Electronically delivered
October 15, 2019

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

RE: 245499
Cycle Start Date: September 20, 2019

Dear Administrator:

On September 20, 2019, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 9, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 9, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 9, 2019.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC was the NATCEP trigger)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 9, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Caledonia Rehabilitation & Retirement Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 9, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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 March 20, 2020 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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
	245499	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA REHABILITATION & RETIREMENT CENTER	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

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F 000	INITIAL COMMENTS On 9/5/19 and 9/20/19 abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5499022C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	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 record review the facility failed to implement measures	F 689	F689 This plan of correction constitutes	10/17/19

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

Electronically Signed | 10/17/2019

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

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F 689	Continued From page 1 to prevent accidents for 1 of 2 residents (R1) reviewed who exhibited wandering and elopement behaviors. This resulted in actual harm for R1 who fell in a stairwell sustaining left side rib fractures. Findings include: A late entry documented on 8/28/19, indicated R1 had an incident 8/27/19 at 6:10 p.m. The documentation indicated a WanderGuard alarm had sounded at a stairwell door leading to the assisted living where the resident's wife resided. The notes indicated the resident had presumably taken the stairs to get to his wife, and had fallen. When staff responded, the resident was found lying on the floor with complaints of pain. Incident documentation further indicated an ambulance had arrived at 6:35 p.m. to transport the resident, who had suspected rib fractures. An initial Facility Reported Incident (FRI) report was submitted to the State Agency (SA) 8/28/19 at 5:35 p.m. The report included: "WanderGuard sounded and CNA (certified nursing assistant) responded and found resident at the bottom of the stairs outside of dining room with walker remaining at top of stairs." The report further included: "Resident was transferred to the emergency room and will be evaluated for safety if sent back to facility. Wander Guard Company also came out 8/28/19 to ensure Wander guard system was working properly, which it was." R1's admission record documentation identified the resident as having diagnoses including: Diabetes, abnormalities of gait [walking] and mobility, dementia and anxiety.	F 689	Caledonia Rehab & Retirement□s written allegation of compliance for deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by state and federal law. CORRECTION DATE 10/17/2019 Correction action for residents affected by the deficient practice. It is the practice and policy at Caledonia Rehab & Retirement to ensure that each resident receives adequate supervision and assistive devices to prevent accidents. Resident R1 experienced actual harm from a fall in the facility. Resident R1 was reviewed to verify adequate supervision to prevent access to the stairwell in which the fall occurred. There are two doors that have access to the stairwell and one of them is now permanently locked and the other has a new keypad installed and this now locks the door rather than an alarming delayed egress when there is a presence of a WanderGuard. No changes were made to the care plan. All staff were educated on the policy and procedure of the WanderGuard alarm, response to alarms, WanderGuard Bracelet functioning, Elopement Policy, the facility Elopement Book, Policy and Procedure for Fall Reduction, including Fall Scene Investigation and root cause analysis of falls. Identification of residents with potential to be affected by deficient practice and	

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F 689	Continued From page 2 R1's quarterly Minimum Data Set (MDS) assessment dated 8/15/19, indicated the resident had severe cognitive decline, exhibited rejection of care, and did not exhibit wandering. The MDS also indicated R1 needed extensive assistance for transfers with one person, used a walker, required supervision when off the unit, and had unsteady balance. Review of R1's progress notes revealed behaviors including: 6/3/19 at 4:02 a.m., "[R1] was hallucinating. Claiming he was seeing twi [sic] kids running in his room and doing unnecessary behavior. Resident is very upset when comforted. Wandered in the hallways looking for exits. Had 1:1 with the resident, snack given, asked for pain medication for his headache. Comforted by talking 1:1, offered snacks and redirected, pain meds (medications) given." 6/19/19 at 4:35 a.m., progress note indicated R1 was restless at the beginning of the night and wandering around without pants on setting off alarms. The note indicated R1 was put back to bed but kept getting up stating he was looking for his room. R1 got tired halfway through the night and finally fell asleep in bed. However, the notes indicated while awake, the resident was pleasantly confused. Actions taken were identified as including; R1 was reoriented each time and shown where his room was. The note also indicated R1 was toileted and changed each time before assisted back to bed.	F 689	corrective action taken to prevent potential for being affected. No other residents experienced ill effects due to the noted observations. Measures/systematic changes to ensure deficient practice does not reoccur. There are two doors that have access to the stairwell and one of them is now permanently locked and the other has a new keypad installed and this now locks the door rather than an alarming delayed egress when there is a presence of a WanderGuard. A folding security gate was also ordered as a secondary barrier to the stairwell. The security gate will be installed upon its delivery to the building and the anticipated date of delivery is 10/25/2019. How facility will monitor performance to ensure solutions are sustained. WanderGuard system audits and locked door audits will be completed by the Maintenance Director or designee weekly for a minimum of 3 months or until 100% compliance has been met. The results of these audits will be reviewed weekly in morning stand up and at scheduled and Ad Hoc QAPI committee meetings. Additional education and monitoring will be conducted as identified.	

