placement and interdisciplinary team (IDT) recommendations. How the score was determined was not indicated on the form. R2's Self Preservation assessment completed on 8/27/20, indicated R2 was at moderate risk for wandering. The form indicated IDT recommended the placement of a wander guard and to be accompanied to all outside appointments. No further interventions were identified or implemented. R2's progress note(s) identified the following: - 8/27/20, at 1:35 p.m. R2 had attempted to leave the facility a minimum of five times since his arrival. R2's daughter called and spoke with him and this calmed him down. A wander guard was placed. - 9/4/20, at 5:33 a.m. R2 was awake and packing his suitcase. R2 stated he was moving somewhere tomorrow. R2 seemed confused about his situation. When assisted, R2 did remain in his bed. - 9/8/20, at 11:05 p.m. R2 was exhibiting exit seeking behaviors. R2 had his luggage packed and stated he was leaving. R2 was dressed and ambulated toward the exit doors. Staff was able to redirect R2 back to his room, where he	F 689	response checklist will be used when a reason is not quickly identified for why the door alarm sounded to ensure a head count of all residents is completed. Nursing Staff were educated regarding the three policies and two forms by 1/15/2021. Nursing Staff Education included review of emergency plan regarding elopements and significant exit seeking behavior which included education on completing a new self-preservation assessment as well as updating the resident□s care plan after any elopement or significant exit seeking behavior by a resident. Staff were educated on how to respond to door alarms and educated that when an alarm goes off and a reason for the alarm is not quickly identified, a full facility head count may need to be completed. Staff were educated that after any elopement or significant exit seeking behavior a full facility head count should be completed. 4. Audits will be conducted weekly for 4 weeks by the Administrator or Designee to ensure that any elopement or significant exit seeking behavior is investigated properly, that self-preservation assessment has been completed, that care plan was updated, and that head count was completed. If there are no elopements or significant exit seeking behaviors during a week, then an elopement drill will be conducted to audit staff□s response. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting.	

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F 689	Continued From page 8 remained the rest of the night. - 10/8/20, at 5:35 p.m. R2 was exhibiting exit seeking behaviors. R2 asked staff how to get out of the building as he wanted to go home. Staff reoriented R2. R2 continued to search for a door to exit for 30 to 45 minutes. R2 settled down and went to his room. - 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 p.m. R2 was moved to a new room on the east wing of the facility. The facility incident report dated 11/3/20, at 12:15 p.m. indicated staff heard the facility exit door alarm go off. The responding nurse went to the alarmed door and checked for residents near and/or outside of the door. No residents were seen. The responding nurse then cleared the alarm. Later, the responding nurse received a telephone call indicating another nurse had found R2 outside of the facility in the parking lot. The nurse went out to assist R2 back into the building. They were unable to redirect R2 and a third staff member was called to assist. The three staff members were able to redirect R2 back into the facility and back to his room safely. R2's daughter was called to help redirect R2. Signs were made to assist R2 with where his room was. The wander guard was checked to ensure it was working properly. R2 had exited the facility through the exit door named the Park Street exit. On 11/12/20, a note was added to the facility incident report dated 11/3/20, which indicated R2	F 689	5. 1/15/2021	

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had dementia and was often confused as to where he was at. R2 was easily redirected when he was confused. He had made no further attempts to exit the facility. R2 walked independently with a walker and became confused with directions. Signs have been placed in common areas and on R2's room door with his name. Staff would continue to monitor R2 and guide R2 in right direction when confused.

R2's medical record lacked evidence R2 was comprehensively reassessed to identify and address the ongoing risk of elopement despite continued wandering behaviors and making several statements and/or attempts to elope. Further, R2 was not reassessed following the 11/3/20, elopement from the building including circumstances surrounding the elopement along with potential causative factors and patterns in an effort to reduce the incidences of elopement.

R2's care plan revised 10/8/20, indicated R2 was at risk for elopement related to dementia. Interventions included: make [R2] feel secure and safe in the facility, call his daughter to calm him down when he tried to leave the facility, encourage him to verbalize his feelings, redirect him when he made attempts to elope and reorient him to his room and unit and would require an escort for all outside . Interventions related to R2's risk for elopement were dated 10/8/20. Although, R2 had a successful elopement from the facility, R2's interventions remained unchanged.

During observation on 11/17/20, at 2:22 p.m. R2 was seated in a chair with the television on in the east lobby area with four other residents. R2 was fully dressed and had a light coat on and was

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sleeping.

-At 3:25 p.m. R2 awoke and reached for his walker, stood up and started walking down the hall in the direction of his room. R2 asked an unidentified nurse where his room was and the nurse verbally directed R2 down the east hall to the room with his name on the door. R2 turned and started to ambulate toward the opposite hall than which the nurse had directed him. R2 stated he would go out that door, referring to a door on the opposite wing. The unidentified nurse was able to redirect R2 back to his own unit with verbal redirection and walked him to his room.

