Electronically delivered

June 2, 2020

Administrator
Crossroads Care Center
965 McMillan Street
Worthington, MN 56187

SUBJECT: SURVEY RESULTS
CCN: 245395
Cycle Start Date: May 14, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 14, 2020, the Minnesota Department of Health completed a complaint investigation and at Crossroads Care Center to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 14, 2020 survey. Crossroads Care Center may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 14, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
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An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;

- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Crossroads Care Center may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	C 05/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	**965 MCMILLAN STREET WORTHINGTON, MN 56187**

(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 5/12/20 through 5/14/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. At the time of the abbreviated survey, an onsite investigation was completed and the following complaint was found to be SUBSTANTIATED: H5395016C with deficiencies cited at F689. The IJ began on 4/27/20, when the facility failed to ensure locked dementia unit windows were secured, which resulted in the elopement of 1 of 1 resident (R1). The facility's lack of securing windows in the dementia unit resulted in Immediate Jeopardy (IJ), for 1 of 1 resident (R!) who was at risk for elopement. The facility's administrator (A) and director of nursing (DON) were notified of the IJ on 3/14/20 at 10:00 a.m.. The immediacy was removed on 5/14/20 at 4:21 p.m. In addition, an extended survey was completed on 5/14/20. 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	F 000		

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

Electronically Signed | 06/08/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 regulations has been attained in accordance with your verification.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 21 windows located in both resident rooms and common areas of the locked unit were secured to prevent elopement, resulting in the elopement of 1 of 1 resident (R1) on two separate occurrences. The facility's lack of intervention insuring safety with regard to open window access resulted in an Immediate Jeopardy (IJ) for R1, with the potential for serious harm, injury, or death. The IJ began on 4/27/20 at 5:00 p.m., when R1 removed a window screen, opened the window and exited falling 4.5 feet to the ground resulting in minors scrapes. Interventions included removal of window cranks from the common areas only and the initiation of 15 minute checks. On 5/9/20 at 11:30 p.m. R1 again exited the facility from a window located in R4's unoccupied room, fell 5 feet to the ground, and sustained minor injuries. He was located by law enforcement 5 blocks from the facility and returned following evaluation in the emergency department. The facility administrator	F 689	This Plan of Correction (POC) constitutes our credible allegation of compliance with the deficiencies cited. It is submitted to meet the requirements established by State and Federal law. 1. Upon return to the facility following R1's elopement the night of 5-9-20, R1's wander guard was checked against the facility's wander guard system. R1's wander guard was found to be functioning properly. 2. Staff were re-educated on elopement and the process to be followed should one occur. 3. The cranks that were on the windows in resident rooms were removed on 5-10-20 ensuring the windows would not be able to be opened until safety devices could be installed on them. Cranks had previously been removed from the	6/8/20

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F 689	Continued From page 2 (A) and director of nursing (DON) were notified of the IJ on 5/14/20 at 10:00 a.m. The IJ was removed on 5/14/20 at 4:21 p.m., but non-compliance remained at the lower scope and severity of D, isolated, no actual harm but the potential for harm that is not immediate jeopardy. Findings include: R1's 4/30/20 admission Minimum Data Set (MDS) identified R1 had severe cognitive impairment with diagnoses which included vascular dementia with behavioral disturbance, anxiety, and agitation. R1 required limited assistance with personal cares, dressing and grooming, but was independent with transfers and ambulation. R1 had daily wandering behavior and exit seeking. The 4/23/20 elopement risk assessment identified R1 as being at risk for elopement. The elopement risk assessment dated 4/27/20 identified R1 as increased risk of elopement from a 7 to 8 (more at risk). R1's 4/24/20, baseline care plan identified he was independent with bed mobility, and ambulation, required limited assist with dressing, personal hygiene, and toileting. Behavior: problems related to dementia, evidenced by paranoia, verbal and/or physical aggression, wandering, and exit seeking. Interventions included: administration of medications as ordered, intervention as necessary. Elopement risk: history of attempts to leave the facility unattended, impaired safety awareness, and wandered aimlessly. A wander guard device was applied to R1's right ankle due to his risk of elopement and exit seeking behavior. The care plan also included ongoing communication and recommendations from the Geripsychiatry	F 689	windows in the common areas of the dementia unit following R1's elopement on 4-27-20. 4. An order was placed for Swisco Casement Sash Stop Devices (#39-398) and installation of the devices on all the windows in the dementia unit was completed on 5-17-20. The devices prevent the windows from being opened more than 4 inches. 5. Audits of the Casement Sash Stop Devices to ensure they are in place and functioning properly will be conducted as follows: 3X per week for 2 weeks, then 2X per week for 2 weeks, then 1X per week for 4 weeks. 6. All audits will be brought to QAPI for determination of compliance or continued monitoring.	

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F 689	Continued From page 3 Program and Behavioral Recovery Outreach Team (BRO) which continued to follow R1 after his discharge from the Veteran's Administration facility in Sioux Falls SD. R1's Progress Notes identified the following. 1) 4/23/20 at 11:00 a.m., R1 arrived at approximately 10:15 a.m. Wander guard applied to right ankle. Resident is exit seeking and attempted to go through exit doors shortly after his arrival. 2) 4/23/20 through 4/24/20 R1 attempted to leave the unit, looked for exit doors and a couple of times was able to open the exit door connecting the unit to the South unit. 3) 4/24/20 at 10:22 p.m., R1 demonstrated behaviors through shift of wanting to go home, was short tempered, and pushed staff if thought they were in his way. R1 went through the South door which was wander guarded by pressing and holding the release bar for 15 seconds and became aggressive when staff attempted redirection. After walking the length of the hall staff were able to redirect R1 back into the locked unit. 4) 4/25/20 5:01 a.m., R1 very restless, wandering the halls all night. R1 brought all his clothes from his room to the day room, asked multiple times to have his wanderguard taken off and to get a ride to leave. At 4:00 a.m. he again pushed open the exit door to enter the South unit, the wander guard alarm sounded, and he began entering resident rooms on the South hall. Was redirected back to the locked unit by staff. 5) 4/25/20 through 4/26/20, R1 continued to attempt to make attempts to leave the facility by pushing and holding the bar on the alarmed door until it released and he was able to enter the South unit.	F 689		