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F 689	Continued From page 3 6/21/19 at 4:21 a.m., progress note indicated R1 was wandering before going to bed, and had gone into another resident's room to chat before allowing staff to take him back to his room. A late entry progress note documented 7/14/19 at 10:30 a.m., indicated on 7/12/19 R1 had been wandering around setting off alarms all night and day searching for his wife. The note indicated R1 wanted to leave to catch his wife in the act of cheating. Further, the note indicated R1 had been wide-awake for about 48 hours. R1 set off an alarm and when staff responded, the resident's wheel chair was parked at the top of the stairs, and R1 was observed to have walked half way down the stairs, and R1 was identified as trying to go to see his wife. A progress note 8/7/19 at 5:27 a.m., indicated R1 was confused and agitated and attempting to leave the building. The note indicated staff had taken the resident outside to de-escalate his behaviors and staff were able to redirect R1. The progress note from 8/7/19 at 9:00 a.m., indicated the IDT (interdisciplinary team) had reviewed R1's behaviors. R1 had a history of delusions of paranoia regarding his wife, related to his diagnoses of progressing dementia (with behaviors) and paranoid state. Care plan reviewed and interventions identified as in place to reduce potential for injury to other residents. Root cause: R1 has paranoia and dementia with perseveration on his wife's alleged infidelity (unfounded). New interventions were identified to include: Placing R1 on 15 min (minutes) checks x 24 hours, care plan revised to include keeping other residents at arm's length if resident	F 689		

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F 689	Continued From page 4 is expressing concerns regarding wife's infidelity. A progress note from 8/25/19 at 2:15 a.m., indicated R1 was aggressive and exhibited sexually inappropriate and physically abusive behaviors towards caregivers. Interventions implemented included 1:1 with resident. An additional progress note from 8/25/19 at 3:35 a.m., also indicated R1 was exhibiting aggressive behaviors towards the nursing staff. The note further indicated the physician had been called and had prescribed lorazepam (an antianxiety medication) 0.5 mg (milligrams) x 1, and to call the local authorities if behavior were very disruptive and the resident threatened to hurt caregivers. The note indicated the nurse had called 911 for assistance, when the resident was not listening and could not be redirected. The resident was placed in restraints and was sent to the hospital. Follow up notes indicated the resident was readmitted 8/26/19. A progress note from 8/27/19 at 6:11 p.m., reiterated the wandering behavior R1 exhibited and his fall in the stairwell. A late entry progress note dated 8/28/19 at 10:00 a.m., indicated the IDT reviewed R1's incident: "Resident has advancing dementia with a history of sun downing, poor safety awareness, falls and attempting to follow his wife back to attached Assisted Living." Interventions identified as in place to reduce potential falls and injury to resident were identified to include: "Resident has WanderGuard in place, and was verified to be functioning. ROOT CAUSE: Resident often becomes distressed when his wife leaves after	F 689		

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F 689	Continued From page 5	F 689		

evening visit and attempts to follow her back to assisted living. He uses FWW (front wheeled walker) for ambulation. Previous attempts to educate wife on effects of her late visits during sun downing were ineffective as they choose to enjoy their time together and it is within the resident's rights to allow these visits. NEW INTERVENTION: IDT met to discuss incident. Team verified resident's WanderGuard and key pads were functional in area of incident. Further review of adding keypad entry to access these areas is underway at time of writing. Resident is currently in hospital; care plan will be evaluated upon planned return to address additional interventions. No caregiver misconduct is suspected."

