

**Office of Health Facility Complaints Investigative Report
PUBLIC**

Facility Name: The Estates at Linden			Report Number: H5337028	Date of Visit: February 2, 2017
Facility Address: 105 West Linden Street			Time of Visit: 8:15 a.m. to 5:00 p.m.	Date Concluded: April 28, 2017
Facility City: Stillwater			Investigator's Name and Title: Lisa Ciesinski, RN, Special Investigator	
State: Minnesota	ZIP: 55082	County: Washington		

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when facility staff failed to notify the resident's guardian s/he was leaving the facility. The resident has not returned and has been gone for multiple days.

- ☒ 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 Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect of supervision occurred when facility staff did not ensure adequate supervision was provided to a resident who left the facility. The resident was an elopement risk. The resident left the facility with a friend and did not return. The resident's whereabouts are unknown.

The resident was admitted to the facility from the hospital with diagnoses of acute necrotizing hemorrhagic encephalopathy and alcohol abuse. Hospital documentation indicated the resident was confused with intermittent erratic behavior. During the hospitalization, the resident required a continuous one-to-one supervision due to the resident's elopement risk. A family member was appointed as the resident's emergency guardian. Due to the resident's elopement risk, the resident did not attend the emergency guardianship hearing.

The resident ambulated independently and resided on a secure unit at the facility due to the resident's elopement risk. The resident's care plan identified the resident had a tendency of "wandering with no rational purpose seemingly oblivious to safety needs." Staff placed a Wanderguard bracelet on the resident's wrist to alert staff if the resident attempted to leave the unit.

The facility received documentation, at the time of the resident's admission, of a hearing to confirm the appointment of the family member as the resident's emergency guardian. The hearing was scheduled for four days after admission. Staff indicated they had attempted to reach the guardian several times over the weekend, as the guardian needed to come to the facility to sign the resident's admission paperwork;

however, the staff were unable to reach the guardian. The resident was given a copy of the hearing paperwork by staff and the resident arranged for a friend to transport the resident to the court hearing. Four days later, staff allowed the resident to leave the facility with the friend to attend the court hearing. Staff did not inform the guardian before the resident left. The resident did not return to the facility.

When staff contacted the friend who transported the resident, the friend informed staff that upon arriving to the court house, s/he learned the resident did not have a court hearing scheduled. The friend told staff the resident recognized two men in the waiting area. The friend went to the bathroom, and when s/he returned, the resident was gone. The friend reported court staff informed her/him the resident left with the two men.

When interviewed, the guardian stated the resident's court hearing was re-scheduled. The guardian stated the resident would not have been taken out of the facility for the hearing as the guardian felt once the resident left, the resident would not return back to the facility. The guardian stated s/he received one text from the resident indicating s/he was safe and warm.

Law enforcement was contacted by the facility and was able to receive a ping from the resident's cell phone in Minnesota. Facility staff received texts from the resident indicating s/he was out of state and headed to Texas.

Contact was made with the resident via the phone during the investigation. The resident stated s/he was safe and ended the call. The whereabouts of the resident are unknown.

After the incident, the facility took immediate action for the safety of all other residents at the facility. All resident records were reviewed to ensure guardian contact information was up-to-date. A policy was created, and all staff were educated, directing that a resident's guardian must be contacted prior to the resident leaving the facility.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Abuse | <input checked="" type="checkbox"/> Neglect | <input type="checkbox"/> Financial Exploitation |
| <input checked="" type="checkbox"/> Substantiated | <input type="checkbox"/> Not Substantiated | <input type="checkbox"/> 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:

Facility staff did not ensure adequate supervision was provided to a resident with elopement risk. The facility did not have policy or procedure in place for staff to notify a resident's guardian prior to the resident leaving the facility for an appointment.