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F 689	Continued From page 4 6) 4/27/20 at 5:33 a.m., R1 wandered in the halls during the night. Attempted to open a window in the day room, but staff were able to redirect. 7) 4/27/20 at 5:15 p.m., a call was received from a neighbor that a resident might be outside the facility. Staff immediately responded and upon re-entry R1 was able to show nursing assistant (NA)-A where and how he had exited the facility through the widow in the East lounge. Provider updated and a one time order for Haldol (antipsychotic) 0.5 milligram (mg) intramuscular (IM) received for agitation. R1's elopement risk and care plan were updated. Review of the incident tracking report dated 4/27/20 at 6:11 p.m., identified R1 had a wander guard device in place on his right ankle, which did activate the door alarm when he returned to the building, but due to exiting via a window in the East lounge no alarms were activated. Upon return to the facility R1 was able to demonstrate to staff how he had removed the screen, opened the window with the crank and exited the facility. Interventions included removal of window cranks from common area windows, and 15 minute checks when not in the common areas. When in the common areas staff were present and able to provide ongoing monitoring. Appropriate notifications were documented. Review of the incident report on 5/9/20 at 11:15 p.m., identified R1 was observed going into his room, at 11:30 p.m. the 15 minute checks revealed R1 was not in his room, and the initial search revealed the window in R4's room had the screen removed and the window open. The distance from the window sill to the ground was measured at 5 feet. Initiation of a "CODE GREEN" (missing resident) resulted in a search	F 689		

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of the facility and grounds for R1. A shoe was found on the ground outside the open window, and R1 was not located. 911 was called, and appropriate notifications made, and at 12:09 a.m. R1 was located by law enforcement about 5 blocks from the facility. The police report identified R1 was shivering, wearing only one shoe, had bruising and skin tears on his right forearm and slight swelling of his left foot and ankle. Law enforcement notified the facility R1 had been located and was being transferred to the emergency department for further evaluation and treatment. On 5/10/20 at 4:39 a.m. R1 returned to the facility via emergency medical transport and interventions included assessments for pain, vital signs and continuous monitoring by having him remain in a recliner in the main lounge to allow for continuous monitoring by staff. The 1:1 observation continued until 5/10/20 at 9:00 a.m. when the administrator (A) arrived and removed window cranks from all windows on the locked dementia unit. One window crank was left in the medication cart to allow staff to open a resident's window if needed.

Review of the National Weather Service website identified the temperature at 11:30 p.m. on 5/9/20 at 64/31 Fahrenheit (Fé) and on 5/10/20 as 44/33 Fé.

R1's elopement risk assessment on 5/10/20 at 10:52 a.m. identified a risk for elopement with interventions which included: personal safety alarm, exit alarm, secure unit placement, frequent monitoring, behavior log and analysis, medication review, activities of interest, staff is aware of elopement risk. The Care Plan was updated to reflect the listed interventions.

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F 689	Continued From page 6 Further review of R1's progress notes identified: 1) 4/28/20 at 1:15 p.m. R1's elopement reviewed at ID. All interventions in place. MD report filed. 2) 4/28/20 at 10:14 p.m., New order for dispersion (antipsychotic) 0.5 milligram (mg) by mouth (PO) twice daily (BID) and 0.5 mg PO BID as needed (PRN). 3) 4/29/20 at 11:00 a.m. R1 attempting to leave unit via South alarmed door and held bar until door released, and staff accompanied R1 to end of hall. 4) 4/29/20 at 9:23 p.m., R1 wandering on unit and attempted to leave several times. 1:1 monitoring most of shift. 5) 4/30/20 at 10:40 a.m., meeting with Geripsychiatry Program and Behavioral Recovery Outreach Team (BRO) from the Veterans Administration (continuing to work with R1 as an outpatient). The team made suggestions to decrease his behaviors in addition to suggesting non-pharmacological activities to keep R1 busy. No medication changes were recommended at the time of meeting. 6) 5/1/20 at 12:21 p.m., R1 received PRN dose of risperdone for severe agitation, increased anxiety, restless, and behaviors. 7) 5/2/20 at 1:36 p.m., R1 observed holding wander guard device in his hand and placing in his pocket. Closer inspection identified it had been removed by breaking off the ends which attach the device to the band. The ends appeared to have been cut and search of R1's room identified a wire cutter lying on the shelf in his closet. R1 became upset when staff attempted to apply a new wander guard. Staff continued the 15 minute checks until later in the evening when a new wander guard was able to be applied to R1's ankle. R1 continued to wander between his room and the East lounge.	F 689		

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F 689	Continued From page 7 8) 5/2/20 at 10:04 p.m., note: 3:30 p.m., R1 came out of his room upset over new wander guard being applied and looked for something to cut off device. He went to the South unit by depressing the bar on the South door until it released and was not able to be redirected. He attempted to open the windows and indicated he wanted to jump out. Nursing assistant (NA)- A was able to bring R1 back to the East unit per wheelchair after talking and redirecting him. 9) 5/3/20 at 10:40 p.m., R1 left locked unit entering South unit, after pushing nurse aside. He walked to the end of the South hall and sat in the living area. Was returned to the East unit with difficulty. 1:1 provided for a period and continued on 15 minutes checks. 10) 5/3/20 - 5/7/20 a.m. continued with needing intermittent doses of risperdone for agitation, and anxiety. On 5/7/20 at 10:07 p.m. R1 exited onto South hall via alarmed door and attempted to exit via the elevator. After a period of time was brought back to locked unit via wheelchair. 11) 5/9/20 at 1:26 p.m. R1 pleasant and no attempts to leave unit, but asked staff to take him home. 9:18 p.m. note: after supper R1 walking around and in other resident rooms, trying to open windows. Redirected to Day Room and after couple of minutes he returned to an unidentified resident room and attempted to open the window. Immediate intervention implemented was 1:1 monitoring from 6:00 p.m. - 9:00 p.m.. 12) 5/10/20 at 3:40 a.m. RN-C received a telephone call from the emergency department to update the facility on R1's status and that he would be returning via ambulance. On 5/10/20 at 4:40 a.m., R1 returned to facility. Notification of the incident and deposition was documented along with a summary of the events which had taken place. Follow R1's return he remained in a	F 689		

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recliner and had 1:1 monitoring through out the remainder of the night.