An nursing progress note from 8/30/19 at 10:56 a.m., indicated R1 was readmitted after a fall with multiple left sided rib fractures.

R1's current care plan identified R1 as an elopement risk/wanderer, initiated 2/20/19. Interventions included: "Check placement of WanderGuard every shift and function every night shift, distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. The care plan indicated R1 preferred TV (television) or reading, and included: Identify pattern of wandering- Is wandering purposeful, aimless or escapist? Is the resident looking for something? Does it indicate the need for more exercise?" Additional care plan interventions included: provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Wander alert: WanderGuard on walker and check

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F 689	Continued From page 6 function nightly. The care plan also indicated R1 was at risk for falls related to dementia and use of an assistive device for mobility. The goal initiated 2/20/19 included: Will be free of falls. Interventions included: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance... Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. In addition, the care plan identified the resident had a behavior problem related to dementia identified 4/2/19. The goal included: Will have fewer episodes of behavior. Interventions included: Monitor behavior episodes and attempt to determine the underlying cause. Consider: Location, time of day, persons involved, and situations. Document behavior and potential causes. R1's Elopement Assessment completed 7/12/19, identified the resident's risk for elopement with identification of behavior and mood. The assessment indicated R1 was resistive to long term care placement, and verbalized a desire or plan to leave the facility unauthorized/unsupervised and had cognitive impairment. The assessment also indicated R1 had a history of attempts to get to his wife's living place in the assisted living. The assessment indicated R1 had impaired safety awareness, made attempts made to take elevator and/or	F 689		

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F 689	Continued From page 7	F 689		

stairs to get to assisted living and does not notify staff. Wander guard in place, function checked every shift. Uses 4WW (four wheeled walker) to ambulate throughout the facility, and indicated "May be redirected at times, other times verbally confrontational with staff and threatens to run staff down with walker. Occasionally states he is going to throw his walker through the window. Believes male staff are having an affair with his wife, female staff are preferred during paranoid delusions about his wife."

Although the facility had identified R1's behaviors and risk for leaving the unit to go see his wife in the assisted living, the resident was not adequately supervised to prevent access to the stairwell.

Post fall, R1 was assessed by Occupational Therapy (OT) 9/3/19. The OT assessment indicated R1 was a high fall risk and required one person assist for transfers and ambulation to ensure his safety. In addition, the assessment indicated R1 required assist with toileting, self-cares-do not leave unattended in bathroom, and for staff to anticipate needs such as offering assist for toileting, and walking to meals before he self-transferred.

During an observation and interview on 9/5/19 at 11:40 a.m., dietary aide (DA)-A verified there were no physical barriers in front of the dining room exit door to prevent someone from walking through. Although there was a letter size posting which read, "stop, no residents beyond this point." DA-A opened the door to show the surveyor the stairwell. There was a steel pipe that appeared to be cemented into the floor

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	245499	A. BUILDING _____ B. WING _____	C 09/20/2019

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CALEDONIA REHABILITATION & RETIREMENT CENTER	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

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which was not new. DA-A stated maintenance and kitchen are located downstairs.

During an observation and interview on 9/5/19 at 1:00 p.m., family member (FM)-A was sitting in R1's room while R1 was sleeping in his recliner. FM-A said R1 had been in the hospital over the last week. FM-A said R1 had been trying to follow his wife back to the assisted living and had fallen down the steps and broke ribs. FM-A stated, "You have to take the elevator but can get to the assisted living from the steps, but it is a level down." FM-A stated R1 has dementia. FM-A said R1 had followed his wife over to the assisted living before but had not previously fallen. FM-A verified staff had asked R1's wife not to come visit as often in the evenings.