On 11/18/20, at 11:40 a.m. registered nurse (RN) -A was interviewed and explained she had heard the exit door alarm go off and when the alarm panel was checked, it was flashing Park Street exit. RN-A stated she immediately went to the exit door and looked around outside but could not see anyone around. RN-A stated the exit doors would alarm from staff or maintenance going through them but staff still checked the exits when they alarmed to be sure it had not been a resident. She returned to the nursing station and cleared the alarm and returned to her work duties. RN-A stated she did not initiate a facility head count to ensure all residents were safely inside the building. They would not typically do a full resident count, but they would check for those at risk to elope and make sure they were in the building. Further she did not think it was a resident with a wanderguard that set off the alarm because the wanderguard system did not alarm. About 5 minutes after shutting off the alarm, RN-A stated she received a telephone call from a nurse in the parking lot who indicated R2 was outside in the parking lot. RN-A stated she

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immediately went out to the lot to try to bring R2 back into the building. R2 was resistive and needed to call for further staff assistance to bring R2 back into the facility.

When interviewed on 11/18/20, at 11:58 a.m. RN-B stated the exit door alarms would sometimes alarm because the wind would set them off. When an exit door alarm sounded, she would call the nurse on unit where the alarm was sounding and have her check to see what had triggered the alarm. When she got the all clear from the unit nurse, she would clear the alarm. RN-B stated if no resident was seen when a door alarmed, the staff would check on the residents that were at risk for elopement.

During interview on 11/18/20, at 11:56 a.m. nursing assistant (NA)-B stated if an alarm sounded staff would check the alarming exit door and look for residents. If no residents were seen by the exit door, the staff would check and make sure their wanderers were around. NA-B indicated they would not do a full resident head count.

R1's quarterly MDS dated 10/21/20, identified R1 had severe cognitive impairment and required supervision with transfers and ambulation. The MDS identified R1 had wandering behaviors. Diagnoses included Parkinson's disease and dementia.

R1's Self Preservation assessment dated 10/15/20, identified R1 was at moderate risk for wandering. The IDT checked off the recommendation to use of a wander guard alert and staff was not to leave R1 unattended when out of the facility for medical appointments. No

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further interventions were identified or implemented.

R1's progress notes from 7/21/20, through 11/17/20, identified the following:

- 7/21/20, at 1:44 p.m. R1 was exhibiting exit seeking behaviors. R1 attempted to exit the facility through the courtyard doors. The staff redirected R1 to his bedroom.

- 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.

- 10/15/20, at 8:46 p.m. a Self Preservation assessment was completed and indicated R1 was at moderate risk for wandering. The IDT recommended to continue use of the wander guard and to accompany R1 to all outside appointments. No further interventions were identified or implemented to reduce the chances for elopement even though progress notes in September 2020, identified R1 was wandering and distraction was not always effective.

- 11/7/20, at 2:24 p.m. staff were unable to locate R1. A search was conducted of the unit. A radio call to all staff was made to alert all staff to search for R1. The facility received a phone call from a neighboring home owner reporting R1 was at their front door. The facility staff retrieved R1

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from their front door. R1 was unable to indicate why he had exited the facility. The officer of the day (OD) indicated no alarms or code yellow had sounded to alert staff of R1's exit from the facility. The staff checked all the exit doors with R1 and the doors did lock and the alarm did sound code yellow as it was supposed to. Staff were encouraged to be extra diligent and monitor R1's whereabouts closely. R2 had exited the facility through the exit door named the Park Street exit.

- 11/13/20, at 11:27 a.m. R1 had a quarterly MDS completed. R1 continued to wander frequently and the facility would continue the current focus, goals and interventions. No further assessment was completed.

During observation on 11/17/20, at 2:08 p.m. R1 was wandering about the memory care unit. R1 was pleasant, however, was unable to communicate effectively. R1 attempted to enter other resident rooms and required staff redirection to the day room. Staff responded timely and R1 was receptive to the redirection.

R1's medical record lacked evidence R1 was comprehensibly reassessed to identify and address the ongoing risk of elopement despite continued wandering behaviors and making several statements and/or attempts to elope. Further, R1 was not reassessed following the 11/7/20, elopement from the building including circumstances surrounding the elopement along with potential causative factors and patterns in an effort to reduce the incidences of elopement.

R1's care plan reviewed 11/10/20, identified R1 had severe cognitive impairment and was at risk for elopement related to dementia. R1 wandered

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around the facility and did go into other's spaces. Interventions directed the following: encourage to verbalize his feelings, intervene right away when [R1] entered other resident rooms and redirect him to the day room, redirect away from fire alarm pull stations, redirect when making attempts to elope, re-orientate him to his room and unit, escort to all outside appointments along with identifying [R1] had wander guard placed on his right wrist. Interventions related to risk for elopement were dated 4/17/19. Although, R1 had a successfully eloped from the facility, R1's interventions remained unchanged.

During interview on 11/18/20, at 8:25 a.m. LPN-A stated when a code yellow (an alert identifying to staff a resident with a wanderguard exited the door) goes over the intercom, the staff on the memory unit do not hear it. LPN-A indicated the alarm sounded on the east and west wings and the charge nurse would notify the memory unit staff via their talkies and the alarmed sounded as it could not be heard in the memory care wing. LPN-A stated staff had to put in a code at the alarming door, to stop the alarm from sounding and that most of the staff were aware of the code. LPN-A stated the charge nurse had told her the code had never sounded when R1 exited the facility on 11/7/20. The facility had been having trouble with the alarm system before and if a resident with a wander guard stood by the door long enough, the door would unlock and the resident could go through. LPN-A verified the wander guard alarm should have sounded code yellow when R1 passed through them, as well as the exit door alarm should have sounded when R1 opened the facility exit door. LPN-A stated she did not know why both alarms did not sound. LPN-A stated she thought the same thing had

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happened the previous week when R4 had exited the facility.