Interview on 5/12/20 at 10:00 a.m., with the director of nursing identified R1 had eloped from the facility on two separate dates, 4/27/20 and 5/9/20. On 4/27/20 at 5:00 - 5:15 p.m. R1 eloped from the facility through a window in the East lounge and had been intercepted before leaving the grounds. He received minor scrapes on his forearms, but no serious injury. Immediate intervention was removal of the window cranks in the common areas and initiation of 15 minute checks when R1 was not in the common areas which were monitored by staff. On 5/9/20 at 11:30 p.m., R1 exited from the window in R4's room after he removed the window screen, opening the window with the attached crank, and exited the building. R1 was not able to be located at the 11:30 p.m. check and 911 was activated. R1 was located by law enforcement about 5 blocks from the facility and taken to the emergency room for evaluation and treatment of bruising and skin tears on his right forearm. R1 returned to the facility on 5/10/20 at 4:00 a.m. and remained on continuous observation until the next morning when window cranks were removed from all windows on the locked unit. Appropriate notifications were made following the incident. The DON identified an elopement assessment, pain assessment, and monitoring of vital signs were completed following R1's return to the facility. In addition, wander guard devices were checked for functioning on an every shift basis and documented. Doors are also equipped with wander guard alarms and key pad access.

Interview on 5/12/20 at 11:15 a.m., with the administrator (A) identified he had been notified

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on 5/9/20 at 11:45 p.m. of R1's elopement and return to the facility. He identified he had responded to the facility immediately on 5/10/20 at 9:00 a.m. and removed all of the window cranks from the windows on the locked dementia unit.

Interview on 5/12/20 at 1:45 p.m., with registered nurse (RN)-A identified she worked primarily the day shift. R1 spent most of his time in the main lounge area where he was able to be observed. She was aware of the incidents of R1 eloping, and was on 15 minute checks in addition to his wander guard checked every shift. R1 went to the alarmed doors occasionally, but the alarm would sound and staff responded and redirected him. RN-A denied any observations of R1 attempting to remove screens from the windows while she was working.

Interview on 5/12/20 at 4:15 p.m., with NA-B identified she was working on 4/27/20 when R1 had exited through the window in the East lounge. She indicated she had been working with another resident when the code green had been paged and had responded to assist in the search. She denied hearing any alarms which would have indicated a resident had possibly exited through one of the alarmed doors and when she got outside R1 was seated on the steps in front of the building. After coming back into the building NA-A asked R1 how he had exited and he pointed to the window. This was reported to the nurse on duty and the cranks were removed from the windows in the common areas. NA-B identified R1 knew how to open the windows as he would ask staff where the cranks were located. She indicated staff replied by answering they did not know and attempted to divert his

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	245395	A. BUILDING _____ B. WING _____	C 05/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	**965 MCMILLAN STREET WORTHINGTON, MN 56187**

(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
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attention by offering food and drink and also 1:1 visiting and diversion.

Interview on 5/12/20 at 4:30 p.m, with NA-A identified he had worked on the South hall on 4/27/20, and was told R1 had gotten out of the building. He identified he had a good relationship with R1 and responded to assist. He observed RN-B and the DON walking with R1 as they attempted to redirect him back to the building. NA-A indicated he had retrieved a wheelchair and gone to assist in bringing R1 back to the facility. R1 was agitated and attempting to find something, (not certain what looking for), he became excited when he saw NA-A and went back to the facility with him. Upon arrival back on the locked unit, NA-A asked R1 how he had left the facility, and R1 motioned NA-A to follow him and proceeded to take NA-A to the window in the East lounge that was open and the screen leaning against the wall. The immediate intervention was the removal of window cranks in the common areas.

Interview on 5/12/20 at 4:40 p.m., with RN-B identified she was the charge nurse working on the locked unit on the afternoon of 4/27/20. R1 had been anxious and she had provided a lot of 1:1 and diversional activity. She identified he was exit seeking, going to doors, and had figured out how to activate the code box to open the door, but he was not aware of the code. At that time R1 had not discovered the doors would release after 15 seconds of continuous pressure, so when they did not release he turned away. RN-B identified she knew his wander guard was functioning as he had been close to the doors and activated the alarm. RN-B identified she had observed R1 walk toward the East lounge, but

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had no reason to be concerned. RN-B identified after approximately 5 minutes the phone rang with a neighbor who reported a resident outside the building. RN-B went to check R1's location due to his exit seeking behavior and as she passed the DON office requested her to page a Code Green. The alarmed door in the East lounge was not alarming at that time, but did sound when she exited to look for R1. The door located at the bottom of the stairs exiting the building also alarmed as she exited and ran toward Clary street where the neighbor reported the resident. As she rounded corner of the building she observed R1 standing with the neighbor, on the facility lawn. The DON and additional staff persons also responded to the scene. R1 was mad and refused to return to the building and began walking accompanied by RN-B and the DON. NA-A arrived with a wheelchair and R1 was happy to see him and returned to the facility with him. R1 was upset that he had to return to the facility and became combative toward staff close to him. Once in facility, R1 assessed for injury and had no visible injuries other than a few slight scrapes on his forearms. NA-A identified he had asked R1 how he had exited the facility and R1 motioned him to follow as he lead him to the window in the East lounge where the window was open and screen prompted against the wall. The DON was updated and the intervention was to remove the window cranks in common areas in addition to R1 being placed on 15 min checks. The provider updated of the incident and ordered a one time dose of Haldol IM. Through out the remainder of the shift R1 continued exit seeking but was calmer and had decreased anxiety and agitation. At shift change, R1 was observed walking to the West lobby area and removing window screens,