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:

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 Statutes 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:

Facility Corrective Action:

The facility took the following corrective action(s):

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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Progress Notes
- ☒ Care Plan Records
- ☒ Facility Incident Reports

Other pertinent medical records:

- ☒ Hospital Records

Additional facility records:

- ☒ Resident/Family Council Minutes
- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports
- ☒ Personnel Records/Background Check, etc.
- ☒ Facility In-service Records

Facility Name: The Estates at Linden

Report Number: H5337028

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

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: Discharged

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ☐ Yes ☐ No ☒ N/A

Specify: _____

If unable to contact complainant, 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: Discharged

Did you interview additional residents? ☒ Yes ☐ No

Total number of resident interviews: Four

Interview with staff: ☒ Yes ☐ No ☐ N/A Specify: _____

Tennessee Warnings

Tennessee Warning given as required: ☒ Yes ☐ No

Total number of staff interviews: Seven

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 _____

Facility Name: The Estates at Linden

Report Number: H5337028

Observations were conducted related to:

☒ 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

Stillwater Police Department

Stillwater City Attorney

Washington County Attorney



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 18, 2017

Mr. Eric Andersen, Administrator
The Estates At Linden LLC
105 West Linden Street
Stillwater, Minnesota 55082

RE: Project Number H5337028

Dear Mr. Andersen:

On March 30, 2017, an abbreviated standard survey survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is electronically delivered.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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:

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulations Division
Minnesota Department of Health

Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 9, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, Office of Health Facility Complaints 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 30, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

The Estates At Linden LLC

April 18, 2017

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result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 30, 2017 (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.

INFORMAL DISPUTE RESOLUTION

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

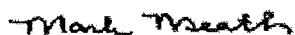
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

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 related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 18, 2017

Mr. Eric Andersen, Administrator
The Estates At Linden LLC
105 West Linden Street
Stillwater, Minnesota 55082

Re: State Nursing Home Licensing Orders - Complaint Number H5337028

Dear Mr. Andersen:

A complaint investigation was completed on March 30, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each licensing order not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health State form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

The Estates At Linden LLC

April 18, 2017

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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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulations Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970

Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135 Fax: (651) 281-9796

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/19/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LINDEN LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST LINDEN STREET STILLWATER, MN 55082		
(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}	<p>INITIAL COMMENTS</p> <p>A Post Certification revisit was conducted on 5/19/2017, to follow up on deficiencies issued related to complaint H5337028. The Estates at Linden LLC is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.</p> <p>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.</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/07/2017

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2017
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE ESTATES AT LINDEN LLC

**105 WEST LINDEN STREET
STILLWATER, MN 55082**

(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}	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5337028. The Estates at Linden LLC was found in compliance with state regulations.</p> <p>The facility is enrolled in ePOC and therefore a</p>	{2 000}		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/07/17

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LINDEN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST LINDEN STREET STILLWATER, MN 55082		
(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 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}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/06/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LINDEN LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST LINDEN STREET STILLWATER, MN 55082		
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F 000	INITIAL COMMENTS	F 000			
F 323 SS=D	<p>An abbreviated standard survey was conducted to investigate case #H5337028. As a result, the following deficiency is issued.</p> <p>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(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.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(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 interview and document review, the facility failed to provide adequate supervision for 1 of 4 residents reviewed, (R1), when staff allowed the resident to leave the facility with a</p>	F 323			

