DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
The Estates at Fridley LLC

Facility Address:
5700 East River Road

Facility City:
Fridley

State: Minnesota | **ZIP:** 55432 | **County:** Hennepin

☒ **Nursing Home**

Report Number:
H5201054

Date of Visit:
October 31, 2017

Time of Visit:
9:00 a.m. to 3:30 p.m.

Date Concluded:
January 22, 2018

Investigator's Name and Title:
Michele Strahan, RN, Special Investigator

Allegation(s):

It is alleged that the resident was neglected when staff failed to provide adequate supervision for the resident during an off-site appointment. The transportation company did not return the resident to the facility. The facility failed to ensure the resident returned to the facility and failed to initiate th facilities missing person policy after the resident never came back.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☒ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

Conclusion:

Based on a preponderance of evidence neglect occurred when the facility sent the resident to a canceled clinic appointment without supervision. A person in the community found the resident several hours later and ten miles away from the clinic.

The resident's diagnoses included dementia, Parkinson's disease, and sepsis. The resident was confused, weak, unable to ambulate short distances, and used a wheelchair for mobility. The resident required extensive assistance of one staff person to transfer, toilet, and grooming.

The resident's admitting papers from his/her previous facility, listed a clinic appointment approximately one month after admission to the facility. Office staff person spoke with the resident's family member and it was decided that the family would go with the resident to the appointment. A week prior to the

appointment facility office staff spoke with family regarding the appointment. The day before the appointment office staff called the family, left a voice-mail with an appointment reminder, and asked if the family were to meet the resident at the appointment or pick the resident up from the facility. The family did not return the call and the office staff assumed the family was going to meet the resident at the clinic. Facility office staff arranged transportation with a medical transportation company.

The day shift nurse assigned to the resident was unaware that the resident had a clinic appointment at 3:30 p.m. Between 2:00 p.m. and 2:30 p.m., the day nurse gave report to the evening nurse and did not report that the resident had a clinic appointment at 3:30 p.m. The transportation company arrived at the facility at approximately 2:30 p.m., spoke with the office staff, and picked up the resident to bring him/her to the clinic appointment. The clinic called the facility at approximately 3:00 p.m. and reported to the office staff that the appointment had been rescheduled. The clinic called the transportation company to request a return ride. At 4:30, the transportation company was not at the clinic and the clinic closed. The clinic staff called the office staff at the facility to say that the ride was on the way to bring the resident back to the facility. The clinic staff took the resident to the clinic lobby and left him/her there with a security guard. The transportation company arrived at the clinic lobby at 5:00 p.m., did not see the resident, and left. The transportation company did not call the facility to report that they did not give the resident a ride back to the facility.

A nursing assistant reported to the evening shift nurse, first that the resident was not in his room at the start of the shift and then the resident was not at dinner. The evening nurse responded that s/he would look into the matter. At approximately 6:00 p.m., a therapist checked the appointment book and reported to the nursing assistant that the Resident was at a clinic appointment.

At approximately 8:00 p.m., the resident's family called the facility and spoke with the evening nurse. The evening nurse told the family that the resident was in his room at the facility. The family told the evening nurse that a person in the community found the resident at a bus stop in downtown St. Paul. The family called the Police and went to the facility to collect the resident's medication. The family took the resident home. The next day the family took the resident back to the facility for a meeting. Facility staff assessed the resident. The resident was calm, content, pain free, and with stable vital signs.

The facilities internal investigation indicated that the clinic initially called the resident's previous health care facility to change the appointment date. A person in the community found the resident at a bus stop in St. Paul ten miles from the clinic appointment, on the ground with his/her wheelchair nearby.

During an interview, the resident stated s/he did not recall going to a clinic appointment or getting lost.