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but cranks had been removed, so he was not able to open the windows. The night staff intervened with diversional activity which was effective. RN-B identified she was not aware of R1 attempting to exit through the window in his room, or the rational for removing the crank. She confirmed R1 had remained on 15 minute checks since that time. She identified at some point R1 had obtained a wire cutter and cut off his wander guard bracelet. She identified this was discovered when R1 was observed removing the wander guard from his pocket and looking at it. RN-B denied any knowledge of how R1 had obtained a wire cutter, as this was not something normally found on the unit. R1 did have the wander guard reapplied and a search of his room did not reveal any additional tools that could be utilized to remove his wanderguard or exit the facility.

Interview on 5/12/20 at 5:00 p.m., with the DON identified the unit had been searched and no additional tools were discovered and no one was aware of how R1 obtained the wire cutter, but as a precaution, maintenance no longer was to bring a cart containing tools onto the unit. R1 had discovered the 15 second pressure delay on the egress doors, and had attempted to exit to the South unit, but staff were aware and intervened with redirection. The DON identified the facility was working to develop additional interventions with 1:1 monitoring in an attempt to allow R1 to go outside as the weather improved. She identified the window crank had been removed from R1's room on 4/27/20 at 11:00 a.m. due to his opening the window and leaving it open which resulted in other residents complaining of being cold. She stated he had made no attempt to remove the screen at that time.

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F 689	Continued From page 13 Interview on 5/12/20 at 5:15 p.m., with RN-C identified she had worked on 5/9/20 when R1 had eloped through the window in R4's room. She identified R1 had spent most of the evening in the main lounge watching TV. She identified she had last observed R1 at 11:00 p.m. seated in a recliner in the main lounge watching TV. She had exited to the South unit to give report and at 11:30 p.m. she was notified R1 was missing, and the screen was off the window and window was open in R4's room. RN-C immediately notified staff to initiate a search of all areas in the facility and outside surrounding the building. Upon investigation RN-C identified R1 had gone to his room at 11:15 p.m. and when NA-C went to do the 11:30 p.m. he was not located. The building was searched, a CODE GREEN was activated, all other residents were accounted for. A loafer type shoe was found outside the window, the DON, administrator (A) and law enforcement were notified of R1 missing from the facility. R1 was found by law enforcement at 12:09 a.m., wearing an army hat, gray sweater and maroon pants, and one loafer. The weather was cool and damp, but she was uncertain of the temperature on that night. At 12:15 a.m., law enforcement notified the facility R1 had been located and was being transported to the emergency room for evaluation of scrapes, bruises and to be assessed for any additional injuries. Received update from nurse at hospital on R1's status and he returned about 4:00 a.m., via ambulance. R1 was monitored in the main lounge area the remainder of the night following assessment of vital signs and pain assessment. Upon his return R1 received every 15 minute checks and verification his wander guard was in place and functioning. R1 was alert and not happy at	F 689		

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F 689	Continued From page 14	F 689		

having to return to the facility. He was able to move all extremities and denied any pain or discomfort. Upon return R1's left wrist was wrapped with coban and his right forearm wrapped with kerlix due to a skin tear on his right forearm and swelling in the left wrist.

Interview on 5/13/20 at 9:00 a.m., with the DON identified only the window cranks located on windows in the common areas were removed following the 4/27/20 incident due to R1 not having a history of entering other resident rooms that she was aware of, and she had not wanted to violate other resident's rights to open their windows at will.

Interview on 5/14/20 at 8:17 a.m., with the maintenance director identified he was not aware of an incident prior to R1's elopement of a resident able to remove the clips holding the screens in place and having the ability to get up and out of a window. He identified he was not aware of how much force it would require to force a window open without using the crank to open it.

On 5/14/20 at 10:30 a.m. the medical director was interviewed and voiced knowledge of R1's two elopements from the facility and was surprised R1 had been able to exit the facility through the window on two occasions. He identified R1 was at risk for serious injury with his comorbidities including age and falling from four to five feet to the ground. He identified his expectation of the facility had been to assess all residents admitted, insure safety measures were in place and to incorporate interventions for areas of concern.

Review of the 10/15/18 policy: Elopements:

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F 689	Continued From page 15 Superior Healthcare Management Minnesota Region: Identified all residents were to be screened both upon admission and annually for significant changes and the potential of elopement on an elopement assessment. This has primary importance for residents with cognitive issues, those that state they are leaving, family concerns of safety related to exit seeking behavior, those that exhibit depression about placement in the facility and indicate intent to leave. Based on assessment a resident may be placed on routine safety checks or have a wander guard for safety. The IJ that began on 4/27/20 at 5:00 p.m, was removed on 5/14/20 at 4:20 p.m., when it could be verified the facility had secured all windows on the locked unit, and had developed and implemented all staff education on policies and procedures for elopement and safety measures. In addition, it was verified the facility had implemented immediate intervention by removal of all window cranks from the secure unit and educating staff that windows were to remain closed until the ordered additional window security devices could be installed.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 2, 2020

Administrator
Crossroads Care Center
965 McMillan Street
Worthington, MN 56187

Re: Event ID: S53T11

Dear Administrator:

The above facility survey was completed on May 14, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

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	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/12/20 through 5/14/20, surveyors of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaint: H5395016C. The complaint was found to be SUBSTANTIATED, with NO licensing orders issued.	2 000		