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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LINDEN LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST LINDEN STREET STILLWATER, MN 55082		
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F 323	<p>Continued From page 1</p> <p>friend to attend a court hearing, without notifying or obtaining permission from the guardian. The resident did not return to the facility and the resident's whereabouts are unknown.</p> <p>Findings include:</p> <p>R1's medical record was reviewed and indicated diagnoses, which included, acute necrotizing hemorrhagic encephalopathy and alcohol abuse. Hospital records indicated R1 was confused with intermittent erratic behavior. While hospitalized, R1 had made several attempts to leave and required a continuous 1:1 supervision due to R1's elopement risk. Family member (FM)-C was court appointed as R1's emergency guardian on 1/13/17. R1 did not attend the court hearing due to R1's elopement risk. The resident was admitted from the hospital to the facility's secure unit on 1/20/17. Additional hospital records identified a 1/24/17 hearing to confirm the appointment of FM-C as R1's emergency guardian and conservator.</p> <p>An admission "CLINICAL HEALTH STATUS" assessment, dated 1/20/17 related to R1's risk for elopement indicated staff checked yes for each of the following questions: Is the resident physically able to leave the building on their own? Is the resident cognitively impaired? Experience a recent move in room or facility? Although the resident was an elopement risk at the hospital, staff checked no to the question: Is there a history of wandering or elopement? R1's care plan, dated 1/24/17 for elopement risk identified a problem area of "Persistent anger with self, anger at placement." and "Wandering with no rational purpose seemingly oblivious to safety needs." Interventions included a wanderguard</p>	F 323			

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F 323	<p>Continued From page 2 bracelet on R1's right wrist.</p> <p>A 1/20/17 progress note indicated R1 was independent with eating, transfers, grooming and bed mobility. R1 ambulated without any assistive devices.</p> <p>A 1/21/17 progress note indicated R1 was self-ambulatory. R1 had a wanderguard on her left wrist.</p> <p>Review of R1's Admission Record (face sheet) indicated information related to FM-C guardianship was entered on 1/23/17 at 4:12 p.m, three days after admission.</p> <p>A 1/24/17 progress note at 7:51 a.m. indicated "LOA [leave of absence] with friend [Friend-D] transporting to court. Left building at 0700."</p> <p>A 1/24/17 progress note at 3:51 p.m. indicated social service coordinator (SSC)-B notified FM-C via the phone that R1 had not returned from the scheduled court hearing. FM-C replied "She has a habit of surrounding herself with unsavory individuals so it doesn't surprise me that she's not back."</p> <p>An interview with licensed practical nurse (LPN)-F was conducted on 2/2/17 at 1:10 p.m. LPN-F stated R1 requested a copy of her court paperwork on 1/23/17. LPN-F stated the paperwork indicated R1 had a court hearing for guardianship on 1/24/17. LPN-F stated she reviewed R1's facesheet for contact information on 1/23/17 and the facesheet did not identify a guardian. The resident arranged for a friend to take her to court. The next morning, LPN-F stated she received report from the night nurse around</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>6:30 a.m. The night nurse reported that Friend-D was coming to escort R1 to a morning court hearing. Friend-D arrived a short time later. Friend-D signed R1 out using the sign out book. Friend-D and R1 left the building.</p> <p>An interview with FM-C was conducted on 2/6/17 at 2:35 p.m. FM-C stated the facility did not contact him regarding the court hearing. FM-C stated the 1/24/17 court date had actually been rescheduled to a later date. FM-C stated he would not have allowed Friend-D to take R1 out of the facility. FM-C went on to say, he would not have taken R1 out of the facility, as he did not believe once R1 left she would return. FM-C stated since R1 left the facility, he has received one text from R1 stating she was safe and warm. FM-C in unaware of FM-C's whereabouts.</p> <p>An interview with the director of nursing (DON) conducted on 2/2/17 at 10:40 a.m. The DON stated she spoke to Friend-D via the phone at approximately 5:00 p.m. on 1/24/17. The DON stated Friend-D said, upon arriving to the court house, they learned R1 did not have a court hearing scheduled. R1 recognized two men in the waiting area. Friend-D went to the bathroom. When Friend-D returned from the bathroom R1 was gone. Friend-D told the DON court staff said R1 left with the two men. The DON stated at the time of the incident, the facility had no policy directing staff to notify the guardian prior to an appointment.</p> <p>An interview with the executive director was conducted on 2/2/17 at 9:50 a.m. The executive director stated several phone calls were placed over the weekend to reach FM-C, as FM-C needed to sign R1's admission paperwork. The</p>	F 323			