During an interview, a family member stated that a person in the community called to report s/he found the resident wandering around in downtown St. Paul. S/he stated that the family and the facility had an understanding that if the family could not take the resident to appointments a facility staff would go with the resident to appointments. The facility staff called the family a week prior to the appointment and not on the day of the appointment. The family member did not recall receiving a voice-mail the day before the appointment. The family member stated that she called the facility and staff were unaware that the

resident was not at the facility.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

Although the facility had policies and procedures in place in case a resident did not return to the facility from a leave of absence there were no systems in place to make staff aware of the missing residents.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Weight Records
- ☒ Nurses Notes

- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Activities Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Police Report

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Twelve

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Sixteen

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Nursing Services

☒ Infection Control

☒ Dignity/Privacy Issues

☒ Safety Issues

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ○ N/A

Were photographs taken: ○ Yes ○ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Fridley Police Department

Hennepin County Attorney

Fridley City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 6, 2018

Ms. Michaela Hagenow, Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

RE: Project Number H5201054

Dear Ms. Hagenow:

On February 13, 2018, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 6, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of February 13, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 6, 2018.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on December 6, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our February 13, 2018 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 13, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 6, 2017, as of December 10, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of February 13, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 6, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 6, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 6, 2018, is to be rescinded.

In our letter of February 13, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 6, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 10, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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
	245201	A. BUILDING _____ B. WING _____	R-C 02/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 A Post Certification revisit was conducted on 02/13/18, to follow up on deficiencies issued relate to complaint #H5201054. The Estates at Fridley LLC is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 6, 2018

Ms. Michaela Hagenow, Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

Re: Enclosed Reinspection Results - Complaint Number H5201054

Dear Ms. Hagenow:

On February 13, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on December 6, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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	00935	A. BUILDING: _____ B. WING _____	R-C 02/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

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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: A licensing order follow-up was completed to follow up on correction orders issued related to complaint #H5201054. The Estates at Fridley LLC was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

Minnesota Department of Health

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{2 000}	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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	245201	A. BUILDING _____ B. WING _____	C 12/06/2017

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THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5201054. As a result, the following deficiencies are (deficiency is) issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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F 226	Continued From page 1 (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on documentation review, and interview, the facility failed to follow their Abuse Prevention Policy to protect the safety of one of four residents, (R1), when R1 went to an appointment at approximately 2:30 p.m. and did not return to the facility. Staff were not aware that R1 was not in the facility until R1's family contacted the facility three hours after R1's expected return. R1 was found approximately three hours later and ten miles away from the clinic. Findings include: A policy titled Abuse Prevention/Vulnerable Adult Plan, undated, indicated that in case a resident does not return from a planned leave of absence staff is to contact the family within 2 hours of their planned return time. R1's medical record was reviewed. R1's diagnoses included dementia, Alzheimer's disease, urinary retention, heart failure, and sepsis. R1's minimum data set (MDS) assessment dated 08/10/17, indicated R1 had a brief interview for mental status score of 8 out of 15. Which indicated R1 had moderately impaired cognition. R1's care assessment summary dated 08/11/17, indicated that R1 had cognitive loss, dementia,	F 226		

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F 226	Continued From page 2	F 226		

falls, and communication issues.

R1's care plan dated 08/17/17, indicated that R1 required extensive assistance of one staff person for transfer, wheelchair mobility, bed mobility, toileting, dressing, and grooming. R1 had an indwelling urinary catheter.

A nurse's note dated 09/06/17, indicated R1's family called the facility at 8:30 p.m. to report a good samaritan found R1 ten miles away from the clinic appointment. R1's family was upset and did not bring R1 back to the facility. R1's family picked up R1's medication from the facility ad took R1 home.

A police report dated 09/06/17, indicated police arrived at the facility to assist FM-1 with a civil matter at the facility at 9:51 p.m. R1 was found at bus stop ten miles away from the clinic.

A nurse's note dated 09/07/17, indicated R1 and his family came into the facility for a meeting. R1's vital signs and blood sugar were stable. R1 showed no non-verbal signs of pain, and was calm and content.

An internal investigation undated indicated the clinic called the resident's prior health care facility to change the appointment date from 09/06/17, to 08/31/17. The facility sent R1 to the appointment on 09/06/17, and the Travelon transportation company picked R1 up at between 2:20 p.m. and 2:40 p.m. from the facility. The clinic called the facility at approximately 3:10 p.m. and told MR-F that R1 did not have an appointment that day. The clinic staff called Travelon for a return ride, Travelon told the clinic the computers were down, and Travelon needed to call the clinic later. The