During a phone interview on 9/5/19 at 1:36 p.m., nursing assistant (NA)-C said R1 had experienced an unwitnessed fall and stated she (NA-C) was the first to see R1. NA-C said she'd been in the common area when the alarm sounded. NA-C said she'd thought to go in the stair well to check the entrance because, "R1 has gone there before." NA-C said no one saw R1 go by the dining room. NA-C said when she went through the closed door, she saw R1 laying on the second landing, ran down to assist him, and the left alarm sounding until other staff arrived. NA-C said R1's wife uses the door off the common room when she goes back to the assisted living. NA-C said R2 had previously gone through the doors to the stairwell, but had not fallen. NA-C said the keypad was protected and a person had to punch in a code to open the outside exit door, but the doors from the hallway and dining room do not have that feature, so a

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person could walk through. NA-C stated, "There is a wheelchair (WC) stopper to prevent WC from going down the stairs, but R1 used a walker and is independent to walk around the facility." NA-C said R1's wife had left about 20 minutes prior to R1 going into the stairwell.

On 9/5/19, at 2:15 p.m. registered nurse (RN)-A stated, "Nurses were sitting at the nurse's station (overlooks the common area) and were in the middle of a shift change report at the time of the incident." RN-A said, "[NA-C] told us (the nurses) [R1] was by the stairs, but we did not hear the alarms." RN-A stated he'd checked the stairwell and observed R1 lying on the floor with NA-C by him holding his head. RN-A said they decided to send the resident to the ER [emergency room]. RN-A was asked again if the alarm was sounding. RN-A said he had not heard any alarm adding the shift report occurs at the nurses' station. RN-A said if an alarm was sounding we should have heard the alarm. RN-A stated there are two accesses to the stair well. One off the common room and the other from the main dining room. RN-A said R1 was independent before the incident happened but now requires assistance. RN-A added he really didn't know how R1 got on the other side of the door. RN-A said the facility was working on a plan following the incident, and the director of nursing (DON) was working on care plan updates after the incident. RN-A also verified R1's wife uses the door off the common area to go back to the assisted living, and that they'd placed a sign on the door that reads STAFF ONLY. However, RN-A verified R1 has dementia and may not be able to, or understand, the sign on the door. During the interview, RN-A reviewed the notes in the computer and

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reiterated the incident occurred on 8/27/19 about 6:11 p.m. RN-A verified R1 had been looking for his wife prior to the incident.

During interview with the maintenance director on 9/5/19 at 3:10 p.m., the maintenance director explained the alarm system in the common room, and stated the dining room door was the same type of system stating, "Residents with a WanderGuard will sound the alarm if close to the sensor and the door is opened. The facility is having the alarm company give an estimated for making the two doors lock." When the maintenance director opened the door, it was noted the alarm was faint at the nursing station. At that time, DON-A was asked about the alarm sounding. DON-A verified the faint beeping alarm coming from the door. The maintenance director said the alarm continues to sound until manually shut off and stated a warning "name" is announced on the walkie-talkie the staff carry with them. The maintenance director stated after the incident, maintenance was told to get an estimate to have the automatic doors be key padded like the other outside exit doors. This would ensure if someone with a WanderGuard got close to the doors, it would lock to prevent the resident from opening and going through the door.

On 9/6/19, at 5:30 a.m. RN-B said he recalled R1's incident. RN-B said the nurses were at the nurses' station having shift report and heard a faint sound. The sound was faint because the doors were closed to the main dining room. RN-B verified R1 had been found on the floor in the stairwell with complaints of his left side hurting. RN-B said prior to the fall, R1 had been

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F 689	Continued From page 11 exhibiting inappropriate behaviors towards an NA. RN-B also said R1 was likely looking for his wife who lives in the assisted living. RN-B said R1 must have used the side door to the dining room. RN-B was unable to recall any other instances of R1 getting out that door, but stated, "He is a wanderer and sets off the other alarmed doors. He used to be independent to move around the facility but he now needs assistance." RN-B verified they'd called 911 to get emergency transport for R1 due to the resident's pain. During a phone interview with DON-B and the administrator on 9/20/19 at 2:05 p.m., DON-B verified R1 had previously been found in the stairwell 7/12/19. DON-B verified she is part of the IDT meeting and was unsure why there had been no follow to the 7/12/19 incident documented 7/14/19. The administrator stated staff training had been completed on 9/5/19. The administrator said they had already put interventions in place, such as contact with the wireless alarm company to get a quote on an updated system which would lock if someone wearing a WanderGuard came close to the door. However, the administrator stated the quote is $5800 and had not yet been initiated. The administrator verified they'd previously posted a sign indicating Staff Only and NO Resident Beyond this Point. The administrator also stated staff now walk with R1's wife and the resident when the wife is getting ready to leave the facility to deter the resident from following his wife back to the assisted living. The DON stated additional safety interventions put in place included additions to the new hire education plan including more dementia training to describe methods for how to deescalate/redirect resident behaviors.	F 689		