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

Electronically Signed | 06/08/20

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

Electronically delivered

June 2, 2020

Administrator
Crossroads Care Center
965 McMillan Street
Worthington, MN 56187

SUBJECT: SURVEY RESULTS
CCN: 245395
Cycle Start Date: May 14, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 14, 2020, the Minnesota Department of Health completed a complaint investigation and at Crossroads Care Center to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 14, 2020 survey. Crossroads Care Center may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 14, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;

- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Crossroads Care Center may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

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

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 000	INITIAL COMMENTS On 5/12/20 through 5/14/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. At the time of the abbreviated survey, an onsite investigation was completed and the following complaint was found to be SUBSTANTIATED: H5395016C with deficiencies cited at F689. The IJ began on 4/27/20, when the facility failed to ensure locked dementia unit windows were secured, which resulted in the elopement of 1 of 1 resident (R1). The facility's lack of securing windows in the dementia unit resulted in Immediate Jeopardy (IJ), for 1 of 1 resident (R!) who was at risk for elopement. The facility's administrator (A) and director of nursing (DON) were notified of the IJ on 3/14/20 at 10:00 a.m.. The immediacy was removed on 5/14/20 at 4:21 p.m. In addition, an extended survey was completed on 5/14/20. 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	F 000		

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

Electronically Signed | 06/08/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 regulations has been attained in accordance with your verification.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 21 windows located in both resident rooms and common areas of the locked unit were secured to prevent elopement, resulting in the elopement of 1 of 1 resident (R1) on two separate occurrences. The facility's lack of intervention insuring safety with regard to open window access resulted in an Immediate Jeopardy (IJ) for R1, with the potential for serious harm, injury, or death. The IJ began on 4/27/20 at 5:00 p.m., when R1 removed a window screen, opened the window and exited falling 4.5 feet to the ground resulting in minors scrapes. Interventions included removal of window cranks from the common areas only and the initiation of 15 minute checks. On 5/9/20 at 11:30 p.m. R1 again exited the facility from a window located in R4's unoccupied room, fell 5 feet to the ground, and sustained minor injuries. He was located by law enforcement 5 blocks from the facility and returned following evaluation in the emergency department. The facility administrator	F 689	This Plan of Correction (POC) constitutes our credible allegation of compliance with the deficiencies cited. It is submitted to meet the requirements established by State and Federal law. 1. Upon return to the facility following R1's elopement the night of 5-9-20, R1's wander guard was checked against the facility's wander guard system. R1's wander guard was found to be functioning properly. 2. Staff were re-educated on elopement and the process to be followed should one occur. 3. The cranks that were on the windows in resident rooms were removed on 5-10-20 ensuring the windows would not be able to be opened until safety devices could be installed on them. Cranks had previously been removed from the	6/8/20

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F 689	Continued From page 2 (A) and director of nursing (DON) were notified of the IJ on 5/14/20 at 10:00 a.m. The IJ was removed on 5/14/20 at 4:21 p.m., but non-compliance remained at the lower scope and severity of D, isolated, no actual harm but the potential for harm that is not immediate jeopardy. Findings include: R1's 4/30/20 admission Minimum Data Set (MDS) identified R1 had severe cognitive impairment with diagnoses which included vascular dementia with behavioral disturbance, anxiety, and agitation. R1 required limited assistance with personal cares, dressing and grooming, but was independent with transfers and ambulation. R1 had daily wandering behavior and exit seeking. The 4/23/20 elopement risk assessment identified R1 as being at risk for elopement. The elopement risk assessment dated 4/27/20 identified R1 as increased risk of elopement from a 7 to 8 (more at risk). R1's 4/24/20, baseline care plan identified he was independent with bed mobility, and ambulation, required limited assist with dressing, personal hygiene, and toileting. Behavior: problems related to dementia, evidenced by paranoia, verbal and/or physical aggression, wandering, and exit seeking. Interventions included: administration of medications as ordered, intervention as necessary. Elopement risk: history of attempts to leave the facility unattended, impaired safety awareness, and wandered aimlessly. A wander guard device was applied to R1's right ankle due to his risk of elopement and exit seeking behavior. The care plan also included ongoing communication and recommendations from the Geripsychiatry	F 689	windows in the common areas of the dementia unit following R1's elopement on 4-27-20. 4. An order was placed for Swisco Casement Sash Stop Devices (#39-398) and installation of the devices on all the windows in the dementia unit was completed on 5-17-20. The devices prevent the windows from being opened more than 4 inches. 5. Audits of the Casement Sash Stop Devices to ensure they are in place and functioning properly will be conducted as follows: 3X per week for 2 weeks, then 2X per week for 2 weeks, then 1X per week for 4 weeks. 6. All audits will be brought to QAPI for determination of compliance or continued monitoring.	

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F 689	Continued From page 3 Program and Behavioral Recovery Outreach Team (BRO) which continued to follow R1 after his discharge from the Veteran's Administration facility in Sioux Falls SD. R1's Progress Notes identified the following. 1) 4/23/20 at 11:00 a.m., R1 arrived at approximately 10:15 a.m. Wander guard applied to right ankle. Resident is exit seeking and attempted to go through exit doors shortly after his arrival. 2) 4/23/20 through 4/24/20 R1 attempted to leave the unit, looked for exit doors and a couple of times was able to open the exit door connecting the unit to the South unit. 3) 4/24/20 at 10:22 p.m., R1 demonstrated behaviors through shift of wanting to go home, was short tempered, and pushed staff if thought they were in his way. R1 went through the South door which was wander guarded by pressing and holding the release bar for 15 seconds and became aggressive when staff attempted redirection. After walking the length of the hall staff were able to redirect R1 back into the locked unit. 4) 4/25/20 5:01 a.m., R1 very restless, wandering the halls all night. R1 brought all his clothes from his room to the day room, asked multiple times to have his wanderguard taken off and to get a ride to leave. At 4:00 a.m. he again pushed open the exit door to enter the South unit, the wander guard alarm sounded, and he began entering resident rooms on the South hall. Was redirected back to the locked unit by staff. 5) 4/25/20 through 4/26/20, R1 continued to attempt to make attempts to leave the facility by pushing and holding the bar on the alarmed door until it released and he was able to enter the South unit.	F 689		