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F 226	Continued From page 3 clinic staff heard from Travelon at 4:28 p.m. that the ride was on the way to pick up R1. The clinic called the facility at 4:30 p.m. to say the ride had not arrived and the clinic was now closed. The clinic staff took R1 to the clinic lobby, left him with the security guard, told the guard to call Travelon if they did not arrive in 15 minutes. Travelon Company staff arrived at the lobby at 5:00p.m., did not see R1 and left the clinic. During an interview on 10/31/17, at 1:37 p.m. the director of nursing (DON)-D stated R1 went to a clinic appointment on 09/06/17. There was a miscommunication, the facility thought the family was meeting R1 at the clinic, and the facility was not aware the clinic rescheduled the appointment. The facility staff were unaware that R1 did not return to the facility after the appointment. R1's family took R1 home that night, and brought him to the facility the next day for an assessment. During an interview on 10/31/17, at 1:54 p.m. medical records staff (MR)-F stated she arranged transportation for R1 to go to an appointment on 09/06/17. MR-F stated she spoke with R1's family member a week before and was told family would go with R1 to the appointment. The day before R1's appointment MR-F called FM-1 and left a message asking if FM-1 was going to give R1 a ride or meet him at the medical appointment. MR-F stated FM-1 told her family would meet R1 at the appointment. MR-F stated she was at the nurse's desk when the Travelon transportation company picked up R1 and she saw R1 leave the facility. MR-F stated that the clinic called the facility shortly after R1 left for his appointment and the clinic told MR-F R1 did not have an appointment. MR-F stated that the clinic called the transportation company to pick up R1	F 226		

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	245201	A. BUILDING _____ B. WING _____	C 12/06/2017

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F 226	Continued From page 4 and return him to the facility. During an interview on 10/31/17, at 2:26 p.m. Licensed Social Worker, Director of Social Services, (SW)-G stated that R1 could not leave the facility without supervision. She stated R1 left on 09/06/17, with medical transport staff and no other supervision During an interview on 10/31/17, at 2:37 p.m. Registered Nurse (RN)-H, stated he worked on 09/06/17, on the evening shift. RN-H had R1 on his assignment and he did not know R1 was at a clinic appointment. RN-H stated that he did not get report that R1 was at a clinic appointment and did not know R1 was not in the facility until nursing assistant staff informed him at approximately 6:00 p.m. that R1 was at an appointment. He received a phone call from R1's family member at approximately 8:00 p.m. R1's family came to the facility that evening at approximately 9:00 p.m. did not bring R1 into the facility, requested to speak with a manager, and requested medication. RN-H gave R1's medication to R1's family and R1 went home with his family. During an interview on 11/13/17, at 1:12 p.m. family member (FM)-I stated R1's family and the facility had an understanding that if the family could not take the resident to appointments the facility staff would accompany resident. The facility staff called the family a week prior to the appointment and not on the day of the appointment. FM-I did not recall receiving a voice-mail the day before the appointment. On the evening of the appointment, a good samaritan called the family member and told him/her he found R1 alone in his wheelchair approximately	F 226		

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F 226	Continued From page 5 eight miles away from the clinic. FM stated the good samaritan looked into R1's wallet to obtain a phone number to contact. FM-I member stated that she called the facility and staff were unaware that the resident was not at the facility. During an interview on 11/16/17, at 3:04 p.m. the director of nursing (DON)-D stated she cared for R1 on the day shift on 09/06/17. DON-H stated she was not aware that R1 had an afternoon appointment and he was still in the facility when she gave report to LPN-H between 2:00 p.m. and 2:30 p.m.	F 226		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		

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F 323	Continued From page 6 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on documentation review, and interview, the facility failed to ensure supervision to protect the safety of one of four residents, (R1), when R1 went to an appointment at approximately 2:30 p.m. and did not return to the facility. Staff were not aware that R1 was not in the facility until R1's family contacted the facility three hours after R1's expected return. R1 was found approximately three hours later and ten miles away from the clinic. Findings include: R1's medical record was reviewed. R1's diagnoses included dementia, Alzheimer's disease, urinary retention, heart failure, and sepsis. R1's minimum data set (MDS) assessment dated 08/10/17, indicated R1 had a brief interview for mental status score of 8 out of 15. Which indicated R1 had moderately impaired cognition. R1's care assessment summary dated 08/11/17, indicated that R1 had cognitive loss, dementia, falls, and communication issues. R1's care plan dated 08/17/17, indicated that R1 required extensive assistance of one staff person for transfer, wheelchair mobility, bed mobility, toileting, dressing, and grooming. R1 had an indwelling urinary catheter.	F 323		

