DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2020

Administrator
Divine Providence Health Center
312 East George St. PO Box 136
Ivanhoe, MN 56142

RE: CCN: 245327
Survey Start Date: July 8, 2020

Dear Administrator:

On July 8, 2020 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 April 8, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

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

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

Electronically Submitted
April 1, 2020

Administrator
Divine Providence Health Center
312 East George Street PO Box 136
Ivanhoe, MN 56142

RE: CCN: 245327
Cycle Start Date: March 16, 2020

Dear Administrator:

During this period of pandemic COVID-19 outbreak, the Centers for Medicare and Medicaid Services (CMS) has directed the State Agencies (MDH) to change the process for survey prioritization and enforcement remedies. CMS is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit an electronic plan of correction (ePOC). Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's ePOC during this time and the case will be held. Your facility may delay submission of an ePOC until the prioritization period is over.

On March 16, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 14, 2020, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for

imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 15, 2020.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 15, 2020, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 15, 2020, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 16, 2020. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care,

483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Divine Providence Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 16, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 16, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	**312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142**

(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 3/10/20 through 3/16/20, an abbreviated survey was completed at your facility to conduct a complaint investigation by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. At the time of the abbreviated survey, an onsite investigation was completed and the following complaint was found to be SUBSTANTIATED: H5327005C with deficiencies cited at F689. The survey resulted in an immediate jeopardy (IJ) to resident health and safety . The IJ began on 2/23/20, when the facility failed to ensure 3 of 3 alarm systems were appropriately maintained, monitored and tested which resulted in the elopement of 1 of 1 resident (R2). The facility's lack of monitoring, testing and maintenance of the alarm system resulted in an Immediate Jeopardy (IJ), for 3 residents (R1, R2, and R3) who were at risk for elopement. The facility's administrator (A) and director of nursing (DON) were notified of the IJ on 3/12/20 at 3:07 p.m. The immediacy was removed on 3/14/20 at 3:30 p.m. In addition, an extended survey was completed on 3/12/20 through 3/16/20 related to the Substandard Quality of Care findings. 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	F 000		

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

Electronically Signed | 04/08/2020

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 000	Continued From page 1 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 689 SS=J	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 3 of 3 alarm systems were appropriately maintained, tested and monitored which resulted in the elopement of 1 of 1 resident (R2). Additionally, 2 other residents who exhibited wandering behaviors were R1 and R3. Due to the system failure all resident with wander guards are at risk for the immediacy The facility's lack of monitoring, testing and maintenance of the alarm systems resulted in an Immediate Jeopardy (IJ), with the potential for serious harm, injury, or death. The IJ began on 2/23/20, when R2 exited the building, crossing a major hi-way, tripped on a curb and sustained minor injuries before being seen by an off duty staff person. The facility's	F 689	The Elopement or Unsafe Wandering Policy and Procedure was reviewed and revised as needed by 3/14/2020. To improve the process of implementing the policy, and thus keep residents free of accident hazards and receive adequate supervision and assistance devices to prevent accidents, the following was immediately implemented: 1. On 3/13/2020, R2 was transferred to another facility that had a more adequate alarm system. 2. An Elopement Risk Assessment was performed on all residents on 3/14/2020. At that point, it was determined that R1 no longer met the criteria for the use of an assistive device (wanderguard)and it was	4/8/20