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F 323	Continued From page 4 executive director stated staff should not have allowed R1 to leave with Friend-D without FM-C's permission and confirmed staff did not do this. The executive director received text messages from R1, which indicated R1 was out of state and headed to Texas. The executive director notified the police on 1/24/17 at approximately 3:30 p.m. The executive director stated the police received a ping from the resident's phone near Elko Minnesota, but have not been able to locate R1. An interview was attempted with R1 via phone on 2/7/17 at 3:04 p.m. R1 stated she was safe and ended the call.	F 323			

Minnesota Department of Health

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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5337028. As a result, the following correction orders are issued.</p>	2 000	<p>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.</p>	

Minnesota Department of Health

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2 000	Continued From page 1	2 000	<p>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, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
2 830	<p>MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General</p> <p>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</p>	2 830		

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2 830	<p>Continued From page 2</p> <p>written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 4 residents reviewed, (R1), when staff allowed the resident to leave the facility with a friend to attend a court hearing, without notifying or obtaining permission from the guardian. The resident did not return to the facility and the resident's whereabouts are unknown.</p> <p>Findings include:</p> <p>R1's medical record was reviewed and indicated diagnoses, which included, acute necrotizing hemorrhagic encephalopathy and alcohol abuse. Hospital records indicated R1 was confused with intermittent erratic behavior. While hospitalized, R1 had made several attempts to leave and required a continuous 1:1 supervision due to R1's elopement risk. Family member (FM)-C was court appointed as R1's emergency guardian on 1/13/17. R1 did not attend the court hearing due to R1's elopement risk. The resident was admitted from the hospital to the facility's secure unit on 1/20/17. Additional hospital records identified a 1/24/17 hearing to confirm the appointment of FM-C as R1's emergency guardian and conservator.</p> <p>An admission "CLINICAL HEALTH STATUS" assessment, dated 1/20/17 related to R1's risk for elopement indicated staff checked yes for each of</p>	2 830		

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2 830	<p>Continued From page 3</p> <p>the following questions: Is the resident physically able to leave the building on their own? Is the resident cognitively impaired? Experience a recent move in room or facility? Although the resident was an elopement risk at the hospital, staff checked no to the question: Is there a history of wandering or elopement? R1's care plan, dated 1/24/17 for elopement risk identified a problem area of "Persistent anger with self, anger at placement." and "Wandering with no rational purpose seemingly oblivious to safety needs." Interventions included a wanderguard bracelet on R1's right wrist.</p> <p>A 1/20/17 progress note indicated R1 was independent with eating, transfers, grooming and bed mobility. R1 ambulated without any assistive devices.</p> <p>A 1/21/17 progress note indicated R1 was self-ambulatory. R1 had a wanderguard on her left wrist.</p> <p>Review of R1's Admission Record (face sheet) indicated information related to FM-C guardianship was entered on 1/23/17 at 4:12 p.m., three days after admission.</p> <p>A 1/24/17 progress note at 7:51 a.m. indicated "LOA [leave of absence] with friend [Friend-D] transporting to court. Left building at 0700."</p> <p>A 1/24/17 progress note at 3:51 p.m. indicated social service coordinator (SSC)-B notified FM-C via the phone that R1 had not returned from the scheduled court hearing. FM-C replied "She has a habit of surrounding herself with unsavory individuals so it doesn't surprise me that she's not back."</p>	2 830		

