DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 23, 2021

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: July 23, 2021

Dear Administrator:

On August 13, 2021, we notified you a remedy was imposed. On September 16, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 13, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 28, 2021 be discontinued as of September 13, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 13, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 13, 2021. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 23, 2021

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

Re: Reinspection Results
Event ID: 033X12 and SVJI12

Dear Administrator:

On September 16, 2021 and September 9 ,2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 16, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
September 3, 2021

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: July 23, 2021

Dear Administrator:

On August 13, 2021, we informed you of imposed enforcement remedies.

On August 13, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On August 13, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 28, 2021, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 28, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 28, 2021.

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

managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of August 13, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 28, 2021. However, due to the extended survey the new NATCEP loss date is August 13, 2021.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Villa St Vincent is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 13, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice

will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the

latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	**516 WALSH STREET CROOKSTON, MN 56716**

(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 8/11/21 through 8/13/21, a standard abbreviated and extended survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5484047C (MN75354, MN75417), with a deficiencies cited at F689. As part of the investigation a related deficiencies was cited at F609. The survey resulted in substandard quality of care and Immediate Jeopardy (IJ) situations to resident safety at F689. The IJ began on 7/14/21, when R1 was moved off of the secured unit of the facility and was allowed to go outside the facility independently to smoke. The director of nursing (DON) and licensed social worker (LSW)-A were informed of the IJ on 8/12/21, at 1:39 p.m. The IJ was removed on 8/13/21, when the facility had provided evidence they had removed the immediacy. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to	F 000		

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

Electronically Signed | 09/09/2021

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 validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report a resident elopement to the state agency (SA) for 1 of 1 residents (R1)	F 609	1) Corrective Action: All Elopements will be reported to the state agency within 2 hours per regulation.	9/13/21

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F 609	Continued From page 2 reviewed. Findings Include: R1's quarterly Minimum Data Set (MDS) dated 8/5/21, identified moderate cognitive impairment and indicated R1 displayed behaviors that included verbal behavioral symptoms, rejection of care and wandering. The MDS indicated R1 required supervision or oversight when ambulating. R1's care plan dated 7/14/21, indicated a potential for injury related to his choice to smoke. The care plan indicated R1 could smoke independently. The care plan identified vulnerabilities that included dementia and a history of a traumatic brain injury. R1's care plan further identified a risk for elopement related to dementia, wandering and impulsive behaviors and indicated R1 wore a wander guard device (WanderGuard devices alert the caregiver when a resident breached his or her perimeter or strayed too far) on his wrist. R1's Progress Note dated 7/31/21, indicated the facility staff received a phone call from an outside member of the community. He stated he had been approached by a possible resident of the facility in his driveway. The community member stated the resident had been looking for a lighter. When staff went to look for R1 he had returned to the smoke shack outside the facility. A correlating report to the SA indicated the elopement was reported on 8/2/21, two days after the elopement occurred. During interview on 7/11/21, at 3:57 p.m. the	F 609	2). Actions as it applies to others: All residents that do not have unsupervised time in the community and wander are at risk. Policy on wandering reviewed, and staff education will be provided on timely reporting and review of these expectations for reporting these incidences within 2 hours to SA. 3). Measures to prevent and ensure deficient practice will not reoccur: Staff training is given upon hire, and annually, and as needed to reinforce education of the expectation of reporting incidences of suspected abuse (including elopement). training included the reporting requirement of all abuse within 2 hours. The facility elopement policy has been reviewed and revised to ensure processes are in place so that any resident at risk for elopement does not leave the facility without supervision of staff or responsible Guardian. Any elopement will be reported timely per policy. An event will be completed with care pan update. 4). How the facility will monitor: A daily review of Progress Notes will be conducted in the event that an elopement would occur to ensure protocol is followed as per training. Formal policy and protocol for reporting would be followed if event occurs. Will review and discuss at each quality counsel meeting for ensured compliance ongoing. responsible party: Social Services, DON,	

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F 609	Continued From page 3 director of nursing (DON) stated the elopement had been reported late to the SA. The DON stated it had been discussed and she had felt R1 wasn't wandering and that the elopement had been purposeful. A facility policy Abuse Preventing Plan dated 8/14/20, indicated if an event involves abuse or results in serious bodily injury, the individual is required to report the suspicion immediately, but not later than 2 hours after forming the suspicion.	F 609	and Unit Managers.	
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 adequately assess 1 of 1 resident (R1) who was at risk for elopement prior to discharging him from the secured unit and failed to provide supervision while outside smoking on the facility property which led to R1 eloping. This resulted in an immediate jeopardy (IJ) situation for R1 who eloped from the facility on two separate occasions. The IJ began on 7/14/21, when R1 was transferred from the secured unit of the facility and was allowed to go outside the facility independently to smoke. The director of nursing	F 689	10. Corrective action: R1 had a formal Matrix-Care Elopement Risk Assessment completed upon his admission, and now readmission to the memory care unit. He was assessed to smoke safely independently in secured courtyard. He has been readmitted back in the Memory Care Unit where he can be more closely observed. We continue to explore appropriate placement options for R1. Actions at it applies to others: Elopement risk assessment will be completed on all residents upon admission, significant	9/13/21