During interview on 11/18/20, at 9:30 a.m. NA-A stated R1 must have been standing by the double doors long enough for the alarm to disengage. NA-A indicated R1 did not seem to intentionally try to exit the facility and staff tried to engage R1 with conversation or snacks when he was wandering, which was effective.

R3's quarterly MDS dated 8/11/20, indicated R3 had moderate cognitive impairment and was independent with transfer and ambulation. The MDS indicated R3 was also independent with mobility on and off the unit. R3 had a diagnosis of dementia.

R3's physician orders dated 4/21/20, identified R3 had a wanderguard placed for decreased safety awareness and wandering.

R3's Self Preservation assessment completed on 8/6/20, indicated R3 was at moderate risk for wandering. IDT recommendations were to continue use of the wander guard and not to be left unattended during outside appointments. No further interventions were identified or implemented.

R3's progress notes identified the following:

- 7/24/20, at 11:18 a.m. a code yellow alert sounded. R3 had gotten outside from the Park street exit and was redirected immediately back to his unit. R3's wander guard was tested and was working properly.

- 8/17/20, at 2:23 p.m. a coed yellow alert

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sounded. An LPN found R3 outside the Park street exit, walking away from the building. R3 immediately returned to the facility when called. The wander guard was working properly.

- 9/4/20, at 12:56 p.m. code yellow park street exit sounded. R3 was found coming out of a room on the memory unit and was redirected back to the east wing and his room.

- 9/22/20, at 9:46 a.m. R3 was found on the west wing and was redirected back to the east wing.

- 11/2/20, at 3:12 p.m. staff heard the east wing door open and went to check it. Staff observed R3 exit the Park Street exit and attempted to redirect R3 back into the facility. R3 was combative and unable to redirect. R3 ran across the facility lawn, crossed Park Street and began banging on windows and doors of the neighboring homes, with staff following. Staff eventually got R3 to return to the facility.

R3's incident reports dated 7/24/20, 8/17/20, and 11/2/20, each identified R3 would become easily confused. R3 had a wander guard on and staff would continue to monitor. No further interventions were added to R3's care plan to reduce wandering and elopement attempts.

R3's medical record lacked evidence R3 had been comprehensibly reassessed to identify and address the ongoing risk of elopement despite continued wandering behaviors and having several statements and/or attempts to elope. There was no evidence R3's wandering, nor the circumstances surrounding the elopement attempts, had been accounted for and assessed for possible contributing factors and solutions.

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R3's care plan revised 9/1/20, indicated R3 was at risk for elopement related to a diagnosis of dementia. There were no interventions listed to direct staff related to his risk of elopement. The risk for elopement was identified on 4/21/20. Although R3 had a successful elopement from the facility, R3 had no interventions listed for safety and prevention of his identified risk for elopement.

During observation on 11/17/20, at 2:14 p.m. R3 wandered to the east hall wing, frequently going toward the double exit doors of the east wing. Staff frequently redirected R3 back to the common lobby area.

-At 3:24 p.m. R3 again wandered to the east hall wing. Staff frequently redirected R3 back to the common lobby area and was able to divert R3's attention with conversation and television in the lobby.

-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.

-At 4:15 p.m. R3 began to follow a resident down the east hall wing. An unidentified staff member approached R3 and began discussing the supper meal choices with R3. R3 followed the staff member out of the wing into the lobby area.

During interview on 11/18/20, at 11:56 a.m. NA-B stated when a code yellow sounded, staff would go to the door and look for residents and then tell the nurse all clear. NA-B indicated R3 was usually just going for a walk when going up and

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down the halls and she would usually give him a snack and the newspaper or turn on the television as a diversion. NA-B indicated she thought R3 was looking for his wife, when walking up and down the halls.

R4's annual MDS dated 8/20/20, indicated R4 had severe cognitive impairment and was independent with transfer and ambulation, however, required supervision on and off the unit. R4 had a diagnosis of dementia.

R4's Self Preservation assessment completed on 10/15/20, indicated R4 was a moderate risk for wandering. IDT recommendations were to continue use of the wander guard and not to be left unattended during outside appointments. No further interventions were identified or implemented.

R4's progress note(s) identified the following:

- 10/29/20, at 2:38 p.m. a code yellow was going off, when memory care unit staff received a phone call from the east wing staff. East wing staff indicated R4 had been found outside of the Park street exit. Staff had responded promptly and R4 was brought back to his unit.

- 10/29/20, at 1:50 p.m. indicated the code yellow alarm was going off and staff responded to the alarm promptly. Staff found R4 outside of the facility and promptly returned him to his room. the wanderguard was checked on his return and determined to be working properly. The staff concluded R4 had stood near the door long enough for the lock to disengage, thus allowing R4 to exit through the doors.