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F 689	Continued From page 2 administrator (A) and director of nursing (DON) were notified of the IJ on 3/12/20 at 3:07 p.m. The was removed on 3/14/20 at 3:30 p.m., but non-compliance remained at the lower scope and severity of D, isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R2's 2/7/20, baseline care plan identified she was confused, walked independently, had no behaviors of wandering or at risk for elopement as identified on the baseline care plan. R2's progress noted identified the following: 1) 2/8/20 at 6:19 a.m., R2 was up from her bed and wandering into other resident's rooms. 2) 2/8/20 at 5:02 p.m., R2 up walking frequently and wandered into other resident's rooms. Had gone past doors a couple of times setting off the alarm. 3) 2/10/20 at 5:05 a.m., staff had a difficult time with R2 wanting to go outside to find her car and go home. R2 had wandered into other resident's rooms and used the bathroom in one of the rooms. 4) 2/13/20 at 1:08 p.m., identified R2 exhibited wandering behaviors in the halls often looking for a restroom or her room and showed confusion. R2's 2/13/20, admission Minimum Data Set (MDS) identified R2 had severe cognitive impairment with diagnoses of dementia with behavioral disturbance, generalized anxiety disorder, and disorientation. R2 required supervision of one staff for walking in her room and in the corridor. R2 had no wandering	F 689	removed. This left R3 as the only resident who still met the criteria. 3. On 3/12/2020 at 2pm, a checklist had been implemented to perform 15-minute checks on R1, R2, and R3. On 3/13/2020 at 5pm, after the transfer of R2 and the removal of the wanderguard from R1, the checks on R3 changed to continuous direct supervision. 4. When R3 is in the dining room, nursing staff will have direct supervision of resident since nursing station is located here. When in her room at night, a chair will be placed outside her room for staff to sit and monitor. This will continue on indefinitely until the alarm system is assessed by the manufacturer and is deemed functional again. 5. All staff assigned to shifts beginning 3/13-3/16/2020 were educated on the above plan to keep R3 safe. Staff also completed a Resident Safety Competency. Future staff will also be educated on the safety plan for R3. 6. In addition to the above safety checks, the care plan for R3 has been updated to include continuous visual supervision and CNAs will have to sign off on Point-of-Care charting each shift to show this is being followed. It has also been added to CNA assignment sheets, that R3 has a wanderguard in place. This will be followed by any additional resident who may need a wanderguard. Finally, it was added onto the MAR for the charge nurse to check off each shift that R3 is being continuously monitored. This was all updated on 3/13/2020.	

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F 689	Continued From page 3 behaviors noted on her assessment even though the nursing notes identified wandering behaviors. There was no indication an elopement assessment had been completed. R2's 2/13/20, comprehensive care plan completed the same day as the MDS, identified R2 had behavioral symptoms of wandering. Interventions currently in place at the time of the assessment included a WanderGuard bracelet to R2's right ankle related to wandering. R2's 2/14/20, physician's progress report identified nursing staff reported R2 continued to wander but was easily redirected. There were no other interventions implemented by the physician at that time. Further review of R2's progress notes identified on: 1) 2/20/20 at 6:06 p.m., R2 was confused and wandered into other resident's rooms. 2) 2/22/20 at 5:26 p.m., R2 had exited out door 6 (D6). R2 was outside on the sidewalk looking for her car. R2 was redirected back into building. The standard door alarm system had audibly sounded however there was no mention if the R2's WanderGuard bracelet she was wearing had sounded. R2's 2/22/20, Event Summary Report identified the D6 door had alarmed at the time of the elopement, with standard door alarm heard by staff. R2 had the newer style WanderGuard bracelet was on her person, however, that bracelet did not activate that door as that door had not been wired to work with the new style WanderGuard. There was no mention additional	F 689	5. R3, and any residents needing wanderguards, will have their device checked weekly. Due to the fact that the device needs to be brought to the door to test it and concerns of creating an undesirable behavior to these cognitively impaired residents, nursing will not do daily checks. This will be recorded in two places - on the MAR and on a second form that will be placed in front of the MAR. This was added to R3 MAR on 3/13/2020. DON contacted Peter Saia from Accutech Security who supply the wanderguard devices and requested some guidance on what the manufacture recommends in regards to how often the wanderguard devices should be checked. Per Mr. Saia, he did find an old installation manual for the Accutech VP wandering system that our facility is still using. Unfortunately, he didn't see any documentation on recommendations about how often testing should be done on the devices. So, Accutech Security recommends testing the devices/sensors on a weekly basis to confirm they are functioning properly. He also went on to say that they would recommend testing the door/exit equipment on a monthly basis to ensure they are alarming properly. Based on his recommendations, we will continue to follow the weekly checking of R3's wanderguard device. 6. On 3/13/2020, a checklist was created for nursing to document on the alarm control panel to visualize that none of the buttons are pushed into "silence" mode.	