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F 689	Continued From page 12 The administrator verified their alarm system could generate reports of data on the time the alarms were set off and how long they were on for. However, reports were not available for the surveyor. The administrator also said the previous DON had been working on the issue with R1 and his attempts to go through the stairwell doors to get to the assisted living in July. He said it was unclear whether the previous DON had reviewed the reports from the computer for alarm data from the July incident. The facility's 8/2014 policy Wandering, Unsafe Resident, included: The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). The policy also included; the staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 15, 2019

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

Re: State Nursing Home Licensing Orders - Complaint Number H5499022C

Dear Administrator:

A survey was completed on September 20, 2019. At the time of the investigation, the surveyor assessed compliance with Minnesota Department of Health Nursing Home Rules. The surveyor from the Minnesota Department of Health, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyor's 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.

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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

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

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
	00073	A. BUILDING: _____ B. WING _____	C 09/20/2019

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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 9/5/19 and 9/20/19, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be substantiated: H5499022C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic	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 record review the facility failed to implement measures to prevent accidents for 1 of 2 residents (R1) reviewed who exhibited wandering and elopement behaviors. This resulted in actual harm for R1 who fell in a stairwell sustaining left side rib fractures.	2 830	F689 This plan of correction constitutes Caledonia Rehab & Retirement□s written allegation of compliance for deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is	10/17/19

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2 830	Continued From page 2 Findings include: A late entry documented on 8/28/19, indicated R1 had an incident 8/27/19 at 6:10 p.m. The documentation indicated a WanderGuard alarm had sounded at a stairwell door leading to the assisted living where the resident's wife resided. The notes indicated the resident had presumably taken the stairs to get to his wife, and had fallen. When staff responded, the resident was found lying on the floor with complaints of pain. Incident documentation further indicated an ambulance had arrived at 6:35 p.m. to transport the resident, who had suspected rib fractures. An initial Facility Reported Incident (FRI) report was submitted to the State Agency (SA) 8/28/19 at 5:35 p.m. The report included: "WanderGuard sounded and CNA (certified nursing assistant) responded and found resident at the bottom of the stairs outside of dining room with walker remaining at top of stairs." The report further included: "Resident was transferred to the emergency room and will be evaluated for safety if sent back to facility. Wander Guard Company also came out 8/28/19 to ensure Wander guard system was working properly, which it was." R1's admission record documentation identified the resident as having diagnoses including: Diabetes, abnormalities of gait [walking] and mobility, dementia and anxiety. R1's quarterly Minimum Data Set (MDS) assessment dated 8/15/19, indicated the resident had severe cognitive decline, exhibited rejection of care, and did not exhibit wandering. The MDS also indicated R1 needed extensive assistance for transfers with one person, used a walker,	2 830	submitted to meet the requirements established by state and federal law. CORRECTION DATE 10/17/2019 Correction action for residents affected by the deficient practice. It is the practice and policy at Caledonia Rehab & Retirement to ensure that each resident receives adequate supervision and assistive devices to prevent accidents. Resident R1 experienced actual harm from a fall in the facility. Resident R1 was reviewed to verify adequate supervision to prevent access to the stairwell in which the fall occurred. There are two doors that have access to the stairwell and one of them is now permanently locked and the other has a new keypad installed and this now locks the door rather than an alarming delayed egress when there is a presence of a WanderGuard. No changes were made to the care plan. All staff were educated on the policy and procedure of the WanderGuard alarm, response to alarms, WanderGuard Bracelet functioning, Elopement Policy, the facility Elopement Book, Policy and Procedure for Fall Reduction, including Fall Scene Investigation and root cause analysis of falls. Identification of residents with potential to be affected by deficient practice and corrective action taken to prevent potential for being affected. No other residents experienced ill effects due to the noted observations. Measures/systematic changes to ensure deficient practice does not reoccur. There are two doors that have access to	