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F 689	Continued From page 4 (DON) and licensed social worker (LSW)-A were informed of the IJ on 8/12/21, at 1:39 p.m. The IJ was removed on 8/13/21, at 1:45 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R1's Resident Face Sheet indicated he admitted to the facility on 12/31/20, with diagnosis that included vascular dementia with behavioral disturbance, history of falls and history of a traumatic brain injury. Review of R1's records revealed an untitled, undated document which indicated unit manager recommendations: R1 mildly cognitively impaired, "exit seeks and is a major elopement risk." An Admission Screening undated, indicated R1 had "lots of behaviors" due to not being able to smoke. R1's Care Area Assessment (CAA) dated 5/7/21, identified cognitive loss/dementia and indicated R1 wandered at times and displayed exit seeking behaviors. The CAA further identified behavioral symptoms and indicated R1 tended to wander and exit seek and verbalized that he "wants to get out of here." R1's quarterly Minimum Data Set (MDS) dated 8/5/21, identified moderate cognitive impairment and indicated R1 displayed behaviors that included verbal behavioral symptoms, rejection of care and wandering. The MDS indicated R1 required supervision or oversight when	F 689	change, annually and as needed including transfer or discharge from the secured unit into another unit. All residents who are currently assessed to be at risk for elopement have a functioning wander-guard present. The wander-guard is checked and placement noted at least every 24 hours. Wander-guard codes have been reset. Measures put into place to ensure deficient practice will not occur;. Policy review was done, and updated on smoking and elopement, with training provided to all staff on wandering and elopement prevention, response, and reporting. Staff will review progress notes for wandering behaviors every day and discuss at the IDT. Social Services will do a weekly audit of all wander-guard checks and a monthly summary of those with a wander-quard placed indicating appropriateness of continued need and use of the wander-guard. How the Facility will monitor: Audits will be done on elopement assessments bi-monthly for 30 days per Social Service Director. After 30 days, this practice will be reviewed at Quality Counsel, if acceptable compliance, we will decrease to monthly for 60 days, will review again at that time at Quality Counsel, and if acceptable compliance, we will decrease to quarterly ongoing. Responsible Party's Social Services and Unit Managers, with oversight of DON	

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F 689	Continued From page 5	F 689		

ambulating.

R1's care plan dated 7/14/21, indicated a potential for injury related to his choice to smoke. The care plan indicated R1 could smoke independently. The care plan identified vulnerabilities that included dementia and a history of a traumatic brain injury. R1's care plan further identified a risk for elopement related to dementia, wandering and impulsive behaviors and indicated R1 wore a WanderGuard device (WanderGuard devices alert the caregiver whenever a resident breeched a perimeter or strayed too far) on his wrist.

An Elopement Risk Assessment dated 5/7/21, indicated R1 verbalized statements about leaving the facility, resided on the secured memory care unit and was at moderate risk for elopement. An Elopement Risk Assessment dated 8/12/21, one month after moving off the secured unit, identified a high risk for elopement.

The designated smoking area was observed on 8/12/21, at 7:12 a.m. There was a set of doors leading to a short hallway with doors that opened to the outside of the building. A wander alert system was visible on the interior doors. Outside the door and to the left was a shed designated for smoking. The area was not enclosed and was between two buildings of the campus in the parking lot designated for vendors/deliveries. Accessible from the parking lot was a neighborhood with multiple houses and side streets which allowed R1 to leave the area unnoticed by staff.

R1's records indicated he was moved from the secured unit to the general care unit on 7/14/21.

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F 689	Continued From page 6	F 689		

R1's records lacked evidence of an elopement re-assessment, justification for care changes, care plan revisions or physician records indicating support of the care change.

R1's Resident Progress Notes identified the following:

- 7/14/21, R1 tried to go outside and set off the alarm at door number four.

- 7/14/21, R1 had a WanderGuard placed due to moving out of the secured memory care unit. R1 had a history of threats of leaving the facility and had been breaking facility property.