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R4's care plan revised on 9/2/20, indicated R4 was at risk for elopement related to his history of wandering and dementia. The care plan directed staff to make [R4] feel secure and safe in the facility, encourage family participation when available, wander guard placement and an escort for all outside appointments. Interventions related to risk for elopement were dated 9/2/20. Although, R4 had a successful exited the facility on 10/29/20, R4's interventions remained unchanged.

R4's medical record lacked evidence R4 had been comprehensibly reassessed to identify and address the ongoing risk of elopement despite continued wandering behaviors and having several statements and/or attempts to elope. There was no evidence R4's wandering, nor the circumstances surrounding the elopement attempts had been accounted for and assessed for possible contributing factors and solutions.

During interview on 11/18/20, at 12:48 p.m. RN-B stated if an outside door alarm sounded and they could not determine the cause, the staff would check their wanderers and make sure they were there. RN-B indicated sometimes the staff would do a head count, especially if it was winter. RN-B stated there were so few doors that just had the exit alarm on them that it wasn't a problem. RN-B stated the only real problem was the exit door between the east and memory unit doors.

When interviewed on 11/18/20, at 10:28 a.m. the DON stated if a code yellow alarmed (wanderguard alarm), the resident's picture would show on the system behind the nurse's station. If staff did not see that resident at the exit, they were expected to go and look for the resident on

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the unit. If the resident was found outside, staff were to bring the resident back into the facility, assess for injury and assure the wander guard was functioning properly. They would try to determine why the resident left with staff interviews and rounds on the unit. They would try to determine if the resident was exit seeking or more related to the resident's dementia or a behavior. Incident reports were reviewed at daily meetings. The DON identified R1's elopement had been reviewed and she was told the wander guard alarm and the Ademco system alarm had not sounded. The DON indicated both alarms were checked within minutes of R1's return to the facility and both alarms were working properly when checked. The DON stated she did not know why either alarm did not sound in that instance. The DON stated they did place furniture near the memory unit double doors and a do not enter sign on the double doors to distract R1 from attempting to leave until the alarm company could come and check the alarm system the next day. The DON stated sometimes a resident will stand by the wander guard doors long enough that the lock would disengage as a safety feature, however the alarm would still sound. Further, the facility used the Self Preservation form to assess for wanderguard use, the forms were filled out quarterly and as needed, that form was the facility's comprehensive assessment.

During interview on 11/18/20, at 12:15 p.m. the administrator stated when a resident exits the building the facility completes an investigation. The investigation included checking the door alarms and wander guards for function. The administrator stated an elopement investigation was not like a fall investigation, because it was always related to whether the alarms or doors

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	245636	A. BUILDING _____ B. WING _____	C 11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

were functioning. The administrator stated if a reason was determined for the elopement you would find it on the incident reports or if it was determined the resident was wandering more the IDT would look at that to see if placement on the memory unit was needed. The administrator stated the double doors on the wings had the wander guard system with magnetic locks. The exit doors of the facility had the Ademco system alert in place. The staff would still have to respond to the exit alarm and determine why it was sounding, but the alarm was silenced behind the nurses station. The administrator indicated the facility had recently purchased a "screech alarm" and intended to install it on the Park Street exit door, as that exit door was identified as the door the residents were able to exit more frequently. This alarm would be heard on both the east wing and the memory unit and would require the staff to physically go to the door to disable the alarm. The facility had not installed the alarm yet, as the staff had not been trained on it, but planned to train staff and place the alarm by the end of the following week. The administrator stated it was not the facility's policy to do a resident head count if an alarm sounded; however it would not be a bad idea to add that to the policy.

The facility's policy titled Wander Management and Door Alarm System with revision date of 3/19, indicated a resident's risk for wandering would be determined during pre-admission assessment and if a need was determined, a wander guard would be placed. If at any time during a resident's stay, a wander risk was identified, a wander guard may be placed. This would be reviewed quarterly and as needed. The policy indicted the Park Street exit door did not

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F 689	Continued From page 22 have a magnetic lock and was not connected to the wander guard system because a resident would have to pass through a door that is connected to the system with a magnetic lock immediately before reaching this exit door. All staff were responsible to respond to a sounding alarm immediately. Upon each alarm, it must be determined which resident set off the alarm and their current location before the alarm is reset. If a resident exited the building, the resident will be assessed and redirected back into the building.	F 689		

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	C 11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/17/20 and 11/18/20, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint(s) were found to be substantiated: H5636005C (MN67072) Correction order(s) issued at MN Rule 4658.0520 subp.1 H5636006C (MN66934) Correction order(s) issued at MN Rule 4658.0520 subp.1 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. State licensing orders are delineated on 2567, under the Minnesota Department of Health licensing order statute(s) being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "Corrected" in the box available for text. You must then indicate on the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting your plan of correction to the Minnesota Department of Health. 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 found out of compliance is listed in the "Summary Statement of Deficiencies" column, and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidence by ...". Following the surveyors findings are the "Suggested Method of	2 000		

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2 000	Continued From page 2 Correction" and the "Time Period for Correction". PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all residents were accounted for after 1 of 4 residents (R2) sounded the exit alarm while exiting the building. In addition, the facility failed to comprehensively assess for and develop person centered interventions to reduce the risk of	2 830	corrected	1/15/21

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2 830	Continued From page 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:

During a facility tour on 11/17/20, at 1:00 p.m. each wing was observed and each wing had double doors with a wanderguard system on each of the doorways. The east wing and the memory unit double doors were separated by a small room with glass exit doors on either side. One exit door opened to an outside fenced courtyard. The opposite exit door opened to the facility campus, a road, and neighboring houses lined across the road. This exit door was called the Park Street exit. Both exit doors had alarms on them, however, the exit doors did not have wanderguard alarms. The doors on both units were not visible from the nurses station of the east or memory care units. The director of nursing (DON) stated the wanderguard alarms were located on the double doors of each wing and could not be placed on the facility exit doors due to the magnetic locking system used by the wander guard system.