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F 689	Continued From page 4 6) 4/27/20 at 5:33 a.m., R1 wandered in the halls during the night. Attempted to open a window in the day room, but staff were able to redirect. 7) 4/27/20 at 5:15 p.m., a call was received from a neighbor that a resident might be outside the facility. Staff immediately responded and upon re-entry R1 was able to show nursing assistant (NA)-A where and how he had exited the facility through the widow in the East lounge. Provider updated and a one time order for Haldol (antipsychotic) 0.5 milligram (mg) intramuscular (IM) received for agitation. R1's elopement risk and care plan were updated. Review of the incident tracking report dated 4/27/20 at 6:11 p.m., identified R1 had a wander guard device in place on his right ankle, which did activate the door alarm when he returned to the building, but due to exiting via a window in the East lounge no alarms were activated. Upon return to the facility R1 was able to demonstrate to staff how he had removed the screen, opened the window with the crank and exited the facility. Interventions included removal of window cranks from common area windows, and 15 minute checks when not in the common areas. When in the common areas staff were present and able to provide ongoing monitoring. Appropriate notifications were documented. Review of the incident report on 5/9/20 at 11:15 p.m., identified R1 was observed going into his room, at 11:30 p.m. the 15 minute checks revealed R1 was not in his room, and the initial search revealed the window in R4's room had the screen removed and the window open. The distance from the window sill to the ground was measured at 5 feet. Initiation of a "CODE GREEN" (missing resident) resulted in a search	F 689		

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of the facility and grounds for R1. A shoe was found on the ground outside the open window, and R1 was not located. 911 was called, and appropriate notifications made, and at 12:09 a.m. R1 was located by law enforcement about 5 blocks from the facility. The police report identified R1 was shivering, wearing only one shoe, had bruising and skin tears on his right forearm and slight swelling of his left foot and ankle. Law enforcement notified the facility R1 had been located and was being transferred to the emergency department for further evaluation and treatment. On 5/10/20 at 4:39 a.m. R1 returned to the facility via emergency medical transport and interventions included assessments for pain, vital signs and continuous monitoring by having him remain in a recliner in the main lounge to allow for continuous monitoring by staff. The 1:1 observation continued until 5/10/20 at 9:00 a.m. when the administrator (A) arrived and removed window cranks from all windows on the locked dementia unit. One window crank was left in the medication cart to allow staff to open a resident's window if needed.

Review of the National Weather Service website identified the temperature at 11:30 p.m. on 5/9/20 at 64/31 Fahrenheit (Fé) and on 5/10/20 as 44/33 Fé.

R1's elopement risk assessment on 5/10/20 at 10:52 a.m. identified a risk for elopement with interventions which included: personal safety alarm, exit alarm, secure unit placement, frequent monitoring, behavior log and analysis, medication review, activities of interest, staff is aware of elopement risk. The Care Plan was updated to reflect the listed interventions.

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F 689	Continued From page 6 Further review of R1's progress notes identified: 1) 4/28/20 at 1:15 p.m. R1's elopement reviewed at ID. All interventions in place. MD report filed. 2) 4/28/20 at 10:14 p.m., New order for dispersion (antipsychotic) 0.5 milligram (mg) by mouth (PO) twice daily (BID) and 0.5 mg PO BID as needed (PRN). 3) 4/29/20 at 11:00 a.m. R1 attempting to leave unit via South alarmed door and held bar until door released, and staff accompanied R1 to end of hall. 4) 4/29/20 at 9:23 p.m., R1 wandering on unit and attempted to leave several times. 1:1 monitoring most of shift. 5) 4/30/20 at 10:40 a.m., meeting with Geripsychiatry Program and Behavioral Recovery Outreach Team (BRO) from the Veterans Administration (continuing to work with R1 as an outpatient). The team made suggestions to decrease his behaviors in addition to suggesting non-pharmacological activities to keep R1 busy. No medication changes were recommended at the time of meeting. 6) 5/1/20 at 12:21 p.m., R1 received PRN dose of risperdone for severe agitation, increased anxiety, restless, and behaviors. 7) 5/2/20 at 1:36 p.m., R1 observed holding wander guard device in his hand and placing in his pocket. Closer inspection identified it had been removed by breaking off the ends which attach the device to the band. The ends appeared to have been cut and search of R1's room identified a wire cutter lying on the shelf in his closet. R1 became upset when staff attempted to apply a new wander guard. Staff continued the 15 minute checks until later in the evening when a new wander guard was able to be applied to R1's ankle. R1 continued to wander between his room and the East lounge.	F 689		

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F 689	Continued From page 7 8) 5/2/20 at 10:04 p.m., note: 3:30 p.m., R1 came out of his room upset over new wander guard being applied and looked for something to cut off device. He went to the South unit by depressing the bar on the South door until it released and was not able to be redirected. He attempted to open the windows and indicated he wanted to jump out. Nursing assistant (NA)- A was able to bring R1 back to the East unit per wheelchair after talking and redirecting him. 9) 5/3/20 at 10:40 p.m., R1 left locked unit entering South unit, after pushing nurse aside. He walked to the end of the South hall and sat in the living area. Was returned to the East unit with difficulty. 1:1 provided for a period and continued on 15 minutes checks. 10) 5/3/20 - 5/7/20 a.m. continued with needing intermittent doses of risperdone for agitation, and anxiety. On 5/7/20 at 10:07 p.m. R1 exited onto South hall via alarmed door and attempted to exit via the elevator. After a period of time was brought back to locked unit via wheelchair. 11) 5/9/20 at 1:26 p.m. R1 pleasant and no attempts to leave unit, but asked staff to take him home. 9:18 p.m. note: after supper R1 walking around and in other resident rooms, trying to open windows. Redirected to Day Room and after couple of minutes he returned to an unidentified resident room and attempted to open the window. Immediate intervention implemented was 1:1 monitoring from 6:00 p.m. - 9:00 p.m.. 12) 5/10/20 at 3:40 a.m. RN-C received a telephone call from the emergency department to update the facility on R1's status and that he would be returning via ambulance. On 5/10/20 at 4:40 a.m., R1 returned to facility. Notification of the incident and deposition was documented along with a summary of the events which had taken place. Follow R1's return he remained in a	F 689		

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recliner and had 1:1 monitoring through out the remainder of the night.