- 7/15/21, R1 was wandering around the area behind the smoke shack and was very resistant to returning inside. Later the same day R1 attempted to go out and was told it was too late and dark then attempted to go out a different door.

- 7/16/21, R1 was walking down the hallways and needed directions to his room.

- 7/17/21, R1 needed frequent reminders on how to get to his room, was easily turned around. Note written at 11:16 p.m. indicated R1 walked out the dining room doors and his Wanderguard set off the alarm. Later the same day R1 was spoken to about the smoking agreement and "again" made the statement that if he couldn't smoke "you can say goodbye to me."

- 7/17/21, at 11:16 p.m. R1 walked out the dining room doors and set off the alarm. Staff spoke with R1 outside and asked him to come back in. R1 stated he did not want to. R1 asked if he could

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	245484	A. BUILDING _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	**516 WALSH STREET CROOKSTON, MN 56716**

(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 7	F 689		

have a cigarette and staff provided it. Staff directed R1 toward the smoke shack as he appeared unsure which direction he had to go. When the alarm sounded at the door to the smoke shack R1 stated he was "pissed off at that damn alarm."

- 7/18/21, R1 was found walking around with no Wanderguard and said he broke it off. R1 was on the phone with his son and was heard saying that when he went out to the smoke shack he could leave whenever he wanted to without a staff member with him.

- 7/19/21, registered nurse (RN)-A visited with R1 about his multiple trips to the smoke shack the previous night and removal of his Wanderguard. RN-A wrote a new smoking agreement which allowed R1 to go out to the smoke shack whenever he wanted and stay out there for up to an hour each time and tell staff when he came back.

- 7/23/21, R1 was observed by staff turning off the Wanderguard system leading to the smoke shack.

- 7/24/21, R1 was pacing the halls and asking for cigarettes past midnight. R1 set off the alarm by dining room door then punched in the code and turned off the alarm. Later note indicated staff spoke to R1 about shutting off the alarms and educated him not to do it.

- 7/26/21, R1 was not wearing his Wanderguard and said he ripped it off because it got caught on a nail. R1's Wanderguard was on a meal tray in his room. Later note indicated R1 was outside in the employee smoke shack and was told he

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should not be in there. Another note that day indicated R1 was walking around without his Wanderguard and when staff asked about it R1 said he did not care, mumbled and swore under his breath and kept walking away out to the smoke shack.

- 7/27/21, R1 had a new Wanderguard placed.

- 7/28/21, R1 was found going out the doors to the smoke shack around 2:00 a.m. R1 made the statement "what would happen if they couldn't find me because that will happen real soon if they can't."

- 7/29/21, R1 attempted to go out the door at 1:30 a.m. Directions were provided back to his room and snack offered but R1 refused.

- 7/30/21, R1 had left the building and was across the street behind the cathedral church and refused to return. Staff called the police and remained by resident. R1 did return with police officer and stated, "I have warned them." R1 stated he had fallen outside and had blood running down his forearm. R1 had a nick on his wrist and later noted to have a 2.4 centimeter (cm) x 1.5 cm skin tear on his left elbow.

-7/30/21, a second note indicated R1 had reported to the nurse manager that he had gone out before midnight and had walked around until his legs and knees started hurting. R1 said if he had not been hurting, he "would have been gone." Safety checks were increased to hourly and R1 had a wander guard on both wrists now.

- 7/30/21, a third progress note indicated R1 was independent with ambulation and able to take

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F 689	Continued From page 9 himself to the designated smoking area. - 7/31/21, at 9:40 p.m. staff received a call from a member of the community who had been approached by R1 in the driveway of his home. When staff went to look for R1 he was sitting outside the smoke shack. R1 agreed to stay on the property but refused to make eye contact with the staff. R1's records lacked evidence of re-assessment, interventions or care plan revisions to address elopement concerns after significant events on 7/15/21, 7/23/21, 7/30/21 and 7/31/21. An untitled document dated 7/19/21, indicated R1 agreed to the following: There would be no smoking schedule, may smoke whenever he liked, would ask nurse for a cigarette when he wanted one and return his lighter at the end of the day. He would be allowed to remain in the smoke shack for an hour at a time and would notify staff when he returned and may stay outside until midnight. He would wear Wanderguard at all times and not remove or cut the strap. The document was amended on 7/29/21, to include R1's failure to follow the agreement may result in having staff supervision while smoking (if staffing allowed), losing privileges or moving back to the memory care unit. Review of the medical record indicated R1 was moved back to the secured unit on 8/3/21. On 8/11/21, at 1:25 p.m. nursing assistant (NA)-C stated R1 had just moved back to the secured unit two weeks prior. NA-C stated R1 liked to go out and smoke and said R1 had a Wanderguard	F 689		

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that would alarm if he tried to go out alone. NA-C stated he did not know why R1 was moved off the unit and did not know why he was moved back but stated he understood R1 needed supervision due to potential elopement.