R2's admission Minimum Data Set (MDS) dated 9/2/20, indicated R2 had minimal cognitive impairment and required supervision with transfer and ambulation. The MDS identified R2 exhibited wandering behaviors that did not place him at risk or intrude on others. R2 had a diagnosis of dementia.

The facility's Self Preservation assessment form identified risk factors for wandering and elopement. The form used a check list system that included the following information: level of orientation, behaviors, recent experiences such

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2 830	Continued From page 4	2 830		

as room change, level of mobility, diagnoses, medications, history of wandering, safety factors, risk factors, negative feelings related to nursing home placement and interdisciplinary team (IDT) recommendations. How the score was determined was not indicated on the form.

R2's Self Preservation assessment completed on 8/27/20, indicated R2 was at moderate risk for wandering. The form indicated IDT recommended the placement of a wander guard and to be accompanied to all outside appointments. No further interventions were identified or implemented.

R2's progress note(s) identified the following:

- 8/27/20, at 1:35 p.m. R2 had attempted to leave the facility a minimum of five times since his arrival. R2's daughter called and spoke with him and this calmed him down. A wander guard was placed.

- 9/4/20, at 5:33 a.m. R2 was awake and packing his suitcase. R2 stated he was moving somewhere tomorrow. R2 seemed confused about his situation. When assisted, R2 did remain in his bed.

- 9/8/20, at 11:05 p.m. R2 was exhibiting exit seeking behaviors. R2 had his luggage packed and stated he was leaving. R2 was dressed and ambulated toward the exit doors. Staff was able to redirect R2 back to his room, where he remained the rest of the night.

- 10/8/20, at 5:35 p.m. R2 was exhibiting exit seeking behaviors. R2 asked staff how to get out of the building as he wanted to go home. Staff reoriented R2. R2 continued to search for a door

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2 830	Continued From page 5 to exit for 30 to 45 minutes. R2 settled down and went to his room. - 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 p.m. R2 was moved to a new room on the east wing of the facility. The facility incident report dated 11/3/20, at 12:15 p.m. indicated staff heard the facility exit door alarm go off. The responding nurse went to the alarmed door and checked for residents near and/or outside of the door. No residents were seen. The responding nurse then cleared the alarm. Later, the responding nurse received a telephone call indicating another nurse had found R2 outside of the facility in the parking lot. The nurse went out to assist R2 back into the building. They were unable to redirect R2 and a third staff member was called to assist. The three staff members were able to redirect R2 back into the facility and back to his room safely. R2's daughter was called to help redirect R2. Signs were made to assist R2 with where his room was. The wander guard was checked to ensure it was working properly. R2 had exited the facility through the exit door named the Park Street exit. On 11/12/20, a note was added to the facility incident report dated 11/3/20, which indicated R2 had dementia and was often confused as to where he was at. R2 was easily redirected when he was confused. He had made no further attempts to exit the facility. R2 walked independently with a walker and became confused with directions. Signs have been placed in common areas and on R2's room door with his	2 830		

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2 830	Continued From page 6	2 830		

name. Staff would continue to monitor R2 and guide R2 in right direction when confused.

R2's medical record lacked evidence R2 was comprehensively reassessed to identify and address the ongoing risk of elopement despite continued wandering behaviors and making several statements and/or attempts to elope. Further, R2 was not reassessed following the 11/3/20, elopement from the building including circumstances surrounding the elopement along with potential causative factors and patterns in an effort to reduce the incidences of elopement.

R2's care plan revised 10/8/20, indicated R2 was at risk for elopement related to dementia. Interventions included: make [R2] feel secure and safe in the facility, call his daughter to calm him down when he tried to leave the facility, encourage him to verbalize his feelings, redirect him when he made attempts to elope and reorient him to his room and unit and would require an escort for all outside . Interventions related to R2's risk for elopement were dated 10/8/20. Although, R2 had a successful elopement from the facility, R2's interventions remained unchanged.

During observation on 11/17/20, at 2:22 p.m. R2 was seated in a chair with the television on in the east lobby area with four other residents. R2 was fully dressed and had a light coat on and was sleeping.

-At 3:25 p.m. R2 awoke and reached for his walker, stood up and started walking down the hall in the direction of his room. R2 asked an unidentified nurse where his room was and the nurse verbally directed R2 down the east hall to the room with his name on the door. R2 turned

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2 830	Continued From page 7	2 830		

and started to ambulate toward the opposite hall than which the nurse had directed him. R2 stated he would go out that door, referring to a door on the opposite wing. The unidentified nurse was able to redirect R2 back to his own unit with verbal redirection and walked him to his room.

