DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 31, 2020

Administrator
Parmly On The Lake LLC
28210 Old Towne Road
Chisago City, MN 55013

RE: CCN: 245328
Cycle Start Date: March 24, 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 24, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 24, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 24, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	C 03/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE LLC	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

(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 3/24/2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) (was/were) found to be substantiated: H8328033C. Deficiency issued at F Tag 689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	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 interview and document review the	F 689	R1 was located after the execution of the	4/20/20

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

Electronically Signed | 04/06/2020

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F 689	Continued From page 1 facility failed to ensure adequate supervision for 1 of 1 cognitively impaired resident (R1) at risk for elopement. Findings include: R1's quarterly minimum data set dated 3/7/20, indicated he was moderately cognitively impaired and required supervision for all activities of daily living. An Elopement Risk Evaluation dated 12/14/19, indicated R1 had made no attempts to leave the facility, was fully ambulatory and wore a Wanderguard bracelet. The evaluation indicated R1 was at little risk for elopement but had wandering tendencies of walking to places he was not familiar with and unable to find his way back. R1's care plan dated 3/7/20, identified an alteration in cognition related to Alzheimer's, dementia and delirium. The care plan was updated on 3/23/20, to include risk for elopement related to a a history of exit seeking/elopement and indicated on 3/20/20, R1 asked to go outside for fresh air and walked away from the facility. The care plan further indicated R1 continued to make statements about going home and identified the use of a Wanderguard bracelet. An Elopement Risk Evaluation dated 3/20/20, indicated R1 had a history of elopement, was fully ambulatory and wore a Wanderguard bracelet. The evaluation indicated R1 continued to be at risk for elopement due to asking to go out for fresh air and walking away from the facility, exit seeking and statements about	F 689	facility elopement procedure. R1 was assessed upon return to the facility and monitored for change in condition and injury. Resident did not experience any injury. The resident's representative and physician was notified. All residents that are at risk for elopement were identified as having the potential to be affected by the same deficient practice. All these residents had their elopement assessments reviewed and their interventions reviewed to ensure they were accurate. Care plans were reviewed to ensure their elopement risks were documented. WD was educated on the elopement policy and on other tools to identify residents at risk for elopement. The WD was screening essential care workers in regards to COVID-19. All screeners have been educated on the elopement policy and tools available to identify residents at risk for elopement. All staff receive education regarding elopement annually. The Director of Nursing or designee will conduct weekly audits for 4 weeks to review any residents exhibiting signs or symptoms of elopement and to ensure their elopement interventions are implemented effectively. The QAPI committee will review the results of the audits as well as the	

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F 689	Continued From page 2 wanting/needing to go to his old town home. The evaluation indicated R1 was aware how close his previous residence was to the facility but forgot he no longer lived there. Wanderguard remained appropriate. Review of R1's facility Progress Notes indicated the following: 12/15/19, R1 used a Wanderguard and utilized frequent cues and re-direction. 1/11/20, R1 walked with a rolling walker and had a Wanderguard as he got confused and may become exit seeking. 3/15/20, R1 was exit seeking and trying to get home to his apartment. R1 set off the alarm by the chapel doors. Review of documentation identified that on 3/20/20, a writer identified that at 5:45 a.m., a nursing assistant (NA) trainer doing screenings at the front entry asked, "Do you have a resident named [R1]?" Staff coming in for day shift had recognized him in the parking lot and eventually inquired as to why he was outside. Writer stated yes, and immediately left the front exit with another NA to search for R1. Another staff who worked a the facility but not directly with R1 had let him out the front door not knowing he was a resident, therefore his wanderguard was not activated. After searching the immediate vicinity on foot and not successfully locating R1, writer initiated missing persons emergency protocol. 911 was called to report R1 missing and gave his description. After speaking to R1's daughter she gave two addresses where she thought he may	F 689	education completion to determine whether the plan of correction was effective or if continuous monitoring and system changes need to be implemented.	

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F 689	Continued From page 3	F 689		

go, one of which was his previous town home. The search party was alerted to this address and subsequently found R1 near this location behind a storm door in an entryway to one of the town homes. He was located at approximately 6:15 a.m. 30 minutes or so after going missing. Search was then ended and R1 was brought back to facility by police. He was wearing a sweater, a vest over it, and a baseball cap but no coverings on his hands or ears which were red and waxy in appearance. R1 was wrapped in warm blankets immediately and vitals taken. Both of his knees reddened, but R1 stated he did not fall.