Interview on 5/12/20 at 10:00 a.m., with the director of nursing identified R1 had eloped from the facility on two separate dates, 4/27/20 and 5/9/20. On 4/27/20 at 5:00 - 5:15 p.m. R1 eloped from the facility through a window in the East lounge and had been intercepted before leaving the grounds. He received minor scrapes on his forearms, but no serious injury. Immediate intervention was removal of the window cranks in the common areas and initiation of 15 minute checks when R1 was not in the common areas which were monitored by staff. On 5/9/20 at 11:30 p.m., R1 exited from the window in R4's room after he removed the window screen, opening the window with the attached crank, and exited the building. R1 was not able to be located at the 11:30 p.m. check and 911 was activated. R1 was located by law enforcement about 5 blocks from the facility and taken to the emergency room for evaluation and treatment of bruising and skin tears on his right forearm. R1 returned to the facility on 5/10/20 at 4:00 a.m. and remained on continuous observation until the next morning when window cranks were removed from all windows on the locked unit. Appropriate notifications were made following the incident. The DON identified an elopement assessment, pain assessment, and monitoring of vital signs were completed following R1's return to the facility. In addition, wander guard devices were checked for functioning on an every shift basis and documented. Doors are also equipped with wander guard alarms and key pad access.

Interview on 5/12/20 at 11:15 a.m., with the administrator (A) identified he had been notified

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on 5/9/20 at 11:45 p.m. of R1's elopement and return to the facility. He identified he had responded to the facility immediately on 5/10/20 at 9:00 a.m. and removed all of the window cranks from the windows on the locked dementia unit.

Interview on 5/12/20 at 1:45 p.m., with registered nurse (RN)-A identified she worked primarily the day shift. R1 spent most of his time in the main lounge area where he was able to be observed. She was aware of the incidents of R1 eloping, and was on 15 minute checks in addition to his wander guard checked every shift. R1 went to the alarmed doors occasionally, but the alarm would sound and staff responded and redirected him. RN-A denied any observations of R1 attempting to remove screens from the windows while she was working.

Interview on 5/12/20 at 4:15 p.m., with NA-B identified she was working on 4/27/20 when R1 had exited through the window in the East lounge. She indicated she had been working with another resident when the code green had been paged and had responded to assist in the search. She denied hearing any alarms which would have indicated a resident had possibly exited through one of the alarmed doors and when she got outside R1 was seated on the steps in front of the building. After coming back into the building NA-A asked R1 how he had exited and he pointed to the window. This was reported to the nurse on duty and the cranks were removed from the windows in the common areas. NA-B identified R1 knew how to open the windows as he would ask staff where the cranks were located. She indicated staff replied by answering they did not know and attempted to divert his

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attention by offering food and drink and also 1:1 visiting and diversion.

Interview on 5/12/20 at 4:30 p.m, with NA-A identified he had worked on the South hall on 4/27/20, and was told R1 had gotten out of the building. He identified he had a good relationship with R1 and responded to assist. He observed RN-B and the DON walking with R1 as they attempted to redirect him back to the building. NA-A indicated he had retrieved a wheelchair and gone to assist in bringing R1 back to the facility. R1 was agitated and attempting to find something, (not certain what looking for), he became excited when he saw NA-A and went back to the facility with him. Upon arrival back on the locked unit, NA-A asked R1 how he had left the facility, and R1 motioned NA-A to follow him and proceeded to take NA-A to the window in the East lounge that was open and the screen leaning against the wall. The immediate intervention was the removal of window cranks in the common areas.

Interview on 5/12/20 at 4:40 p.m., with RN-B identified she was the charge nurse working on the locked unit on the afternoon of 4/27/20. R1 had been anxious and she had provided a lot of 1:1 and diversional activity. She identified he was exit seeking, going to doors, and had figured out how to activate the code box to open the door, but he was not aware of the code. At that time R1 had not discovered the doors would release after 15 seconds of continuous pressure, so when they did not release he turned away. RN-B identified she knew his wander guard was functioning as he had been close to the doors and activated the alarm. RN-B identified she had observed R1 walk toward the East lounge, but

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had no reason to be concerned. RN-B identified after approximately 5 minutes the phone rang with a neighbor who reported a resident outside the building. RN-B went to check R1's location due to his exit seeking behavior and as she passed the DON office requested her to page a Code Green. The alarmed door in the East lounge was not alarming at that time, but did sound when she exited to look for R1. The door located at the bottom of the stairs exiting the building also alarmed as she exited and ran toward Clary street where the neighbor reported the resident. As she rounded corner of the building she observed R1 standing with the neighbor, on the facility lawn. The DON and additional staff persons also responded to the scene. R1 was mad and refused to return to the building and began walking accompanied by RN-B and the DON. NA-A arrived with a wheelchair and R1 was happy to see him and returned to the facility with him. R1 was upset that he had to return to the facility and became combative toward staff close to him. Once in facility, R1 assessed for injury and had no visible injuries other than a few slight scrapes on his forearms. NA-A identified he had asked R1 how he had exited the facility and R1 motioned him to follow as he lead him to the window in the East lounge where the window was open and screen prompted against the wall. The DON was updated and the intervention was to remove the window cranks in common areas in addition to R1 being placed on 15 min checks. The provider updated of the incident and ordered a one time dose of Haldol IM. Through out the remainder of the shift R1 continued exit seeking but was calmer and had decreased anxiety and agitation. At shift change, R1 was observed walking to the West lobby area and removing window screens,