On 11/18/20, at 11:40 a.m. registered nurse (RN) -A was interviewed and explained she had heard the exit door alarm go off and when the alarm panel was checked, it was flashing Park Street exit. RN-A stated she immediately went to the exit door and looked around outside but could not see anyone around. RN-A stated the exit doors would alarm from staff or maintenance going through them but staff still checked the exits when they alarmed to be sure it had not been a resident. She returned to the nursing station and cleared the alarm and returned to her work duties. RN-A stated she did not initiate a facility head count to ensure all residents were safely inside the building. They would not typically do a full resident count, but they would check for those at risk to elope and make sure they were in the building. Further she did not think it was a resident with a wanderguard that set off the alarm because the wanderguard system did not alarm. About 5 minutes after shutting off the alarm, RN-A stated she received a telephone call from a nurse in the parking lot who indicated R2 was outside in the parking lot. RN-A stated she immediately went out to the lot to try to bring R2 back into the building. R2 was resistive and needed to call for further staff assistance to bring R2 back into the facility.

When interviewed on 11/18/20, at 11:58 a.m. RN-B stated the exit door alarms would sometimes alarm because the wind would set them off. When an exit door alarm sounded, she

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2 830	Continued From page 8 would call the nurse on unit where the alarm was sounding and have her check to see what had triggered the alarm. When she got the all clear from the unit nurse, she would clear the alarm. RN-B stated if no resident was seen when a door alarmed, the staff would check on the residents that were at risk for elopement. During interview on 11/18/20, at 11:56 a.m. nursing assistant (NA)-B stated if an alarm sounded staff would check the alarming exit door and look for residents. If no residents were seen by the exit door, the staff would check and make sure their wanderers were around. NA-B indicated they would not do a full resident head count. R1's quarterly MDS dated 10/21/20, identified R1 had severe cognitive impairment and required supervision with transfers and ambulation. The MDS identified R1 had wandering behaviors. Diagnoses included Parkinson's disease and dementia. R1's Self Preservation assessment dated 10/15/20, identified R1 was at moderate risk for wandering. The IDT checked off the recommendation to use of a wander guard alert and staff was not to leave R1 unattended when out of the facility for medical appointments. No further interventions were identified or implemented. R1's progress notes from 7/21/20, through 11/17/20, identified the following: - 7/21/20, at 1:44 p.m. R1 was exhibiting exit seeking behaviors. R1 attempted to exit the facility through the courtyard doors. The staff redirected R1 to his bedroom.	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 - 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. - 10/15/20, at 8:46 p.m. a Self Preservation assessment was completed and indicated R1 was at moderate risk for wandering. The IDT recommended to continue use of the wander guard and to accompany R1 to all outside appointments. No further interventions were identified or implemented to reduce the chances for elopement even though progress notes in September 2020, identified R1 was wandering and distraction was not always effective. - 11/7/20, at 2:24 p.m. staff were unable to locate R1. A search was conducted of the unit. A radio call to all staff was made to alert all staff to search for R1. The facility received a phone call from a neighboring home owner reporting R1 was at their front door. The facility staff retrieved R1 from their front door. R1 was unable to indicate why he had exited the facility. The officer of the day (OD) indicated no alarms or code yellow had sounded to alert staff of R1's exit from the facility. The staff checked all the exit doors with R1 and the doors did lock and the alarm did sound code yellow as it was supposed to. Staff were encouraged to be extra diligent and monitor R1's whereabouts closely. R2 had exited the facility through the exit door named the Park Street exit.	2 830		

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	00531	A. BUILDING: _____ B. WING _____	C 11/18/2020

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2 830	Continued From page 10 - 11/13/20, at 11:27 a.m. R1 had a quarterly MDS completed. R1 continued to wander frequently and the facility would continue the current focus, goals and interventions. No further assessment was completed. During observation on 11/17/20, at 2:08 p.m. R1 was wandering about the memory care unit. R1 was pleasant, however, was unable to communicate effectively. R1 attempted to enter other resident rooms and required staff redirection to the day room. Staff responded timely and R1 was receptive to the redirection. R1's medical record lacked evidence R1 was comprehensibly reassessed to identify and address the ongoing risk of elopement despite continued wandering behaviors and making several statements and/or attempts to elope. Further, R1 was not reassessed following the 11/7/20, elopement from the building including circumstances surrounding the elopement along with potential causative factors and patterns in an effort to reduce the incidences of elopement. R1's care plan reviewed 11/10/20, identified R1 had severe cognitive impairment and was at risk for elopement related to dementia. R1 wandered around the facility and did go into other's spaces. Interventions directed the following: encourage to verbalize his feelings, intervene right away when [R1] entered other resident rooms and redirect him to the day room, redirect away from fire alarm pull stations, redirect when making attempts to elope, re-orientate him to his room and unit, escort to all outside appointments along with identifying [R1] had wander guard placed on his right wrist. Interventions related to risk for elopement were dated 4/17/19. Although, R1 had a successfully eloped from the facility, R1's	2 830		