A facility Verification of Investigation report dated 3/20/20, indicated R1 was asked if he got out for some fresh air and he responded, yes he did. R1 stated he went out because he wanted to surprise his daughter and said he and his daughter owned a town home nearby. R1 stated he did make it there, "but barely" and said he got tired and cold. The report indicated the Wanderguard was tested and found to be functioning properly but had been disabled by the staff member who let him out the door.

During interview on 3/24/20, at 9:34 a.m. family member (FM) -A stated she was told that R1 had asked to go outside. FM-A stated he was wearing an ankle bracelet that should have locked the door but someone had let him go out. FM-A stated R1 had gone to the town home he used to live in and was found 45 minutes later between a door and a screen door on his knees. FM-A said staff believed he was crouched down trying to warm up and stated it was 23 degrees when they called her. FM-A said R1 was not dressed

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F 689	Continued From page 4	F 689		

appropriately and said he had on a long sleeve shirt, a ball cap and sweat or pajama pants. FM-A stated she was aware the person doing screenings at the desk had let R1 out and stated, "why anyone would let him out, I can't guess, it could have ended much worse." FM-A further stated R1 had previously lived further away down the highway and said she wouldn't put it past him to try to go to that house.

On 3/24/20, at 10:07 a.m. licensed practical nurse (LPN)-A stated R1 had eloped from the facility the previous week. LPN-A stated he went to the front desk and asked if he could go out to get some fresh air. LPN-A stated the staff member at the desk did not know R1 and let him out the doors. She stated another staff member walking in had seen R1 and asked if he was supposed to be outside and the staff member who let him out said she wasn't sure so she contacted the nurse manager on R1's unit, called 911 and began searching for him. LPN-A stated R1 was found approximately 45 minutes later.

At 10:21 a.m. LPN-B stated the morning R1 eloped from the facility, she came in right before 6:00 a.m. and saw people outside. LPN-B said she was told they did not know where R1 was. LPN-B stated she put her stuff down and began searching. LPN-B said "it was kind of a cold day, windy. It was so dark, I was worried, it was so dark we couldn't see anything." LPN-B stated she was so cold she had to come back in and people got in their cars to look for R1. LPN-B got in a car with another staff member and they checked the town home area where R1 had lived previously. LPN-B said she noticed the shape of a person by a glass door on his right knee trying to open the

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F 689	Continued From page 5 door to get in and said it was R1. LPN-B stated they were able to get him up and called for help. LPN-B stated when R1 returned to the facility they tried to check his vital signs but could not get them because he was so cold so they wrapped him in warm blankets. At 10:30 a.m. the wellness director (WD) stated she arrived at the facility at 5:00 a.m. to do screening on the day R1 eloped. The WD said R1 approached her at 5:30 a.m. and asked to go outside for some fresh air. The WD said she used the key pad to unlock the doors which prevented R1's Wanderguard from activating and stated she was not aware he wore a Wanderguard. The WD said she opened the door for him and it was a little chilly out so she told him to knock on the door when he wanted to come in. She stated at some point, a girl from the kitchen asked about R1 being outside, then another staff walked up. The WD asked that staff member if R1 should be outside and the other staff member did not know so she went to find the nurse. She said at that point R1 must have been going toward the road because he was not outside the doors. She said herself and other staff got in their cars and started driving around and stated it was dark and R1 was wearing all black. The WD stated she should have asked someone before letting R1 out the doors. She stated she was unaware there was a book at the desk to check for residents who were at risk for elopement, but since had received Additonal training. At 11:02 a.m. the administrator stated R1 had admitted to the facility in December and had a history of wandering around the building. The administrator stated R1 had recently been talking	F 689		

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F 689	Continued From page 6 more about gong home and had approached the front door about a week prior and stated he was aware R1 had set off the alarm on March 15th. The administrator stated after R1 set off the alarm, they discussed it in their clinical meetings and the nurse manager had conversations with staff. He stated at that point they just kind of increased monitoring. The administrator stated the wellness staff had initially received just general education related to elopement but have now received more training. A facility policy titled Elopement Guideline dated November 2017, indicated elopement is defined as that situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety, needs and therefore at risk for injury outside the confines of the facility, has left the facility without knowledge of staff. The policy indicated a specific system has been developed to notify staff that an external door has been opened in an area accessible to residents and indicated only the administrator (or designee) may authorize disabling the alarm system and is responsible for the method of monitoring for residents safety and resetting the alarm.	F 689		

