P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
September 30, 2019

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: CCN: 245361
Cycle Start Date: September 3, 2019

Dear Administrator:

On September 25, 2019, the Minnesota Department(s) of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 17, 2019

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: Project Number H5361029C

Dear Administrator:

On September 3, 2019, an abbreviated standard 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.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is October 13, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- 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 (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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

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 December 3, 2019 (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 March 3, 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

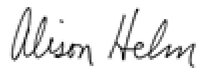
period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 09/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

(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 9/3/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Meeker Manor was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5361029C with a deficiency cited at F689. 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:	F 689		9/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/18/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 1 Based on interview and document review, the facility failed to comprehensively reassess and develop interventions to reduce the risk of elopement for 1 of 3 residents (R1) reviewed who displayed exit seeking behaviors and had sustained previous elopements without harm. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/6/19, identified R1 had moderate cognitive impairment and was independent with locomotion on and off the unit. Further, the MDS identified R1 displayed no wandering behaviors. R1's initial MHM Elopement Risk Evaluation completed 3/6/19, reviewed several factors including R1's history of elopement attempts, mental stability, attitude of placement and mobility. The assessment identified R1 had past attempts of elopement, however, R1 scored a "10" which resulted, "0-14 = No Risk." A section labeled, "Summary & Interventions," identified R1 was not at risk for elopement and listed no specific interventions to prevent repeated attempts to leave the building despite being identified as making an attempt(s) prior. R1's care plan, last reviewed 6/16/19, identified R1 had an alteration in cognition and demonstrated "some confusion," and, "Elopement attempts." The care plan listed several interventions for R1 which included having a "Code Alert" placed due to her attempts to leave the building when confused. R1's progress note(s) were reviewed and identified the following entries:	F 689	Facility will comprehensively reassess and develop interventions for residents at risk of elopement, to reduce risk of elopement. Facility will review careplans of residents who have been identified as at risk for elopement. Education to appropriate staff will be provided to ensure proper assessment and interventions are placed. Audits will be conducted by the IDT weekly x 4, then as needed, on each resident identified as risk for elopement. The DON or designee will be responsible. QAA will provide redirection or change when necessary to ensure completion and or continuation of the monitoring process. 9/27	

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F 689	Continued From page 2	F 689		

On 3/3/19, at 9:42 p.m. R1 attempted to go out the door by the North lobby in attempt to look for the upper floor of the nursing home. A code alert bracelet was placed to her right wrist, and she made no further attempts to leave.

On 3/7/19, at 11:02 p.m. R1 attempted to leave "X 1" on the shift through the North lobby doorway. R1 stated she "...lived across the street and could just walk over."

On 3/12/19, at 11:03 p.m. R1 was recorded, " ... attempted to leave building out South door. She stated she had a car in the parking lot and wanted to drive home. Able to redirect. She did talk to family on the phone and this helped to settle her mood. She made no further attempts to elope."

On 3/15/19, R1 and her husband were found to be smoking outside the facility by the North entrance.

On 4/27/19, at 7:25 a.m. a note was recorded which read, "Early in shift [R1] went to door and proceeded to leave. Alarm went off. [R1] refused to come inside [facility] stated 'no, no I am not coming back in." The note went on, "Night nurse followed in her car repeatedly asking [R1] to please get into her car. This writer walked up to [R1] as she kept walking following her 2 blocks. She continued to refuse to come back. Finally at 2 blocks she agreed to come back. Ativan given [as needed] with good results for anxiety. No further elopement attempts. Door alarm worked as a good intervention."

On 5/6/19, at 8:30 p.m. R1 was spotted outside the facility in the parking lot. R1 stated she was

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F 689	Continued From page 3 "going home" and proceeded to walk away, however, was re-directed and brought back inside the facility. The note outlined, "For some reason code alert did not go off when she went outside but it did go off when [R1] returned back into facility." A subsequent MHM Elopement Risk Evaluation completed 5/7/19, reviewed the same factors as the previous assessment completed on 3/6/19. R1 was now scored "19," however, under a section labeled, "Scoring," the assessment read the same information as the previous assessment, "0-14 = No Risk." Further, the "Summary & Interventions" were listed which included, "Resident is at risk for elopement ... is confused and wanders. Able to ambulate independently. Resident is discontent with stay, although husband requests she stay ... Staff will continue to monitor for elopement events. 1. Wander Guard placed on resident. 2. Monitor whereabouts, redirect as needed. 3. Invite resident to activities and/or provide diversional activities." In addition, R1's most recent MHM Elopement Risk Evaluation completed 6/6/19, identified R1 scored a 19.0 on the assessment which placed her at risk for elopement. The assessment reviewed the same factors as previous assessments, and listed the same three interventions to be completed listed on the previous assessment which read, "1. Wander Guard placed on resident. 2. Monitor whereabouts, redirect as needed. 3. Invite resident to activities and/or provide diversional activities." The assessment lacked any newly assessed or developed interventions to prevent R1's elopement from the facility. On 8/21/19, R1 was discharged from the facility.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 09/03/2019