-At 1:29 p.m. RN-B stated R1 was alert, sometimes he knew where he was at, sometimes "with it" and sometimes not so much and would ask why he was at the facility. RN-B stated R1's cognition fluctuated. RN-B stated when R1 was moved off the unit he would go and smoke but did not always remember where he was supposed to be. RN-B said R1 would ask what would happen if he walked away and over to a house and had moments when he would wander off the grounds. RN-B stated R1 made poor decisions. RN-B further stated someone had mentioned that R1 had learned the code for the door alarms and was able to deactivate them.

-At 1:46 p.m. RN-A stated R1 had been off the unit a few weeks but was moved back to the memory care unit. RN-A stated when R1 first moved to the general care unit there was a verbal agreement that he would go out to smoke three times a day after meals, but he would become agitated, so the nurses allowed him extra times to smoke. RN-A said if the nurses did not give R1 his cigarettes he would go out and smoke butts out of the ashtray, so they started allowing him to go smoke as often as he wanted to as long as he was in the building by midnight. RN-A said R1 would smoke outside the shack so he would not be visible on the monitor that was inside the smoke shack. RN-A said one of the nurses had reported that R1 had figured out the code to deactivate the alarm and he had a tendency to rip off his Wanderguard. RN-B said R1 was not fully

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capable of understanding the smoking contract due to his dementia and brain injury. RN-B said R1 had a good memory for past events but had trouble with short term. RN-B said R1 had impaired decision making and said most of his decisions were not well thought out and said he was very impulsive. RN-B said an elopement risk assessment had not been completed when R1 moved off the secured unit and said when he first moved, she was not aware he was an elopement risk. RN-B said an elopement assessment should have been completed after the first elopement, but it was not done.

The DON and LSW-B were interviewed on 8/11/21, at 3:18 p.m. LSW-B stated when R1 had resided on the secured unit a staff member had discovered R1 had been loosening boards on the courtyard fence when sitting outside and had asked staff for a hammer. LSW-B stated R1 said he felt like a prisoner. LSW-B stated R1 had been a "smoker" and had not been allowed to smoke while he was on the secured unit and said all he would express was a desire to smoke. LSW-B stated the interdisciplinary team had met and discussed concerns about other residents if R1 were to remain on the secured unit and said they felt his quality of life would improve if he was moved off the unit to a less secure area of the facility, however, was not sure if the physician had been involved in the discussion. LSW-B stated they came up with an agreement to move R1 off the secured unit and place a Wanderguard bracelet on him. LSW-B said R1 started smoking the day he was moved and had a smoking plan that staff would keep his cigarettes and he would need to smoke in the designated smoke shack where there was a camera. However, the camera was only visible if staff were present in the

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F 689	Continued From page 12	F 689		

charting office located behind the nurses station and was not continuously monitored. LSW-B stated staff did not go outside with R1 when he smoked. LSW-B stated the Wanderguard was not placed for elopement but so staff would be alerted when R1 went outside. LSW-B also stated she did not think R1 was unsafe to be outside alone. She said he was impulsive and did not always display good judgement, but she felt his elopements were purposeful. She stated the smoking contract was developed to establish a schedule and some boundaries. LSW-B stated after R1 eloped the first time, more frequent checks were added and a second Wanderguard was placed on R1's other wrist. The DON stated the reason for placing an additional alarm was because the closer the bracelet was to the sensor the more effective it became. Regarding the elopement on 7/31/21, LSW-B stated she had come in the next morning and read the progress notes. LSW-B said R1 had walked across the street and asked a man if he had a lighter. The man called the facility and R1 had returned. The DON stated R1 had not gone far, even though he had crossed a street, and said R1 was not wandering or lost and said, "it was purposeful."

On 8/12/21, at 6:08 a.m. nursing assistant (NA)-A stated R1 would get up and walk around the building and liked to go outside between 1:30 a.m. and 2:00 a.m. NA-A stated R1 had a Wanderguard so staff had to keep an eye on him. NA-A said R1 would walk out to the smoke shack and staff would turn off the alarm. NA-A further stated R1 knew how to turn off the alarm. NA-B who was also present during the interview and confirmed staff were never given any instructions in terms of supervision when R1 moved to the unit. NA-B stated they were initially told R1 could

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not go outside alone but then it changed because R1 would get mad if staff followed him out. NA-B stated she was working the morning of 7/30/21, when R1 eloped. NA-B said the nurse was busy getting someone ready to go out to an appointment and said, "we don't know when or how he got out because no alarm went off."