Electronically delivered
March 31, 2020

Administrator
Parmly On The Lake LLC
28210 Old Towne Road
Chisago City, MN 55013

Re: State Nursing Home Licensing Orders
Event ID: T1ON11

Dear Administrator:

The above facility was surveyed on March 24, 2020 through March 24, 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:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 3/24/2020, a complaint investigation survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 H5328033C was substantiated at State tag 0830. 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		
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 interview and document review the facility failed to ensure adequate supervision for 1 of 1 cognitively impaired resident (R1) at risk for elopement. Findings include: R1's quarterly minimum data set dated 3/7/20, indicated he was moderately cognitively impaired	2 830	R1 was located after the execution of the facility elopement procedure. R1 was assessed upon return to the facility and monitored for change in condition and injury. Resident did not experience any injury. The resident's representative and physician was notified. All residents that are at risk for elopement	4/20/20

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	00065	A. BUILDING: _____ B. WING _____	C 03/24/2020

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2 830	Continued From page 2 and required supervision for all activities of daily living. An Elopement Risk Evaluation dated 12/14/19, indicated R1 had made no attempts to leave the facility, was fully ambulatory and wore a Wanderguard bracelet. The evaluation indicated R1 was at little risk for elopement but had wandering tendencies of walking to places he was not familiar with and unable to find his way back. R1's care plan dated 3/7/20, identified an alteration in cognition related to Alzheimer's, dementia and delirium. The care plan was updated on 3/23/20, to include risk for elopement related to a a history of exit seeking/elopement and indicated on 3/20/20, R1 asked to go outside for fresh air and walked away from the facility. The care plan further indicated R1 continued to make statements about going home and identified the use of a Wanderguard bracelet. An Elopement Risk Evaluation dated 3/20/20, indicated R1 had a history of elopement, was fully ambulatory and wore a Wanderguard bracelet. The evaluation indicated R1 continued to be at risk for elopement due to asking to go out for fresh air and walking away from the facility, exit seeking and statements about wanting/needing to go to his old town home. The evaluation indicated R1 was aware how close his previous residence was to the facility but forgot he no longer lived there. Wanderguard remained appropriate. Review of R1's facility Progress Notes indicated the following:	2 830	were identified as having the potential to be affected by the same deficient practice. All these residents had their elopement assessments reviewed and their interventions reviewed to ensure they were accurate. Care plans were reviewed to ensure their elopement risks were documented. WD was educated on the elopement policy and on other tools to identify residents at risk for elopement. The WD was screening essential care workers in regards to COVID-19. All screeners have been educated on the elopement policy and tools available to identify residents at risk for elopement. All staff receive education regarding elopement annually. The Director of Nursing or designee will conduct weekly audits for 4 weeks to review any residents exhibiting signs or symptoms of elopement and to ensure their elopement interventions are implemented effectively. The QAPI committee will review the results of the audits as well as the education completion to determine whether the plan of correction was effective or if continuous monitoring and system changes need to be implemented.	

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2 830	Continued From page 3 12/15/19, R1 used a Wanderguard and utilized frequent cues and re-direction. 1/11/20, R1 walked with a rolling walker and had a Wanderguard as he got confused and may become exit seeking. 3/15/20, R1 was exit seeking and trying to get home to his apartment. R1 set off the alarm by the chapel doors. Review of documentation identified that on 3/20/20, a writer identified that at 5:45 a.m., a nursing assistant (NA) trainer doing screenings at the front entry asked, "Do you have a resident named [R1]?" Staff coming in for day shift had recognized him in the parking lot and eventually inquired as to why he was outside. Writer stated yes, and immediately left the front exit with another NA to search for R1. Another staff who worked a the facility but not directly with R1 had let him out the front door not knowing he was a resident, therefore his wanderguard was not activated. After searching the immediate vicinity on foot and not successfully locating R1, writer initiated missing persons emergency protocol. 911 was called to report R1 missing and gave his description. After speaking to R1's daughter she gave two addresses where she thought he may go, one of which was his previous town home. The search party was alerted to this address and subsequently found R1 near this location behind a storm door in an entryway to one of the town homes. He was located at approximately 6:15 a.m. 30 minutes or so after going missing. Search was then ended and R1 was brought back to facility by police. He was wearing a sweater, a vest over it, and a baseball cap but no coverings on his hands or ears which were red	2 830		