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F 689	Continued From page 4 1:1 supervision was implemented, staff were educated on what alarms worked on what doors, nor had they identified appropriate testing, monitoring, and maintenance of the alarm systems by the manufacturer. R2's 2/23/20 at 3:16 p.m., progress note identified the facility received a call at 3:00 p.m. from the local convenience store at R2 was at their store. They identified R2 had a cut on her head from a fall after tripping on the curb crossing the hi-way to the store. EMS was called, and R2 was elevated at the convenience store, had no injuries and needed no medical attention and was brought back to the nursing home. Upon return to the facility, R2 complained of right wrist pain and had a small laceration by left eye which was cleansed and adhesive Steri-Strips applied. Staff noted a small scrape to her left hand and a small bruise on her left knee. The report also identified R2 was last seen when staff had toileted her at 2:00 p.m., 1 hours and 16 minutes before she was seen at the convenience store. There were no alarms that sounded per staff interviews even though R2 had the newer style WanderGuard bracelet on. Review of R2's 2/23/20, Event Summary Report identified R2 eloped out of facility to a convenience store and tripped on curb causing her to fall. R2 exited through D6. Staff had not remembered hearing either alarm system sounding (door alarm, or WanderGuard). R2 was assessed by EMS and returned to facility. The care plan was updated to offer activities such as sitting and visiting with other residents. The Medical director (MD) discussed the possible need for alternative placement with a more	F 689	This will be done at the beginning and end of all nursing shifts and two nurses will need to sign off. 7. Plant Operations will test all alarmed doors starting 3/16/2020 on a daily basis to determine if they are working properly. This will continue until the manufacturer has assessed the system and determined that it is functional. Even though Accutech Security has recommended checking the doors on a monthly basis, our facility will do it daily. 8. On 3/18/2020, DTB Systems came to facility and assessed the system and couldn't guarantee that the D6 door would always alarm. Because of this, the plan to keep R3 safe will remain in place indefinitely until a new alarm system can be installed. Due to finances, our facility cannot purchase a new alarm system at this point. Because of this, our plan will be carried out indefinitely. 9. On 3/19/2020, DON held a mandatory nursing meeting to review the findings from the Federal Survey and the processes that are being implemented. Those who did not attend the meeting received a copy of the agenda and meeting minutes as well as a copy of the Elopement or Unsafe Wandering Policy and Procedure. DON also did a follow-up call or in-person review of the plan with DPHC scheduled staff and answered any questions they may have had. 10. Other processes that are being implemented are: developing a CNA checklist which now includes the alarm/wanderguard system, a Nurse/New	

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	245327	A. BUILDING _____ B. WING _____	C 03/16/2020

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DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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F 689	Continued From page 5 secured facility. There was no mention staff had tested the door alarm system or the newer-style WanderGuard system bracelet R2 was wearing to ensure these alarms were functioning appropriately. Review of R2's progress notes identified on: 1) 2/25/20 at 1:18 p.m., staff added new intervention to the care plan to be aware of R2's presence. If R2 was not in sight staff were to start a search right way. Staff identified the newer-style WanderGuard bracelet R2 had worn since shortly after admission was not wired to all the doors including D6. As a result, a second older-style WanderGuard system bracelet was placed on R2's left ankle for the old alarm system. The older system was wired on D6 along with the standard door alarm. There was no indication the facility had contacted the alarm system manufacturer to ensure it was functioning properly, nor had the facility performed any routine maintenance or consistent monitoring as identified by the manufacturer of the 3 alarm systems; door alarm, old and new WanderGuard system. 2) 2/27/20 at 3:34 p.m., progress note identified R2 attempted to leave out D6. An alarm sounded and staff were able to redirect before exiting to outside. Review of the facility 2/27/20, Elopement Risk Assessment identified R2 had previous successful elopements. The current interventions in place were identified as appropriate. There was no mention staff had identified the need for any routine maintenance or consistent monitoring of the three alarm systems as identified by the manufacture to ensure they worked	F 689	Hire orientation checklist which also includes education on the alarm/wanderguard system. The Elopement Risk Assessment will be performed on admission with all residents and then quarterly, annually, and with any significant change. 11. Audits will be performed as follows: Plant Operations Manager will monitor the daily checks on all alarmed doors. DON will check on all new admits to ensure that Elopement Risk Assessment is completed. DON will spot-check the alarm panel 3x/wk for one month and then once weekly for 3 months to make sure that none of the buttons are on "silence" mode. DON will check MAR weekly to see if wanderguard on R3 is being checked. DON will check that all new nurses and CNA staff have had alarm competency check-off completed. 12. Audits will be discussed at monthly Quality Assurance Meeting. 13. As previously mentioned, because we are unable to purchase a new alarm system, we will continue on with our plan to keep R3, and any other potential residents who have the tendency to wander, safe with no end date. We will continue to implement the above processes and audits will be performed will discussion at monthly Quality Assurance Meetings.	