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F 689	Continued From page 4 When interviewed on 9/3/19, at 9:41 a.m. nursing assistant (NA)-A stated R1 had several elopements during her stay at the nursing home. NA-A stated R1 seemed to have more attempts to elope when she was stressed or not in a "good mood," and added R1 did really well and often did not exit-seek after she smoked with her husband and he left the facility. During interview on 9/3/19, at 9:49 a.m. NA-B expressed R1 enjoyed smoking and would often try to get outside alone to do so. R1's husband would also go out at times with her which R1 enjoyed. NA-B stated she recalled an event where R1 had gotten outside and "down at the driveway" which the staff discovered as they responded to R1's bracelet alarming the door system. R1's medical record was reviewed and lacked evidence R1 had been comprehensibly reassessed to identify and address the ongoing risk of elopement despite having several statements and/or attempts to elope. There was no evidence R1's desire to smoke with or without her husband, nor the circumstances surrounding the pattern of time(s) of the elopements being almost always on later evenings/nights had been accounted for and assessed for possible contributing factors and solutions despite being identified by the staff as potential contributing causes for the repeated attempts to leave the building and go outside. On 9/3/19, at 10:53 a.m. registered nurse manager (RN)-A was interviewed and explained a resident is assessed upon admission for their elopement risk, then afterwards if they are seen	F 689		

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F 689	Continued From page 5 exit-seeking or wandering which could lead to an elopement. If a resident eloped, the nursing staff and administration then review the situation to attempt to figure out "another process" which could help prevent future elopements. RN-A stated the facility was a non-smoking campus and staff were not allowed to sit outside with her while she smoked; however, RN-A acknowledged R1 seemed to be less restless and at risk to elope after she would smoke with her husband outside. RN-A stated the facility had not incorporated the smoking or time(s) of the elopements into their assessments, and added the assessments they complete should be "more in-depth" to help identify factors such as those. RN-A expressed it was important to do a good, comprehensive assessment in order to identify potential triggers and thus help avoid repeated, multiple elopements. A facility policy on elopement assessment and care planning was requested, however, was not provided.	F 689		

Electronically delivered
September 17, 2019

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

Re: State Nursing Home Licensing Orders - Project Number H5361029C

Dear Administrator:

The above facility was surveyed on September 3, 2019 through September 3, 2019 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.

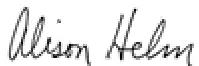
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

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.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775	A. BUILDING: ____ B. WING ____	C 09/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER,	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. State licensing orders are delineated on 2567, under the Minnesota Department of Health	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1	2 000		

licensing order statute(s) being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "Corrected" in the box available for text. You must then indicate on the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting your plan of correction to the Minnesota Department of Health.

On 9/3/19, surveyors from the Minnesota Department of Health (MDH) visited Meeker Manor to conduct a complaint investigation for H5361029C, and the following correction orders were issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775	A. BUILDING: ______ B. WING ______	C 09/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER,	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess and develop interventions to reduce the risk of elopement for 1 of 3 residents (R1) reviewed who displayed exit seeking behaviors and had sustained previous elopements without harm. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/6/19, identified R1 had moderate cognitive impairment and was independent with locomotion on and off the unit. Further, the MDS identified	2 830	Facility will comprehensively reassess and develop interventions for residents at risk of elopement, to reduce risk of elopement. Facility will review careplans of residents who have been identified as at risk for elopement. Education to appropriate staff will be provided to ensure proper assessment and interventions are placed.	9/25/19

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2 830	Continued From page 3 R1 displayed no wandering behaviors. R1's initial MHM Elopement Risk Evaluation completed 3/6/19, reviewed several factors including R1's history of elopement attempts, mental stability, attitude of placement and mobility. The assessment identified R1 had past attempts of elopement, however, R1 scored a "10" which resulted, "0-14 = No Risk." A section labeled, "Summary & Interventions," identified R1 was not at risk for elopement and listed no specific interventions to prevent repeated attempts to leave the building despite being identified as making an attempt(s) prior. R1's care plan, last reviewed 6/16/19, identified R1 had an alteration in cognition and demonstrated "some confusion," and, "Elopement attempts." The care plan listed several interventions for R1 which included having a "Code Alert" placed due to her attempts to leave the building when confused. R1's progress note(s) were reviewed and identified the following entries: On 3/3/19, at 9:42 p.m. R1 attempted to go out the door by the North lobby in attempt to look for the upper floor of the nursing home. A code alert bracelet was placed to her right wrist, and she made no further attempts to leave. On 3/7/19, at 11:02 p.m. R1 attempted to leave "X 1" on the shift through the North lobby doorway. R1 stated she "...lived across the street and could just walk over." On 3/12/19, at 11:03 p.m. R1 was recorded, " ... attempted to leave building out South door. She stated she had a car in the parking lot and wanted to drive home. Able to redirect. She did talk to family on the phone and this helped to settle her mood. She made no further attempts to elope." On 3/15/19, R1 and her husband were found to be smoking outside the facility by the North	2 830	Audits will be conducted by the IDT weekly x 4, then as needed, on each resident identified as risk for elopement. The DON or designee will be responsible. QAA will provide redirection or change when necessary to ensure completion and or continuation of the monitoring process. 9/27	