-At 6:15 a.m. licensed practical nurse (LPN)-A stated the morning R1 eloped she was coming on to her shift and saw another employee in the parking lot who said to her, "Isn't that [R1]?" LPN-A stated R1 would not return to the facility so staff stayed with him until he was brought back by the police. LPN-A said when R1 moved to the unit he had a Wanderguard put on but he was allowed to go outside and smoke by himself without staff supervision. LPN-A said she had no idea how R1 had gotten out that morning.

-At 6:18 p.m. LPN-B stated she worked the overnight shift and R1 would go outside and smoke by himself and staff were supposed to keep an eye on him until he came back inside. LPN-B stated the Wanderguard alerted staff he was outside but said R1 knew how to turn of the alarm. LPN-B said she had seen R1 turn off the alarm and said the code had not been changed after he learned and said it still had not been changed (8/12/21). LPN-B said even after R1 eloped the first-time staff were not told he could not go outside alone. LPN-B further stated the hourly checks that had been implemented were not documented anywhere and said staff documented once per shift that they had checked on him.

A facility policy Elopement-Resident dated 9/2018, indicated the facility ensured residents

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F 689	Continued From page 14 were safe through the implementation of systems for monitoring care delivery and location within the facility premises. The policy indicated residents who were known to wander may wear a signaling divide which activated an alarm should they leave the facility. When the Wanderguard system signaled staff were to go and visualize the area to ensure no resident had left the building safe area. The IJ was removed on 8/13/21, at 1:45 p.m. when it was verified through interview and document review the facility had updated their policy on elopements, including assessment of elopement risk, changing of alarms codes, and included processes so that any resident at risk for elopement does not leave the facility without immediate supervision of staff or responsible guardians. In addition, the facility educated all staff on procedures related to residents who were at risk for elopement and/or wore a Wanderguard.	F 689		

Electronically delivered
September 3, 2021

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

Re: State Nursing Home Licensing Orders
Event ID: 033X11

Dear Administrator:

The above facility was surveyed on August 11, 2021 through August 13, 2021 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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

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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 (DATES), a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	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 The following complaint was found to be SUBSTANTIATED: H5484047C (MN75354/MN75417) with a licensing order issued at 0830. 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 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 surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders 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 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. 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.	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 observation, interview and document review, the facility failed to adequately assess 1 of 1 resident (R1) who was at risk for elopement prior to discharging him from the secured unit and failed to provide supervision while outside smoking on the facility property which led to R1 eloping. This resulted in an immediate jeopardy (IJ) situation for R1 who eloped from the facility on two separate occasions. The IJ began on 7/14/21, when R1 was	2 830	1) Corrective Action: Resident was transferred into the Memory Care Unit. An elopement and smoking assessment were completed. He continued with a wander-guard bracelet. He was determined to be able to smoke independently outside. He had a cigarette receptacle for cigarette butts. A smoke apron and fire blanket are available and encouraged the use of. He is able to smoke outside independently in the	9/13/21

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2 830	Continued From page 3 transferred from the secured unit of the facility and was allowed to go outside the facility independently to smoke. The director of nursing (DON) and licensed social worker (LSW)-A were informed of the IJ on 8/12/21, at 1:39 p.m. The IJ was removed on 8/13/21, at 1:45 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R1's Resident Face Sheet indicated he admitted to the facility on 12/31/20, with diagnosis that included vascular dementia with behavioral disturbance, history of falls and history of a traumatic brain injury. Review of R1's records revealed an untitled, undated document which indicated unit manager recommendations: R1 mildly cognitively impaired, "exit seeks and is a major elopement risk." An Admission Screening undated, indicated R1 had "lots of behaviors" due to not being able to smoke. R1's Care Area Assessment (CAA) dated 5/7/21, identified cognitive loss/dementia and indicated R1 wandered at times and displayed exit seeking behaviors. The CAA further identified behavioral symptoms and indicated R1 tended to wander and exit seek and verbalized that he "wants to get out of here." R1's quarterly Minimum Data Set (MDS) dated 8/5/21, identified moderate cognitive impairment and indicated R1 displayed behaviors that included verbal behavioral symptoms, rejection of	2 830	secured gated courtyard. 2). Actions as it applies to others: All residents that wander are at risk. Policy on wandering reviewed, and staff education will be provided on timely reporting and review of these expectations on for reporting these incidences. 3). Measures to prevent and sure deficient practice will not reoccur: Staff training is given upon hire, and annually, and as needed to reinforce education of the expectation of reporting incidences of suspected abuse (including wandering risks). training included the reporting requirement of and serious bodily harm within 2 hours, and all other events regarding suspicion of abuse within 24 hours. The facility elopement policy has been reviewed and revised to ensure processes are in place so that any resident at risk for elopement Does not leave the facility grounds without supervision of staff or responsible Guardian. Any elopement will be reported timely per policy. An event will be completed with care pan update. 4). How the facility will monitor: A daily review of Progress Notes will be conducted in the event that an elopement would occur to ensure protocol is followed as per training. Formal policy and protocol for reporting would be followed if event occurs. Will review and discuss at each quality counsel meeting for ensured compliance ongoing. responsible party: Social Services, DON,	