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2 830	Continued From page 11 interventions remained unchanged. During interview on 11/18/20, at 8:25 a.m. LPN-A stated when a code yellow (an alert identifying to staff a resident with a wanderguard exited the door) goes over the intercom, the staff on the memory unit do not hear it. LPN-A indicated the alarm sounded on the east and west wings and the charge nurse would notify the memory unit staff via their talkies and the alarmed sounded as it could not be heard in the memory care wing. LPN-A stated staff had to put in a code at the alarming door, to stop the alarm from sounding and that most of the staff were aware of the code. LPN-A stated the charge nurse had told her the code had never sounded when R1 exited the facility on 11/7/20. The facility had been having trouble with the alarm system before and if a resident with a wander guard stood by the door long enough, the door would unlock and the resident could go through. LPN-A verified the wander guard alarm should have sounded code yellow when R1 passed through them, as well as the exit door alarm should have sounded when R1 opened the facility exit door. LPN-A stated she did not know why both alarms did not sound. LPN-A stated she thought the same thing had happened the previous week when R4 had exited the facility. During interview on 11/18/20, at 9:30 a.m. NA-A stated R1 must have been standing by the double doors long enough for the alarm to disengage. NA-A indicated R1 did not seem to intentionally try to exit the facility and staff tried to engage R1 with conversation or snacks when he was wandering, which was effective. R3's quarterly MDS dated 8/11/20, indicated R3 had moderate cognitive impairment and was	2 830		

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2 830	Continued From page 12	2 830		

independent with transfer and ambulation. The MDS indicated R3 was also independent with mobility on and off the unit. R3 had a diagnosis of dementia.

R3's physician orders dated 4/21/20, identified R3 had a wanderguard placed for decreased safety awareness and wandering.

R3's Self Preservation assessment completed on 8/6/20, indicated R3 was at moderate risk for wandering. IDT recommendations were to continue use of the wander guard and not to be left unattended during outside appointments. No further interventions were identified or implemented.

R3's progress notes identified the following:

- 7/24/20, at 11:18 a.m. a code yellow alert sounded. R3 had gotten outside from the Park street exit and was redirected immediately back to his unit. R3's wander guard was tested and was working properly.

- 8/17/20, at 2:23 p.m. a coed yellow alert sounded. An LPN found R3 outside the Park street exit, walking away from the building. R3 immediately returned to the facility when called. The wander guard was working properly.

- 9/4/20, at 12:56 p.m. code yellow park street exit sounded. R3 was found coming out of a room on the memory unit and was redirected back to the east wing and his room.

- 9/22/20, at 9:46 a.m. R3 was found on the west wing and was redirected back to the east wing.

- 11/2/20, at 3:12 p.m. staff heard the east wing

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2 830	Continued From page 13 door open and went to check it. Staff observed R3 exit the Park Street exit and attempted to redirect R3 back into the facility. R3 was combative and unable to redirect. R3 ran across the facility lawn, crossed Park Street and began banging on windows and doors of the neighboring homes, with staff following. Staff eventually got R3 to return to the facility. R3's incident reports dated 7/24/20, 8/17/20, and 11/2/20, each identified R3 would become easily confused. R3 had a wander guard on and staff would continue to monitor. No further interventions were added to R3's care plan to reduce wandering and elopement attempts. R3's medical record lacked evidence R3 had been comprehensibly reassessed to identify and address the ongoing risk of elopement despite continued wandering behaviors and having several statements and/or attempts to elope. There was no evidence R3's wandering, nor the circumstances surrounding the elopement attempts, had been accounted for and assessed for possible contributing factors and solutions. R3's care plan revised 9/1/20, indicated R3 was at risk for elopement related to a diagnosis of dementia. There were no interventions listed to direct staff related to his risk of elopement. The risk for elopement was identified on 4/21/20. Although R3 had a successful elopement from the facility, R3 had no interventions listed for safety and prevention of his identified risk for elopement. During observation on 11/17/20, at 2:14 p.m. R3 wandered to the east hall wing, frequently going toward the double exit doors of the east wing. Staff frequently redirected R3 back to the	2 830		

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2 830	Continued From page 14 common lobby area. -At 3:24 p.m. R3 again wandered to the east hall wing. Staff frequently redirected R3 back to the common lobby area and was able to divert R3's attention with conversation and television in the lobby. -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. -At 4:15 p.m. R3 began to follow a resident down the east hall wing. An unidentified staff member approached R3 and began discussing the supper meal choices with R3. R3 followed the staff member out of the wing into the lobby area. During interview on 11/18/20, at 11:56 a.m. NA-B stated when a code yellow sounded, staff would go to the door and look for residents and then tell the nurse all clear. NA-B indicated R3 was usually just going for a walk when going up and down the halls and she would usually give him a snack and the newspaper or turn on the television as a diversion. NA-B indicated she thought R3 was looking for his wife, when walking up and down the halls. R4's annual MDS dated 8/20/20, indicated R4 had severe cognitive impairment and was independent with transfer and ambulation, however, required supervision on and off the unit. R4 had a diagnosis of dementia. R4's Self Preservation assessment completed on 10/15/20, indicated R4 was a moderate risk for wandering. IDT recommendations were to continue use of the wander guard and not to be	2 830		