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F 323	Continued From page 7 A nurse's note dated 09/06/17, indicated R1's family called the facility at 8:30 p.m. to report a good samaritan found R1 ten miles away from the clinic appointment. R1's family was upset and did not bring R1 back to the facility. R1's family picked up R1's medication from the facility ad took R1 home. A police report dated 09/06/17, indicated police arrived at the facility to assist FM-1 with a civil matter at the facility at 9:51 p.m. R1 was found at bus stop ten miles away from the clinic. A nurse's note dated 09/07/17, indicated R1 and his family came into the facility for a meeting. R1's vital signs and blood sugar were stable. R1 showed no non-verbal signs of pain, and was calm and content. An internal investigation undated indicated the clinic called the resident's prior health care facility to change the appointment date from 09/06/17, to 08/31/17. The facility sent R1 to the appointment on 09/06/17, and the Travelon transportation company picked R1 up at between 2:20 p.m. and 2:40 p.m. from the facility. The clinic called the facility at approximately 3:10 p.m. and told MR-F that R1 did not have an appointment that day. The clinic staff called Travelon for a return ride, Travelon told the clinic the computers were down, and Travelon needed to call the clinic later. The clinic staff heard from Travelon at 4:28 p.m. that the ride was on the way to pick up R1. The clinic called the facility at 4:30 p.m. to say the ride had not arrived and the clinic was now closed. The clinic staff took R1 to the clinic lobby, left him with the security guard, told the guard to call Travelon if they did not arrive in 15 minutes. Travelon Company staff arrived at the lobby at 5:00p.m.,	F 323		

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F 323	Continued From page 8 did not see R1 and left the clinic. During an interview on 10/31/17, at 1:37 p.m. the director of nursing (DON)-D stated R1 went to a clinic appointment on 09/06/17. There was a miscommunication, the facility thought the family was meeting R1 at the clinic, and the facility was not aware the clinic rescheduled the appointment. The facility staff were unaware that R1 did not return to the facility after the appointment. R1's family took R1 home that night, and brought him to the facility the next day for an assessment. During an interview on 10/31/17, at 1:54 p.m. medical records staff (MR)-F stated she arranged transportation for R1 to go to an appointment on 09/06/17. MR-F stated she spoke with R1's family member a week before and was told family would go with R1 to the appointment. The day before R1's appointment MR-F called FM-1 and left a message asking if FM-1 was going to give R1 a ride or meet him at the medical appointment. MR-F stated FM-1 told her family would meet R1 at the appointment. MR-F stated she was at the nurse's desk when the Travelon transportation company picked up R1 and she saw R1 leave the facility. MR-F stated that the clinic called the facility shortly after R1 left for his appointment and the clinic told MR-F R1 did not have an appointment. MR-F stated that the clinic called the transportation company to pick up R1 and return him to the facility. During an interview on 10/31/17, at 2:26 p.m. Licensed Social Worker, Director of Social Services, (SW)-G stated that R1 could not leave the facility without supervision. She stated R1 left on 09/06/17, with medical transport staff and no other supervision	F 323		

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F 323	Continued From page 9 During an interview on 10/31/17, at 2:37 p.m. Registered Nurse (RN)-H, stated he worked on 09/06/17, on the evening shift. RN-H had R1 on his assignment and he did not know R1 was at a clinic appointment. RN-H stated that he did not get report that R1 was at a clinic appointment and did not know R1 was not in the facility until nursing assistant staff informed him at approximately 6:00 p.m. that R1 was at an appointment. He received a phone call from R1's family member at approximately 8:00 p.m. R1's family came to the facility that evening at approximately 9:00 p.m. did not bring R1 into the facility, requested to speak with a manager, and requested medication. RN-H gave R1's medication to R1's family and R1 went home with his family. During an interview on 11/13/17, at 1:12 p.m. family member (FM)-I stated R1's family and the facility had an understanding that if the family could not take the resident to appointments the facility staff would accompany resident. The facility staff called the family a week prior to the appointment and not on the day of the appointment. FM-I did not recall receiving a voice-mail the day before the appointment. On the evening of the appointment, a good samaritan called the family member and told him/her he found R1 alone in his wheelchair approximately eight miles away from the clinic. FM stated the good samaritan looked into R1's wallet to obtain a phone number to contact. FM-I member stated that she called the facility and staff were unaware that the resident was not at the facility. During an interview on 11/16/17, at 3:04 p.m. the director of nursing (DON)-D stated she cared for	F 323		