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2 830	Continued From page 4 care and wandering. The MDS indicated R1 required supervision or oversight when ambulating. R1's care plan dated 7/14/21, indicated a potential for injury related to his choice to smoke. The care plan indicated R1 could smoke independently. The care plan identified vulnerabilities that included dementia and a history of a traumatic brain injury. R1's care plan further identified a risk for elopement related to dementia, wandering and impulsive behaviors and indicated R1 wore a WanderGuard device (WanderGuard devices alert the caregiver whenever a resident breeched a perimeter or strayed too far) on his wrist. An Elopement Risk Assessment dated 5/7/21, indicated R1 verbalized statements about leaving the facility, resided on the secured memory care unit and was at moderate risk for elopement. An Elopement Risk Assessment dated 8/12/21, one month after moving off the secured unit, identified a high risk for elopement. The designated smoking area was observed on 8/12/21, at 7:12 a.m. There was a set of doors leading to a short hallway with doors that opened to the outside of the building. A wander alert system was visible on the interior doors. Outside the door and to the left was a shed designated for smoking. The area was not enclosed and was between two buildings of the campus in the parking lot designated for vendors/deliveries. Accessible from the parking lot was a neighborhood with multiple houses and side streets which allowed R1 to leave the area unnoticed by staff. R1's records indicated he was moved from the	2 830	and Unit Managers.	

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secured unit to the general care unit on 7/14/21. R1's records lacked evidence of an elopement re-assessment, justification for care changes, care plan revisions or physician records indicating support of the care change.

R1's Resident Progress Notes identified the following:

- 7/14/21, R1 tried to go outside and set off the alarm at door number four.

- 7/14/21, R1 had a WanderGuard placed due to moving out of the secured memory care unit. R1 had a history of threats of leaving the facility and had been breaking facility property.

- 7/15/21, R1 was wandering around the area behind the smoke shack and was very resistant to returning inside. Later the same day R1 attempted to go out and was told it was too late and dark then attempted to go out a different door.

- 7/16/21, R1 was walking down the hallways and needed directions to his room.

- 7/17/21, R1 needed frequent reminders on how to get to his room, was easily turned around. Note written at 11:16 p.m. indicated R1 walked out the dining room doors and his Wanderguard set off the alarm. Later the same day R1 was spoken to about the smoking agreement and "again" made the statement that if he couldn't smoke "you can say goodbye to me."

- 7/17/21, at 11:16 p.m. R1 walked out the dining room doors and set off the alarm. Staff spoke with R1 outside and asked him to come back in. R1 stated he did not want to. R1 asked if he could

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have a cigarette and staff provided it. Staff directed R1 toward the smoke shack as he appeared unsure which direction he had to go. When the alarm sounded at the door to the smoke shack R1 stated he was "pissed off at that damn alarm."

- 7/18/21, R1 was found walking around with no Wanderguard and said he broke it off. R1 was on the phone with his son and was heard saying that when he went out to the smoke shack he could leave whenever he wanted to without a staff member with him.

- 7/19/21, registered nurse (RN)-A visited with R1 about his multiple trips to the smoke shack the previous night and removal of his Wanderguard. RN-A wrote a new smoking agreement which allowed R1 to go out to the smoke shack whenever he wanted and stay out there for up to an hour each time and tell staff when he came back.

- 7/23/21, R1 was observed by staff turning off the Wanderguard system leading to the smoke shack.

- 7/24/21, R1 was pacing the halls and asking for cigarettes past midnight. R1 set off the alarm by dining room door then punched in the code and turned off the alarm. Later note indicated staff spoke to R1 about shutting off the alarms and educated him not to do it.