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F 689	Continued From page 6 appropriately. Interview on 3/10/20 at 11:15 a.m., with nursing assistant (NA)-A identified the standard alarm at D6 will sound approximately 30 seconds at the door if no keypad door code is entered to bypass the system. The standard alarm system also has an audible alarm that sounded at the nurse station. The alarm at the nurse's station must be manually turned off in order to stop the alarm. NA-A identified there were 3 residents who exhibited wandering behaviors, R1, R2, and R3. Interview on 3/10/20 at 11:25 a.m., with activities assistant (AA)-A identified when a door alarm sounds staff are to immediately check for potential elopement of residents. AA-A identified the 3 residents who exhibited wandering behaviors were R1, R2, and R3. Interview on 3/10/20 at 11:31 a.m., with NA-B identified the 3 residents who exhibited wandering behaviors were R1, R2, and R3. R2 had a history of frequent elopement attempts and staff were to redirect R2 when that occurred. NA-B was made aware recently by administration D6 was not alarmed with the newer WanderGuard system. Interview on 3/10/20 at 1:34 p.m., with licensed practical nurse (LPN)-A identified after R2's 2/23/20 elopement, staff were to have direct observation of R2 to prevent future elopement. NA-B identified the 3 residents who exhibited wandering behaviors were R1, R2, and R3. NA-B was unsure if Wander guard bracelets were to be checked every 2 weeks or monthly and was not educated on any manufactures inspection of the	F 689		

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F 689	Continued From page 7	F 689		

system. R2 was known to only attempt elopement through D6 and was unaware of any other doors R2 attempted to elope. On 2/23/20, LPN-A received a call from the convenience store alerting her R2 had eloped. None of the alarm system had sounded from door D6 to alert staff of her elopement. At approximately 7:00 p.m., staff identified the standard door alarm had been disarmed at the nurse's station so it was not functioning, and they were unsure how long it was disarmed. LPN-A was unsure where staff were to document wanderguard checks.

Interview on 3/10/20 at 1:39 p.m., with the DON identified after R2's elopement on 2/25/20, the D6 door did not have the newer WanderGuard system wired into the alarm system. They then added the older-style WanderGuard bracelet to R2's ankle in addition to the newer-style WanderGuard. R2 had two bracelet alarms, one for each of the two WanderGuard systems. The DON instructed staff on duty to provide direct observation of R2 to prevent future elopements.

Interview and document review on 3/11/20 at 8:15 a.m., with plant operation manager (POM) identified there was no system for preventative maintenance performed on any of the 3 alarm systems. The POM was unaware door D6 did not have the newer WanderGuard system until the DON told him this on 2/25/20. The POM identified none of the 3 alarm systems were tested for functionality on any of the facility's 6 exit doors at that time. The POM identified the manufacturer required weekly WanderGuard checks and monthly maintenance. The POM had not performed any preventative maintenance or monitoring of the 3 alarm systems. He agreed the

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F 689	Continued From page 8 alarm systems had not been maintained per manufacturer's guidelines and had no knowledge if they functioned appropriately. Further interview on 3/11/20 at 9:40 a.m., with the DON identified she had contacted the manufacturer of the alarm systems. The facility was unable to get bracelets for the older-style WanderGuard system. The manufacturer identified the system was "too old" and bracelets are no longer available. Both the older and newer styled WanderGuard systems were considered antiquated. When staff placed the older-system WanderGuard on R2, the bracelet was located in the medication room in a cup, labeled "DO NOT USE". Staff took the bracelet and tested it next to door D6 and it had worked at that time. She agreed, staff should have checked with the manufacturer prior to placing the older style WanderGuard bracelet on R2. The older-style bracelet was placed on R2's ankle in addition to the current newer-styled bracelet. The DON had been informed the standard alarm system had been disabled at the master switch at the nurses station on 2/23/20, and was discovered at 7:00 p.m.. The DON speculated staff were "tired of the alarm systems sounding" and turned it off. There was no indication the DON had re-educated staff on the importance of not disabling the master control switch at the nurses station. The DON identified facility staff checked the WanderGuard bracelets monthly. But they only tested these bracelets at 2 doors, D1 and D5, which were only alarmed with the standard and newer style WanderGuard alarm systems. She agreed if bracelets to either system were not checked at every exit door, staff had no way of knowing if the bracelets worked at each door. Also they would	F 689		

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F 689	Continued From page 9	F 689		

not know if the resident was wearing the correct bracelet for that specific door alarm or if the door alarms were functioning properly. The DON agreed if the facility had educated staff and performed routine monitoring and maintenance as identified by the manufacture, R2 would not have eloped without staff knowledge. She agreed they were not performing preventative maintenance or testing according to manufacturer's guidelines.

Interview on 3/11/20 at 10:15 a.m., with R2's family member (FM)-D identified he was made aware by facility staff of R2's elopement on 2/23/20. FM-D was advised staff were unsure when or how R2 eloped without the alarm systems sounding.