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2 830	<p>Continued From page 4</p> <p>An interview with licensed practical nurse (LPN)-F was conducted on 2/2/17 at 1:10 p.m. LPN-F stated R1 requested a copy of her court paperwork on 1/23/17. LPN-F stated the paperwork indicated R1 had a court hearing for guardianship on 1/24/17. LPN-F stated she reviewed R1's facesheet for contact information on 1/23/17 and the facesheet did not identify a guardian. The resident arranged for a friend to take her to court. The next morning, LPN-F stated she received report from the night nurse around 6:30 a.m. The night nurse reported that Friend-D was coming to escort R1 to a morning court hearing. Friend-D arrived a short time later. Friend-D signed R1 out using the sign out book. Friend-D and R1 left the building.</p> <p>An interview with FM-C was conducted on 2/6/17 at 2:35 p.m. FM-C stated the facility did not contact him regarding the court hearing. FM-C stated the 1/24/17 court date had actually been rescheduled to a later date. FM-C stated he would not have allowed Friend-D to take R1 out of the facility. FM-C went on to say, he would not have taken R1 out of the facility, as he did not believe once R1 left she would return. FM-C stated since R1 left the facility, he has received one text from R1 stating she was safe and warm. FM-C is unaware of FM-C's whereabouts.</p> <p>An interview with the director of nursing (DON) conducted on 2/2/17 at 10:40 a.m. The DON stated she spoke to Friend-D via the phone at approximately 5:00 p.m. on 1/24/17. The DON stated Friend-D said, upon arriving to the court house, they learned R1 did not have a court hearing scheduled. R1 recognized two men in the waiting area. Friend-D went to the bathroom. When Friend-D returned from the bathroom R1 was gone. Friend-D told the DON court staff said</p>	2 830		

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2 830	<p>Continued From page 5</p> <p>R1 left with the two men. The DON stated at the time of the incident, the facility had no policy directing staff to notify the guardian prior to an appointment.</p> <p>An interview with the executive director was conducted on 2/2/17 at 9:50 a.m. The executive director stated several phone calls were placed over the weekend to reach FM-C, as FM-C needed to sign R1's admission paperwork. The executive director stated staff should not have allowed R1 to leave with Friend-D without FM-C's permission and confirmed staff did not do this. The executive director received text messages from R1, which indicated R1 was out of state and headed to Texas. The executive director notified the police on 1/24/17 at approximately 3:30 p.m. The executive director stated the police received a ping from the resident's phone near Elko Minnesota, but have not been able to locate R1.</p> <p>An interview was attempted with R1 via phone on 2/7/17 at 3:04 p.m. R1 stated she was safe and ended the call.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents guardian status, develop policies on guardianship and residents leaving the facility, and educate staff on the policies. The director of nursing or designee, could conduct random audits to ensure complete.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	2 830			
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights	21850			

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21850	<p>Continued From page 6</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident was free from maltreatment for 1 of 4 residents reviewed, (R1), when the resident was neglected when staff allowed the resident, who was at risk for elopement, to leave the facility with a friend to attend a court hearing, without notifying or obtaining permission from the guardian. The resident did not return to the facility and the resident's whereabouts are unknown.</p> <p>Findings include:</p> <p>R1's medical record was reviewed and revealed diagnoses, which included, acute necrotizing hemorrhagic encephalopathy and alcohol abuse. Hospital records revealed R 1 was confused with intermittent erratic behavior. While hospitalized, R1 had made several attempts to leave and required a continuous 1:1 sitter due to R1's elopement risk. Family member (FM)-C was court</p>	21850		