- 7/26/21, R1 was not wearing his Wanderguard and said he ripped it off because it got caught on a nail. R1's Wanderguard was on a meal tray in his room. Later note indicated R1 was outside in the employee smoke shack and was told he should not be in there. Another note that day

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2 830	Continued From page 7 indicated R1 was walking around without his Wanderguard and when staff asked about it R1 said he did not care, mumbled and swore under his breath and kept walking away out to the smoke shack. - 7/27/21, R1 had a new Wanderguard placed. - 7/28/21, R1 was found going out the doors to the smoke shack around 2:00 a.m. R1 made the statement "what would happen if they couldn't find me because that will happen real soon if they can't." - 7/29/21, R1 attempted to go out the door at 1:30 a.m. Directions were provided back to his room and snack offered but R1 refused. - 7/30/21, R1 had left the building and was across the street behind the cathedral church and refused to return. Staff called the police and remained by resident. R1 did return with police officer and stated, "I have warned them." R1 stated he had fallen outside and had blood running down his forearm. R1 had a nick on his wrist and later noted to have a 2.4 centimeter (cm) x 1.5 cm skin tear on his left elbow. -7/30/21, a second note indicated R1 had reported to the nurse manager that he had gone out before midnight and had walked around until his legs and knees started hurting. R1 said if he had not been hurting, he "would have been gone." Safety checks were increased to hourly and R1 had a wander guard on both wrists now. - 7/30/21, a third progress note indicated R1 was independent with ambulation and able to take himself to the designated smoking area.	2 830		

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2 830	Continued From page 8 - 7/31/21, at 9:40 p.m. staff received a call from a member of the community who had been approached by R1 in the driveway of his home. When staff went to look for R1 he was sitting outside the smoke shack. R1 agreed to stay on the property but refused to make eye contact with the staff. R1's records lacked evidence of re-assessment, interventions or care plan revisions to address elopement concerns after significant events on 7/15/21, 7/23/21, 7/30/21 and 7/31/21. An untitled document dated 7/19/21, indicated R1 agreed to the following: There would be no smoking schedule, may smoke whenever he liked, would ask nurse for a cigarette when he wanted one and return his lighter at the end of the day. He would be allowed to remain in the smoke shack for an hour at a time and would notify staff when he returned and may stay outside until midnight. He would wear Wanderguard at all times and not remove or cut the strap. The document was amended on 7/29/21, to include R1's failure to follow the agreement may result in having staff supervision while smoking (if staffing allowed), losing privileges or moving back to the memory care unit. Review of the medical record indicated R1 was moved back to the secured unit on 8/3/21. On 8/11/21, at 1:25 p.m. nursing assistant (NA)-C stated R1 had just moved back to the secured unit two weeks prior. NA-C stated R1 liked to go out and smoke and said R1 had a Wanderguard that would alarm if he tried to go out alone. NA-C stated he did not know why R1 was moved off the unit and did not know why he was moved back	2 830		

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but stated he understood R1 needed supervision due to potential elopement.

-At 1:29 p.m. RN-B stated R1 was alert, sometimes he knew where he was at, sometimes "with it" and sometimes not so much and would ask why he was at the facility. RN-B stated R1's cognition fluctuated. RN-B stated when R1 was moved off the unit he would go and smoke but did not always remember where he was supposed to be. RN-B said R1 would ask what would happen if he walked away and over to a house and had moments when he would wander off the grounds. RN-B stated R1 made poor decisions. RN-B further stated someone had mentioned that R1 had learned the code for the door alarms and was able to deactivate them.

-At 1:46 p.m. RN-A stated R1 had been off the unit a few weeks but was moved back to the memory care unit. RN-A stated when R1 first moved to the general care unit there was a verbal agreement that he would go out to smoke three times a day after meals, but he would become agitated, so the nurses allowed him extra times to smoke. RN-A said if the nurses did not give R1 his cigarettes he would go out and smoke butts out of the ashtray, so they started allowing him to go smoke as often as he wanted to as long as he was in the building by midnight. RN-A said R1 would smoke outside the shack so he would not be visible on the monitor that was inside the smoke shack. RN-A said one of the nurses had reported that R1 had figured out the code to deactivate the alarm and he had a tendency to rip off his Wanderguard. RN-B said R1 was not fully capable of understanding the smoking contract due to his dementia and brain injury. RN-B said R1 had a good memory for past events but had trouble with short term. RN-B said R1 had

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impaired decision making and said most of his decisions were not well thought out and said he was very impulsive. RN-B said an elopement risk assessment had not been completed when R1 moved off the secured unit and said when he first moved, she was not aware he was an elopement risk. RN-B said an elopement assessment should have been completed after the first elopement, but it was not done.