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but cranks had been removed, so he was not able to open the windows. The night staff intervened with diversional activity which was effective. RN-B identified she was not aware of R1 attempting to exit through the window in his room, or the rational for removing the crank. She confirmed R1 had remained on 15 minute checks since that time. She identified at some point R1 had obtained a wire cutter and cut off his wander guard bracelet. She identified this was discovered when R1 was observed removing the wander guard from his pocket and looking at it. RN-B denied any knowledge of how R1 had obtained a wire cutter, as this was not something normally found on the unit. R1 did have the wander guard reapplied and a search of his room did not reveal any additional tools that could be utilized to remove his wanderguard or exit the facility.

Interview on 5/12/20 at 5:00 p.m., with the DON identified the unit had been searched and no additional tools were discovered and no one was aware of how R1 obtained the wire cutter, but as a precaution, maintenance no longer was to bring a cart containing tools onto the unit. R1 had discovered the 15 second pressure delay on the egress doors, and had attempted to exit to the South unit, but staff were aware and intervened with redirection. The DON identified the facility was working to develop additional interventions with 1:1 monitoring in an attempt to allow R1 to go outside as the weather improved. She identified the window crank had been removed from R1's room on 4/27/20 at 11:00 a.m. due to his opening the window and leaving it open which resulted in other residents complaining of being cold. She stated he had made no attempt to remove the screen at that time.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	**965 MCMILLAN STREET WORTHINGTON, MN 56187**

(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 689	Continued From page 13 Interview on 5/12/20 at 5:15 p.m., with RN-C identified she had worked on 5/9/20 when R1 had eloped through the window in R4's room. She identified R1 had spent most of the evening in the main lounge watching TV. She identified she had last observed R1 at 11:00 p.m. seated in a recliner in the main lounge watching TV. She had exited to the South unit to give report and at 11:30 p.m. she was notified R1 was missing, and the screen was off the window and window was open in R4's room. RN-C immediately notified staff to initiate a search of all areas in the facility and outside surrounding the building. Upon investigation RN-C identified R1 had gone to his room at 11:15 p.m. and when NA-C went to do the 11:30 p.m. he was not located. The building was searched, a CODE GREEN was activated, all other residents were accounted for. A loafer type shoe was found outside the window, the DON, administrator (A) and law enforcement were notified of R1 missing from the facility. R1 was found by law enforcement at 12:09 a.m., wearing an army hat, gray sweater and maroon pants, and one loafer. The weather was cool and damp, but she was uncertain of the temperature on that night. At 12:15 a.m., law enforcement notified the facility R1 had been located and was being transported to the emergency room for evaluation of scrapes, bruises and to be assessed for any additional injuries. Received update from nurse at hospital on R1's status and he returned about 4:00 a.m., via ambulance. R1 was monitored in the main lounge area the remainder of the night following assessment of vital signs and pain assessment. Upon his return R1 received every 15 minute checks and verification his wander guard was in place and functioning. R1 was alert and not happy at	F 689		

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F 689	Continued From page 14	F 689		

having to return to the facility. He was able to move all extremities and denied any pain or discomfort. Upon return R1's left wrist was wrapped with coban and his right forearm wrapped with kerlix due to a skin tear on his right forearm and swelling in the left wrist.

Interview on 5/13/20 at 9:00 a.m., with the DON identified only the window cranks located on windows in the common areas were removed following the 4/27/20 incident due to R1 not having a history of entering other resident rooms that she was aware of, and she had not wanted to violate other resident's rights to open their windows at will.

Interview on 5/14/20 at 8:17 a.m., with the maintenance director identified he was not aware of an incident prior to R1's elopement of a resident able to remove the clips holding the screens in place and having the ability to get up and out of a window. He identified he was not aware of how much force it would require to force a window open without using the crank to open it.

On 5/14/20 at 10:30 a.m. the medical director was interviewed and voiced knowledge of R1's two elopements from the facility and was surprised R1 had been able to exit the facility through the window on two occasions. He identified R1 was at risk for serious injury with his comorbidities including age and falling from four to five feet to the ground. He identified his expectation of the facility had been to assess all residents admitted, insure safety measures were in place and to incorporate interventions for areas of concern.

Review of the 10/15/18 policy: Elopements:

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F 689	Continued From page 15 Superior Healthcare Management Minnesota Region: Identified all residents were to be screened both upon admission and annually for significant changes and the potential of elopement on an elopement assessment. This has primary importance for residents with cognitive issues, those that state they are leaving, family concerns of safety related to exit seeking behavior, those that exhibit depression about placement in the facility and indicate intent to leave. Based on assessment a resident may be placed on routine safety checks or have a wander guard for safety. The IJ that began on 4/27/20 at 5:00 p.m, was removed on 5/14/20 at 4:20 p.m., when it could be verified the facility had secured all windows on the locked unit, and had developed and implemented all staff education on policies and procedures for elopement and safety measures. In addition, it was verified the facility had implemented immediate intervention by removal of all window cranks from the secure unit and educating staff that windows were to remain closed until the ordered additional window security devices could be installed.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 2, 2020

Administrator
Crossroads Care Center
965 McMillan Street
Worthington, MN 56187

Re: Event ID: S53T11

Dear Administrator:

The above facility survey was completed on May 14, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00407	A. BUILDING: _____ B. WING _____	C 05/14/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/12/20 through 5/14/20, surveyors of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaint: H5395016C. The complaint was found to be SUBSTANTIATED, with NO licensing orders issued.	2 000		

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

Electronically Signed | 06/08/20

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