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2 830	Continued From page 4 entrance. On 4/27/19, at 7:25 a.m. a note was recorded which read, "Early in shift [R1] went to door and proceeded to leave. Alarm went off. [R1] refused to come inside [facility] stated 'no, no I am not coming back in." The note went on, "Night nurse followed in her car repeatedly asking [R1] to please get into her car. This writer walked up to [R1] as she kept walking following her 2 blocks. She continued to refuse to come back. Finally at 2 blocks she agreed to come back. Ativan given [as needed] with good results for anxiety. No further elopement attempts. Door alarm worked as a good intervention." On 5/6/19, at 8:30 p.m. R1 was spotted outside the facility in the parking lot. R1 stated she was "going home" and proceeded to walk away, however, was re-directed and brought back inside the facility. The note outlined, "For some reason code alert did not go off when she went outside but it did go off when [R1] returned back into facility." A subsequent MHM Elopement Risk Evaluation completed 5/7/19, reviewed the same factors as the previous assessment completed on 3/6/19. R1 was now scored "19," however, under a section labeled, "Scoring," the assessment read the same information as the previous assessment, "0-14 = No Risk." Further, the "Summary & Interventions" were listed which included, "Resident is at risk for elopement ... is confused and wanders. Able to ambulate independently. Resident is discontent with stay, although husband requests she stay ... Staff will continue to monitor for elopement events. 1. Wander Guard placed on resident. 2. Monitor whereabouts, redirect as needed. 3. Invite resident to activities and/or provide diversional activities." In addition, R1's most recent MHM Elopement Risk Evaluation completed 6/6/19,	2 830		

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2 830	Continued From page 5	2 830		

identified R1 scored a 19.0 on the assessment which placed her at risk for elopement. The assessment reviewed the same factors as previous assessments, and listed the same three interventions to be completed listed on the previous assessment which read, "1. Wander Guard placed on resident. 2. Monitor whereabouts, redirect as needed. 3. Invite resident to activities and/or provide diversional activities." The assessment lacked any newly assessed or developed interventions to prevent R1's elopement from the facility.

On 8/21/19, R1 was discharged from the facility.

When interviewed on 9/3/19, at 9:41 a.m. nursing assistant (NA)-A stated R1 had several elopements during her stay at the nursing home. NA-A stated R1 seemed to have more attempts to elope when she was stressed or not in a "good mood," and added R1 did really well and often did not exit-seek after she smoked with her husband and he left the facility.

During interview on 9/3/19, at 9:49 a.m. NA-B expressed R1 enjoyed smoking and would often try to get outside alone to do so. R1's husband would also go out at times with her which R1 enjoyed. NA-B stated she recalled an event where R1 had gotten outside and "down at the driveway" which the staff discovered as they responded to R1's bracelet alarming the door system.

R1's medical record was reviewed and lacked evidence R1 had been comprehensibly reassessed to identify and address the ongoing risk of elopement despite having several statements and/or attempts to elope. There was no evidence R1's desire to smoke with or without her husband, nor the circumstances surrounding the pattern of time(s) of the elopements being almost always on later evenings/nights had been accounted for and assessed for possible

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2 830	Continued From page 6 contributing factors and solutions despite being identified by the staff as potential contributing causes for the repeated attempts to leave the building and go outside. On 9/3/19, at 10:53 a.m. registered nurse manager (RN)-A was interviewed and explained a resident is assessed upon admission for their elopement risk, then afterwards if they are seen exit-seeking or wandering which could lead to an elopement. If a resident eloped, the nursing staff and administration then review the situation to attempt to figure out "another process" which could help prevent future elopements. RN-A stated the facility was a non-smoking campus and staff were not allowed to sit outside with her while she smoked; however, RN-A acknowledged R1 seemed to be less restless and at risk to elope after she would smoke with her husband outside. RN-A stated the facility had not incorporated the smoking or time(s) of the elopements into their assessments, and added the assessments they complete should be "more in-depth" to help identify factors such as those. RN-A expressed it was important to do a good, comprehensive assessment in order to identify potential triggers and thus help avoid repeated, multiple elopements. A facility policy on elopement assessment and care planning was requested, however, was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise applicable policies and procedures to ensure comprehensive assessment of elopement risk(s) are being completed and implemented; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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