The DON and LSW-B were interviewed on 8/11/21, at 3:18 p.m. LSW-B stated when R1 had resided on the secured unit a staff member had discovered R1 had been loosening boards on the courtyard fence when sitting outside and had asked staff for a hammer. LSW-B stated R1 said he felt like a prisoner. LSW-B stated R1 had been a "smoker" and had not been allowed to smoke while he was on the secured unit and said all he would express was a desire to smoke. LSW-B stated the interdisciplinary team had met and discussed concerns about other residents if R1 were to remain on the secured unit and said they felt his quality of life would improve if he was moved off the unit to a less secure area of the facility, however, was not sure if the physician had been involved in the discussion. LSW-B stated they came up with an agreement to move R1 off the secured unit and place a Wanderguard bracelet on him. LSW-B said R1 started smoking the day he was moved and had a smoking plan that staff would keep his cigarettes and he would need to smoke in the designated smoke shack where there was a camera. However, the camera was only visible if staff were present in the charting office located behind the nurses station and was not continuously monitored. LSW-B stated staff did not go outside with R1 when he smoked. LSW-B stated the Wanderguard was not placed for elopement but so staff would be

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alerted when R1 went outside. LSW-B also stated she did not think R1 was unsafe to be outside alone. She said he was impulsive and did not always display good judgement, but she felt his elopements were purposeful. She stated the smoking contract was developed to establish a schedule and some boundaries. LSW-B stated after R1 eloped the first time, more frequent checks were added and a second Wanderguard was placed on R1's other wrist. The DON stated the reason for placing an additional alarm was because the closer the bracelet was to the sensor the more effective it became. Regarding the elopement on 7/31/21, LSW-B stated she had come in the next morning and read the progress notes. LSW-B said R1 had walked across the street and asked a man if he had a lighter. The man called the facility and R1 had returned. The DON stated R1 had not gone far, even though he had crossed a street, and said R1 was not wandering or lost and said, "it was purposeful."

On 8/12/21, at 6:08 a.m. nursing assistant (NA)-A stated R1 would get up and walk around the building and liked to go outside between 1:30 a.m. and 2:00 a.m. NA-A stated R1 had a Wanderguard so staff had to keep an eye on him. NA-A said R1 would walk out to the smoke shack and staff would turn off the alarm. NA-A further stated R1 knew how to turn off the alarm. NA-B who was also present during the interview and confirmed staff were never given any instructions in terms of supervision when R1 moved to the unit. NA-B stated they were initially told R1 could not go outside alone but then it changed because R1 would get mad if staff followed him out. NA-B stated she was working the morning of 7/30/21, when R1 eloped. NA-B said the nurse was busy getting someone ready to go out to an appointment and said, "we don't know when or

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2 830	Continued From page 12 how he got out because no alarm went off." -At 6:15 a.m. licensed practical nurse (LPN)-A stated the morning R1 eloped she was coming on to her shift and saw another employee in the parking lot who said to her, "Isn't that [R1]?" LPN-A stated R1 would not return to the facility so staff stayed with him until he was brought back by the police. LPN-A said when R1 moved to the unit he had a Wanderguard put on but he was allowed to go outside and smoke by himself without staff supervision. LPN-A said she had no idea how R1 had gotten out that morning. -At 6:18 p.m. LPN-B stated she worked the overnight shift and R1 would go outside and smoke by himself and staff were supposed to keep an eye on him until he came back inside. LPN-B stated the Wanderguard alerted staff he was outside but said R1 knew how to turn of the alarm. LPN-B said she had seen R1 turn off the alarm and said the code had not been changed after he learned and said it still had not been changed (8/12/21). LPN-B said even after R1 eloped the first-time staff were not told he could not go outside alone. LPN-B further stated the hourly checks that had been implemented were not documented anywhere and said staff documented once per shift that they had checked on him. A facility policy Elopement-Resident dated 9/2018, indicated the facility ensured residents were safe through the implementation of systems for monitoring care delivery and location within the facility premises. The policy indicated residents who were known to wander may wear a signaling divide which activated an alarm should they leave the facility. When the Wanderguard system signaled staff were to go and visualize the	2 830		

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2 830	Continued From page 13 area to ensure no resident had left the building safe area. The IJ was removed on 8/13/21, at 1:45 p.m. when it was verified through interview and document review the facility had updated their policy on elopements, including assessment of elopement risk, changing of alarms codes, and included processes so that any resident at risk for elopement does not leave the facility without immediate supervision of staff or responsible guardians. In addition, the facility educated all staff on procedures related to residents who were at risk for elopement and/or wore a Wanderguard. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		