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F 323	Continued From page 10 R1 on the day shift on 09/06/17. DON-H stated she was not aware that R1 had an afternoon appointment and he was still in the facility when she gave report to LPN-H between 2:00 p.m. and 2:30 p.m. A policy titled Abuse Prevention/Vulnerable Adult Plan, undated, indicated that in case a resident does not return from a planned leave of absence staff is to contact the family within 2 hours of their planned return time.	F 323		

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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: A complaint investigation was conducted to investigate complaint #H5201054. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	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 documentation review, and interview, the facility failed to ensure supervision to protect the safety of one of four residents, (R1), when R1 went to an appointment at approximately 2:30 p.m. and did not return to the facility. Staff were not aware that R1 was not in the facility until R1's	2 830		

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2 830	Continued From page 2 family contacted the facility three hours after R1's expected return. R1 was found approximately three hours later and ten miles away from the clinic. Findings include: R1's medical record was reviewed. R1's diagnoses included dementia, Alzheimer's disease, urinary retention, heart failure, and sepsis. R1's minimum data set (MDS) assessment dated 08/10/17, indicated R1 had a brief interview for mental status score of 8 out of 15. Which indicated R1 had moderately impaired cognition. R1's care assessment summary dated 08/11/17, indicated that R1 had cognitive loss, dementia, falls, and communication issues. R1's care plan dated 08/17/17, indicated that R1 required extensive assistance of one staff person for transfer, wheelchair mobility, bed mobility, toileting, dressing, and grooming. R1 had an indwelling urinary catheter. A nurse's note dated 09/06/17, indicated R1's family called the facility at 8:30 p.m. to report a good samaritan found R1 ten miles away from the clinic appointment. R1's family was upset and did not bring R1 back to the facility. R1's family picked up R1's medication from the facility ad took R1 home. A police report dated 09/06/17, indicated police arrived at the facility to assist FM-1 with a civil matter at the facility at 9:51 p.m. R1 was found at bus stop ten miles away from the clinic.	2 830		

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2 830	Continued From page 3 A nurse's note dated 09/07/17, indicated R1 and his family came into the facility for a meeting. R1's vital signs and blood sugar were stable. R1 showed no non-verbal signs of pain, and was calm and content. An internal investigation undated indicated the clinic called the resident's prior health care facility to change the appointment date from 09/06/17, to 08/31/17. The facility sent R1 to the appointment on 09/06/17, and the Travelon transportation company picked R1 up at between 2:20 p.m. and 2:40 p.m. from the facility. The clinic called the facility at approximately 3:10 p.m. and told MR-F that R1 did not have an appointment that day. The clinic staff called Travelon for a return ride, Travelon told the clinic the computers were down, and Travelon needed to call the clinic later. The clinic staff heard from Travelon at 4:28 p.m. that the ride was on the way to pick up R1. The clinic called the facility at 4:30 p.m. to say the ride had not arrived and the clinic was now closed. The clinic staff took R1 to the clinic lobby, left him with the security guard, told the guard to call Travelon if they did not arrive in 15 minutes. Travelon Company staff arrived at the lobby at 5:00p.m., did not see R1 and left the clinic. During an interview on 10/31/17, at 1:37 p.m. the director of nursing (DON)-D stated R1 went to a clinic appointment on 09/06/17. There was a miscommunication, the facility thought the family was meeting R1 at the clinic, and the facility was not aware the clinic rescheduled the appointment. The facility staff were unaware that R1 did not return to the facility after the appointment. R1's family took R1 home that night, and brought him to the facility the next day for an assessment. During an interview on 10/31/17, at 1:54 p.m.	2 830		