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2 830	Continued From page 4 and waxy in appearance. R1 was wrapped in warm blankets immediately and vitals taken. Both of his knees reddened, but R1 stated he did not fall. A facility Verification of Investigation report dated 3/20/20, indicated R1 was asked if he got out for some fresh air and he responded, yes he did. R1 stated he went out because he wanted to surprise his daughter and said he and his daughter owned a town home nearby. R1 stated he did make it there, "but barely" and said he got tired and cold. The report indicated the Wanderguard was tested and found to be functioning properly but had been disabled by the staff member who let him out the door. During interview on 3/24/20, at 9:34 a.m. family member (FM) -A stated she was told that R1 had asked to go outside. FM-A stated he was wearing an ankle bracelet that should have locked the door but someone had let him go out. FM-A stated R1 had gone to the town home he used to live in and was found 45 minutes later between a door and a screen door on his knees. FM-A said staff believed he was crouched down trying to warm up and stated it was 23 degrees when they called her. FM-A said R1 was not dressed appropriately and said he had on a long sleeve shirt, a ball cap and sweat or pajama pants. FM-A stated she was aware the person doing screenings at the desk had let R1 out and stated, "why anyone would let him out, I can't guess, it could have ended much worse." FM-A further stated R1 had previously lived further away down the highway and said she wouldn't put it past him to try to go to that house. On 3/24/20, at 10:07 a.m. licensed practical	2 830		

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2 830	Continued From page 5 nurse (LPN)-A stated R1 had eloped from the facility the previous week. LPN-A stated he went to the front desk and asked if he could go out to get some fresh air. LPN-A stated the staff member at the desk did not know R1 and let him out the doors. She stated another staff member walking in had seen R1 and asked if he was supposed to be outside and the staff member who let him out said she wasn't sure so she contacted the nurse manager on R1's unit, called 911 and began searching for him. LPN-A stated R1 was found approximately 45 minutes later. At 10:21 a.m. LPN-B stated the morning R1 eloped from the facility, she came in right before 6:00 a.m. and saw people outside. LPN-B said she was told they did not know where R1 was. LPN-B stated she put her stuff down and began searching. LPN-B said "it was kind of a cold day, windy. It was so dark, I was worried, it was so dark we couldn't see anything." LPN-B stated she was so cold she had to come back in and people got in their cars to look for R1. LPN-B got in a car with another staff member and they checked the town home area where R1 had lived previously. LPN-B said she noticed the shape of a person by a glass door on his right knee trying to open the door to get in and said it was R1. LPN-B stated they were able to get him up and called for help. LPN-B stated when R1 returned to the facility they tried to check his vital signs but could not get them because he was so cold so they wrapped him in warm blankets. At 10:30 a.m. the wellness director (WD) stated she arrived at the facility at 5:00 a.m. to do screening on the day R1 eloped. The WD said R1 approached her at 5:30 a.m. and asked to go outside for some fresh air. The WD said she	2 830		

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2 830	Continued From page 6 used the key pad to unlock the doors which prevented R1's Wanderguard from activating and stated she was not aware he wore a Wanderguard. The WD said she opened the door for him and it was a little chilly out so she told him to knock on the door when he wanted to come in. She stated at some point, a girl from the kitchen asked about R1 being outside, then another staff walked up. The WD asked that staff member if R1 should be outside and the other staff member did not know so she went to find the nurse. She said at that point R1 must have been going toward the road because he was not outside the doors. She said herself and other staff got in their cars and started driving around and stated it was dark and R1 was wearing all black. The WD stated she should have asked someone before letting R1 out the doors. She stated she was unaware there was a book at the desk to check for residents who were at risk for elopement, but since had received Additonal training. At 11:02 a.m. the administrator stated R1 had admitted to the facility in December and had a history of wandering around the building. The administrator stated R1 had recently been talking more about gong home and had approached the front door about a week prior and stated he was aware R1 had set off the alarm on March 15th. The administrator stated after R1 set off the alarm, they discussed it in their clinical meetings and the nurse manager had conversations with staff. He stated at that point they just kind of increased monitoring. The administrator stated the wellness staff had initially received just general education related to elopement but have now received more training. A facility policy titled Elopement Guideline dated	2 830		

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2 830	Continued From page 7 November 2017, indicated elopement is defined as that situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety, needs and therefore at risk for injury outside the confines of the facility, has left the facility without knowledge of staff. The policy indicated a specific system has been developed to notify staff that an external door has been opened in an area accessible to residents and indicated only the administrator (or designee) may authorize disabling the alarm system and is responsible for the method of monitoring for residents safety and resetting the alarm. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		