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2 830	Continued From page 15 left unattended during outside appointments. No further interventions were identified or implemented. R4's progress note(s) identified the following: - 10/29/20, at 2:38 p.m. a code yellow was going off, when memory care unit staff received a phone call from the east wing staff. East wing staff indicated R4 had been found outside of the Park street exit. Staff had responded promptly and R4 was brought back to his unit. - 10/29/20, at 1:50 p.m. indicated the code yellow alarm was going off and staff responded to the alarm promptly. Staff found R4 outside of the facility and promptly returned him to his room. the wanderguard was checked on his return and determined to be working properly. The staff concluded R4 had stood near the door long enough for the lock to disengage, thus allowing R4 to exit through the doors. R4's care plan revised on 9/2/20, indicated R4 was at risk for elopement related to his history of wandering and dementia. The care plan directed staff to make [R4] feel secure and safe in the facility, encourage family participation when available, wander guard placement and an escort for all outside appointments. Interventions related to risk for elopement were dated 9/2/20. Although, R4 had a successful exited the facility on 10/29/20, R4's interventions remained unchanged. R4's medical record lacked evidence R4 had been comprehensibly reassessed to identify and address the ongoing risk of elopement despite continued wandering behaviors and having several statements and/or attempts to elope.	2 830		

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2 830	Continued From page 16 There was no evidence R4's wandering, nor the circumstances surrounding the elopement attempts had been accounted for and assessed for possible contributing factors and solutions. During interview on 11/18/20, at 12:48 p.m. RN-B stated if an outside door alarm sounded and they could not determine the cause, the staff would check their wanderers and make sure they were there. RN-B indicated sometimes the staff would do a head count, especially if it was winter. RN-B stated there were so few doors that just had the exit alarm on them that it wasn't a problem. RN-B stated the only real problem was the exit door between the east and memory unit doors. When interviewed on 11/18/20, at 10:28 a.m. the DON stated if a code yellow alarmed (wanderguard alarm), the resident's picture would show on the system behind the nurse's station. If staff did not see that resident at the exit, they were expected to go and look for the resident on the unit. If the resident was found outside, staff were to bring the resident back into the facility, assess for injury and assure the wander guard was functioning properly. They would try to determine why the resident left with staff interviews and rounds on the unit. They would try to determine if the resident was exit seeking or more related to the resident's dementia or a behavior. Incident reports were reviewed at daily meetings. The DON identified R1's elopement had been reviewed and she was told the wander guard alarm and the Ademco system alarm had not sounded. The DON indicated both alarms were checked within minutes of R1's return to the facility and both alarms were working properly when checked. The DON stated she did not know why either alarm did not sound in that instance. The DON stated they did place furniture near the	2 830		

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2 830	Continued From page 17 memory unit double doors and a do not enter sign on the double doors to distract R1 from attempting to leave until the alarm company could come and check the alarm system the next day. The DON stated sometimes a resident will stand by the wander guard doors long enough that the lock would disengage as a safety feature, however the alarm would still sound. Further, the facility used the Self Preservation form to assess for wanderguard use, the forms were filled out quarterly and as needed, that form was the facility's comprehensive assessment. During interview on 11/18/20, at 12:15 p.m. the administrator stated when a resident exits the building the facility completes an investigation. The investigation included checking the door alarms and wander guards for function. The administrator stated an elopement investigation was not like a fall investigation, because it was always related to whether the alarms or doors were functioning. The administrator stated if a reason was determined for the elopement you would find it on the incident reports or if it was determined the resident was wandering more the IDT would look at that to see if placement on the memory unit was needed. The administrator stated the double doors on the wings had the wander guard system with magnetic locks. The exit doors of the facility had the Ademco system alert in place. The staff would still have to respond to the exit alarm and determine why it was sounding, but the alarm was silenced behind the nurses station. The administrator indicated the facility had recently purchased a "screech alarm" and intended to install it on the Park Street exit door, as that exit door was identified as the door the residents were able to exit more frequently. This alarm would be heard on both the east wing and the memory unit and would require	2 830		

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2 830	Continued From page 18 the staff to physically go to the door to disable the alarm. The facility had not installed the alarm yet, as the staff had not been trained on it, but planned to train staff and place the alarm by the end of the following week. The administrator stated it was not the facility's policy to do a resident head count if an alarm sounded; however it would not be a bad idea to add that to the policy. The facility's policy titled Wander Management and Door Alarm System with revision date of 3/19, indicated a resident's risk for wandering would be determined during pre-admission assessment and if a need was determined, a wander guard would be placed. If at any time during a resident's stay, a wander risk was identified, a wander guard may be placed. This would be reviewed quarterly and as needed. The policy indicted the Park Street exit door did not have a magnetic lock and was not connected to the wander guard system because a resident would have to pass through a door that is connected to the system with a magnetic lock immediately before reaching this exit door. All staff were responsible to respond to a sounding alarm immediately. Upon each alarm, it must be determined which resident set off the alarm and their current location before the alarm is reset. If a resident exited the building, the resident will be assessed and redirected back into the building. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures for resident's wandering and elopements; then revise as needed to ensure there was comprehensive assessment and care planning of such events; then educate staff and audit to ensure ongoing compliance.	2 830		

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2 830	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		