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STILLWATER, MN 55082**

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21850	<p>Continued From page 7</p> <p>appointed as R1's emergency guardian on 1/13/17. R1 did not attend the court hearing due to R1's elopement risk. The resident was admitted from the hospital to the facilities secure unit on 1/20/17. Additional hospital records identified a 1/24/17 hearing at the Scott County Government Center in Shakopee, MN to confirm the appointment of FM-C as R1's emergency guardian and conservator.</p> <p>An admission "CLINICAL HEALTH STATUS" assessment, dated 1/20/17 related to R1's risk for elopement revealed staff checked yes for the following: Is the resident physically able to leave the building on their own? Is the resident cognitively impaired? Experience a recent move in room or facility? Although the resident was an elopement risk at the hospital, staff checked no to the question: Is there a history of wandering or elopement? R1's care plan, dated 1/24/17 for elopement risk identified a problem area of "Persistent anger with self, anger at placement." and "Wandering with no rational purpose seemingly oblivious to safety needs." Interventions included a wanderguard bracelet on R1's right wrist.</p> <p>A 1/20/17 progress note indicated R1 was independent with eating, transfers, grooming and bed mobility. R1 ambulated without any assistive devices.</p> <p>A 1/21/17 progress note indicated R1 was self-ambulatory. R1 had a wanderguard on her left wrist.</p> <p>Review of R1's Admission Record (face sheet) revealed information related to FM-C guardianship was entered on 1/23/17 at 4:12 p.m, three days after admission.</p>	21850		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/30/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LINDEN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST LINDEN STREET STILLWATER, MN 55082		
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21850	<p>Continued From page 8</p> <p>A 1/24/17 progress note at 7:51 a.m. indicated "LOA [leave of absence] with friend [Friend-D] transporting to court. Left building at 0700."</p> <p>Although FM-C was R1's emergency guardian, R1's medical record lacked documentation of FM-C notification and permission for R1 to leave the facility with Friend-D</p> <p>A 1/24/17 progress note at 3:51 p.m. indicated social service coordinator (SSC)-B notified FM-C via the phone that R1 had not returned from the scheduled court hearing. FM-C replied "She has a habit of surrounding herself with unsavory individuals so it doesn't surprise me that she's not back."</p> <p>An interview with licensed practical nurse (LPN)-F was conducted on 2/2/17 at 1:10 p.m. LPN-F stated R1 requested a copy of her court paperwork on 1/23/17. LPN-F stated the paperwork indicated R1 had a court hearing for guardianship on 1/24/17. LPN-F stated she reviewed R1's facesheet for contact information on 1/23/17 and the facesheet did not identify a guardian. The resident arranged for a friend to take her to court. The next morning, LPN-F stated she received report from the night nurse around 6:30 a.m. The night nurse reported that Friend-D was coming to escort R1 to a morning court hearing. Friend-D arrived a short time later. Friend-D signed R1 out using the sign out book. Friend-D and R1 left the building.</p> <p>An interview with FM-C was conducted on 2/6/17 at 2:35 p.m. FM-C stated the facility did not contact him regarding the court hearing. FM-C stated the 1/24/17 court date had actually been rescheduled to a later date. FM-C stated he</p>	21850		

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21850	<p>Continued From page 9</p> <p>would not have allowed Friend-D to take R1 out of the facility. FM-C went on to say, he would not have taken R1 out of the facility, as he did not believe once R1 left she would return. FM-C stated since R1 left the facility, he has received one text from R1 stating she was safe and warm. FM-C in unaware of FM-C's whereabouts.</p> <p>An interview with the director of nursing (DON) conducted on 2/2/17 at 10:40 a.m. The DON stated she spoke to Friend-D via the phone at approximately 5:00 p.m. on 1/24/17. The DON stated Friend-D said, upon arriving to the court house, they learned R1 did not have a court hearing scheduled. R1 recognized two men in the waiting area. Friend-D went to the bathroom. When Friend-D returned from the bathroom R1 was gone. Friend-D told the DON court staff said R1 left with the two men. The DON stated at the time of the incident, the facility had no policy directing staff to notify the guardian prior to an appointment.</p> <p>An interview with the executive director was conducted on 2/2/17 at 9:50 a.m. The executive director stated several phone calls were placed over the weekend to reach FM-C, as FM-C needed to sign R1's admission paperwork. The executive director stated staff should not have allowed R1 to leave with Friend-D without FM-C's permission and confirmed staff did not do this. The executive director received text messages from R1, which indicated R1 was out of state and headed to Texas. The executive director notified the police on 1/24/17 at approximately 3:30 p.m. The executive director stated the police received a ping from the resident's phone near Elko Minnesota, but have not been able to locate R1.</p> <p>An interview was attempted with R1 via phone on</p>	21850			

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21850	Continued From page 10 2/7/17 at 3:04 p.m. R1 stated she was safe and ended the call. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review the VA policy and procedures and provide staff education. The director of nursing or designee, could conduct random audits to complete. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850			