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2 830	Continued From page 4 medical records staff (MR)-F stated she arranged transportation for R1 to go to an appointment on 09/06/17. MR-F stated she spoke with R1's family member a week before and was told family would go with R1 to the appointment. The day before R1's appointment MR-F called FM-1 and left a message asking if FM-1 was going to give R1 a ride or meet him at the medical appointment. MR-F stated FM-1 told her family would meet R1 at the appointment. MR-F stated she was at the nurse's desk when the Travelon transportation company picked up R1 and she saw R1 leave the facility. MR-F stated that the clinic called the facility shortly after R1 left for his appointment and the clinic told MR-F R1 did not have an appointment. MR-F stated that the clinic called the transportation company to pick up R1 and return him to the facility. During an interview on 10/31/17, at 2:26 p.m. Licensed Social Worker, Director of Social Services, (SW)-G stated that R1 could not leave the facility without supervision. She stated R1 left on 09/06/17, with medical transport staff and no other supervision During an interview on 10/31/17, at 2:37 p.m. Registered Nurse (RN)-H, stated he worked on 09/06/17, on the evening shift. RN-H had R1 on his assignment and he did not know R1 was at a clinic appointment. RN-H stated that he did not get report that R1 was at a clinic appointment and did not know R1 was not in the facility until nursing assistant staff informed him at approximately 6:00 p.m. that R1 was at an appointment. He received a phone call from R1's family member at approximately 8:00 p.m. R1's family came to the facility that evening at approximately 9:00 p.m. did not bring R1 into the facility, requested to speak with a manager, and	2 830		

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2 830	Continued From page 5 requested medication. RN-H gave R1's medication to R1's family and R1 went home with his family. During an interview on 11/13/17, at 1:12 p.m. family member (FM)-I stated R1's family and the facility had an understanding that if the family could not take the resident to appointments the facility staff would accompany resident. The facility staff called the family a week prior to the appointment and not on the day of the appointment. FM-I did not recall receiving a voice-mail the day before the appointment. On the evening of the appointment, a good samaritan called the family member and told him/her he found R1 alone in his wheelchair approximately eight miles away from the clinic. FM stated the good samaritan looked into R1's wallet to obtain a phone number to contact. FM-I member stated that she called the facility and staff were unaware that the resident was not at the facility. During an interview on 11/16/17, at 3:04 p.m. the director of nursing (DON)-D stated she cared for R1 on the day shift on 09/06/17. DON-H stated she was not aware that R1 had an afternoon appointment and he was still in the facility when she gave report to LPN-H between 2:00 p.m. and 2:30 p.m. A policy titled Abuse Prevention/Vulnerable Adult Plan, undated, indicated that in case a resident does not return from a planned leave of absence staff is to contact the family within 2 hours of their planned return time. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary,	2 830		

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	00935	A. BUILDING: _____ B. WING _____	C 12/06/2017

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2 830	Continued From page 6 educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on documentation review, and interview, the facility failed to ensure one of four residents, (R1), reviewed was free from maltreatment when R1 went to an appointment unsupervised at approximately 2:30 p.m. and did not return to the facility. Staff were not aware that R1 was not in the facility until R1's family contacted the facility three hours after R1's expected return. R1 was found approximately three hours later and ten miles away from the clinic.	21850		

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21850	Continued From page 7 Findings include: A policy titled Abuse Prevention/Vulnerable Adult Plan, undated, indicated the policy exists to ensure residents are not subjected to neglect or maltreatment by anyone, including, but not limited to, facility staff, staff or other agencies serving the individual. R1's medical record was reviewed. R1's diagnoses included dementia, Alzheimer's disease, urinary retention, heart failure, and sepsis. R1's minimum data set (MDS) assessment dated 08/10/17, indicated R1 had a brief interview for mental status score of 8 out of 15. Which indicated R1 had moderately impaired cognition. R1's care assessment summary dated 08/11/17, indicated that R1 had cognitive loss, dementia, falls, and communication issues. R1's care plan dated 08/17/17, indicated that R1 required extensive assistance of one staff person for transfer, wheelchair mobility, bed mobility, toileting, dressing, and grooming. R1 had an indwelling urinary catheter. A nurse's note dated 09/06/17, indicated R1's family called the facility at 8:30 p.m. to report a good samaritan found R1 ten miles away from the clinic appointment. R1's family was upset and did not bring R1 back to the facility. R1's family picked up R1's medication from the facility ad took R1 home. A police report dated 09/06/17, indicated police arrived at the facility to assist FM-1 with a civil matter at the facility at 9:51 p.m. R1 was found at	21850		