Observation and interview on 3/11/20 at 10:33 a.m., with the POM and DON identified there were 3 alarm systems in the facility. An older-style WanderGuard, a newer style WanderGuard, and a standard door alarm system. The standard door alarm system alarmed at all exit doors except D1 and the nurses station. This alarm can be silenced by a master shut off switch at the nurses station. The older-styled WanderGuard alarm system only alarmed at door D6, and the nurses station. This alarm can only be silenced at the door using the keypad. The nurses station alarm must be silenced separately. The newer-styled WanderGuard system was to have alarmed at doors D1 and D5. Doors D2, D3 and D4 have no WanderGuard system in place but was alarmed with the standard door alarm. Those doors lead directly outside the facility and would not alarm if the standard alarm had been disabled at the

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F 689	Continued From page 10	F 689		

master switch at the nurses station. During this time, the facility doors were checked and identified D1 alerted with the newer system, but there was no standard door system alarm. D6 failed to alarm with the standard door alarm. Both the DON and POM agreed the alarm systems identified the lack of a standard alarm on D1 and failure of that alarm on D6.

R1's 3/11/20, face sheet identified she was admitted to the facility with diagnoses of vascular dementia, Alzheimer's, and anxiety disorder. R1's undated, current care plan identified a WanderGuard was added to R1's ankle on 11/8/19, related to confusion and wanting to go out front of the facility to see "where the people are". R1 was confused as to where she was at.

R1's Treatment Administration Reports (TAR) identified in January February and March 2020, staff had not documented any wanderguard checks they reportedly were to have completed monthly.

R1's 12/11/19 through 3/5/20 progress notes identified on 1/8/20, staff noted R1 wore a wanderguard but made no mention this was tested per manufacture's guidelines. There was no progress note to identify R1's wanderguard had been tested for functionality.

R3's 3/11/20, face sheet identified she was admitted to the facility with diagnosis of dementia.

R3's Treatment Administration Reports (TAR) identified R3 had a wanderguard check placed on her TAR monthly and replace as needed. In

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January, 2020, R3's wanderguard was documented as checked on 1/7/20. In February, 2020, R3's wanderguard was checked on 2/3/20. There is no documentation how staff checked the wanderguard for functionality.

Interview on 3/11/20 at 12:29 p.m., with administrator identified the 3 alarm systems were antiquated and was unaware how the systems worked and the systems had not been maintained appropriately. The alarm system needed to be fixed, but due to budgeting, that was not addressed.

Interview on 3/11/20 at 4:07 p.m., with medical director (MD) identified R2 had severe dementia. He understood from staff, they were to have had direct observation of R2 in addition to the WanderGuard. The MD was not aware the system had not been monitored, maintained or tested according to manufacturer recommendations. The MD expected staff to follow the manufacture's guidelines for maintenance, monitoring, and testing of all alarm systems in the facility.

Review of the June 2019, Elopement or Unsafe Wandering Policy & Procedure identified through the admission MDS process new residents were to be evaluated for the risk of wandering and elopement. An Elopement Risk Assessment (ERA) was to be completed on any resident determined to be at risk for wandering and/or elopement. The ERA was to have been completed within 24 hours of an elopement to determine if appropriate interventions were in place. All immediate exits from the nursing unit "were equipped with an alarm system." There

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F 689	Continued From page 12 was no mention the doors were not all equipped with all 3 alarm systems. Review of the June 2010, Accutech (WanderGuard) LC 1200 Manual Version 1.05 identified Accutech bracelets operate by an internal battery. The battery is not replaceable. For maximum protection bracelets needed to be tested on a weekly basis. Preventative maintenance testing were to be performed at the minimum on a monthly basis. The IJ that began on 2/23/20, was removed on 3/14/20 at 3:30 p.m. when the facility re-assessed all residents for potential elopement, placed R2 on continuous 1:1 monitoring, contacted the alarm manufacturer for servicing, and educated staff.	F 689		

Electronically delivered
April 1, 2020

Administrator
Divine Providence Health Center
312 East George Street PO Box 136
Ivanhoe, MN 56142

Re: State Nursing Home Licensing Orders
Event ID: Y06711

Dear Administrator:

The above facility was surveyed on March 10, 2020 through March 16, 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:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

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

Please feel free to call me with any questions.

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

Minnesota Department of Health

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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 3/10/20 through 3/16/20, surveyors of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaint: H5327005C. No correction orders were issued.	2 000		

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

Electronically Signed | 04/08/20

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		