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21850	Continued From page 8 bus stop ten miles away from the clinic. A nurse's note dated 09/07/17, indicated R1 and his family came into the facility for a meeting. R1's vital signs and blood sugar were stable. R1 showed no non-verbal signs of pain, and was calm and content. An internal investigation undated indicated the clinic called the resident's prior health care facility to change the appointment date from 09/06/17, to 08/31/17. The facility sent R1 to the appointment on 09/06/17, and the Travelon transportation company picked R1 up at between 2:20 p.m. and 2:40 p.m. from the facility. The clinic called the facility at approximately 3:10 p.m. and told MR-F that R1 did not have an appointment that day. The clinic staff called Travelon for a return ride, Travelon told the clinic the computers were down, and Travelon needed to call the clinic later. The clinic staff heard from Travelon at 4:28 p.m. that the ride was on the way to pick up R1. The clinic called the facility at 4:30 p.m. to say the ride had not arrived and the clinic was now closed. The clinic staff took R1 to the clinic lobby, left him with the security guard, told the guard to call Travelon if they did not arrive in 15 minutes. Travelon Company staff arrived at the lobby at 5:00p.m., did not see R1 and left the clinic. During an interview on 10/31/17, at 1:37 p.m. the director of nursing (DON)-D stated R1 went to a clinic appointment on 09/06/17. There was a miscommunication, the facility thought the family was meeting R1 at the clinic, and the facility was not aware the clinic rescheduled the appointment. The facility staff were unaware that R1 did not return to the facility after the appointment. R1's family took R1 home that night, and brought him to the facility the next day for an assessment.	21850		

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21850	Continued From page 9 During an interview on 10/31/17, at 1:54 p.m. medical records staff (MR)-F stated she arranged transportation for R1 to go to an appointment on 09/06/17. MR-F stated she spoke with R1's family member a week before and was told family would go with R1 to the appointment. The day before R1's appointment MR-F called FM-1 and left a message asking if FM-1 was going to give R1 a ride or meet him at the medical appointment. MR-F stated FM-1 told her family would meet R1 at the appointment. MR-F stated she was at the nurse's desk when the Travelon transportation company picked up R1 and she saw R1 leave the facility. MR-F stated that the clinic called the facility shortly after R1 left for his appointment and the clinic told MR-F R1 did not have an appointment. MR-F stated that the clinic called the transportation company to pick up R1 and return him to the facility. During an interview on 10/31/17, at 2:26 p.m. Licensed Social Worker, Director of Social Services, (SW)-G stated that R1 could not leave the facility without supervision. She stated R1 left on 09/06/17, with medical transport staff and no other supervision During an interview on 10/31/17, at 2:37 p.m. Registered Nurse (RN)-H, stated he worked on 09/06/17, on the evening shift. RN-H had R1 on his assignment and he did not know R1 was at a clinic appointment. RN-H stated that he did not get report that R1 was at a clinic appointment and did not know R1 was not in the facility until nursing assistant staff informed him at approximately 6:00 p.m. that R1 was at an appointment. He received a phone call from R1's family member at approximately 8:00 p.m. R1's family came to the facility that evening at	21850		

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21850	Continued From page 10 approximately 9:00 p.m. did not bring R1 into the facility, requested to speak with a manager, and requested medication. RN-H gave R1's medication to R1's family and R1 went home with his family. During an interview on 11/13/17, at 1:12 p.m. family member (FM)-I stated R1's family and the facility had an understanding that if the family could not take the resident to appointments the facility staff would accompany resident. The facility staff called the family a week prior to the appointment and not on the day of the appointment. FM-I did not recall receiving a voice-mail the day before the appointment. On the evening of the appointment, a good samaritan called the family member and told him/her he found R1 alone in his wheelchair approximately eight miles away from the clinic. FM stated the good samaritan looked into R1's wallet to obtain a phone number to contact. FM-I member stated that she called the facility and staff were unaware that the resident was not at the facility. During an interview on 11/16/17, at 3:04 p.m. the director of nursing (DON)-D stated she cared for R1 on the day shift on 09/06/17. DON-H stated she was not aware that R1 had an afternoon appointment and he was still in the facility when she gave report to LPN-H between 2:00 p.m. and 2:30 p.m. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION:	21850		

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21850	Continued From page 11 Twenty-One (21) days.	21850		