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2 830	Continued From page 3 required supervision when off the unit, and had unsteady balance. Review of R1's progress notes revealed behaviors including: 6/3/19 at 4:02 a.m., "[R1] was hallucinating. Claiming he was seeing twi [sic] kids running in his room and doing unnecessary behavior. Resident is very upset when comforted. Wandered in the hallways looking for exits. Had 1:1 with the resident, snack given, asked for pain medication for his headache. Comforted by talking 1:1, offered snacks and redirected, pain meds (medications) given." 6/19/19 at 4:35 a.m., progress note indicated R1 was restless at the beginning of the night and wandering around without pants on setting off alarms. The note indicated R1 was put back to bed but kept getting up stating he was looking for his room. R1 got tired halfway through the night and finally fell asleep in bed. However, the notes indicated while awake, the resident was pleasantly confused. Actions taken were identified as including; R1 was reoriented each time and shown where his room was. The note also indicated R1 was toileted and changed each time before assisted back to bed. 6/21/19 at 4:21 a.m., progress note indicated R1 was wandering before going to bed, and had gone into another resident's room to chat before allowing staff to take him back to his room. A late entry progress note documented 7/14/19 at 10:30 a.m., indicated on 7/12/19 R1 had been wandering around setting off alarms all night and	2 830	the stairwell and one of them is now permanently locked and the other has a new keypad installed and this now locks the door rather than an alarming delayed egress when there is a presence of a WanderGuard. A folding security gate was also ordered as a secondary barrier to the stairwell. The security gate will be installed upon its delivery to the building and the anticipated date of delivery is 10/25/2019. How facility will monitor performance to ensure solutions are sustained. WanderGuard system audits and locked door audits will be completed by the Maintenance Director or designee weekly for a minimum of 3 months or until 100% compliance has been met. The results of these audits will be reviewed weekly in morning stand up and at scheduled and Ad Hoc QAPI committee meetings. Additional education and monitoring will be conducted as identified.	

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2 830	Continued From page 4	2 830		

day searching for his wife. The note indicated R1 wanted to leave to catch his wife in the act of cheating. Further, the note indicated R1 had been wide-awake for about 48 hours. R1 set off an alarm and when staff responded, the resident's wheel chair was parked at the top of the stairs, and R1 was observed to have walked half way down the stairs, and R1 was identified as trying to go to see his wife.

A progress note 8/7/19 at 5:27 a.m., indicated R1 was confused and agitated and attempting to leave the building. The note indicated staff had taken the resident outside to de-escalate his behaviors and staff were able to redirect R1.

The progress note from 8/7/19 at 9:00 a.m., indicated the IDT (interdisciplinary team) had reviewed R1's behaviors. R1 had a history of delusions of paranoia regarding his wife, related to his diagnoses of progressing dementia (with behaviors) and paranoid state. Care plan reviewed and interventions identified as in place to reduce potential for injury to other residents. Root cause: R1 has paranoia and dementia with perseveration on his wife's alleged infidelity (unfounded). New interventions were identified to include: Placing R1 on 15 min (minutes) checks x 24 hours, care plan revised to include keeping other residents at arm's length if resident is expressing concerns regarding wife's infidelity.

A progress note from 8/25/19 at 2:15 a.m., indicated R1 was aggressive and exhibited sexually inappropriate and physically abusive behaviors towards caregivers. Interventions implemented included 1:1 with resident.

An additional progress note from 8/25/19 at 3:35

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2 830	Continued From page 5 a.m., also indicated R1 was exhibiting aggressive behaviors towards the nursing staff. The note further indicated the physician had been called and had prescribed lorazepam (an antianxiety medication) 0.5 mg (milligrams) x 1, and to call the local authorities if behavior were very disruptive and the resident threatened to hurt caregivers. The note indicated the nurse had called 911 for assistance, when the resident was not listening and could not be redirected. The resident was placed in restraints and was sent to the hospital. Follow up notes indicated the resident was readmitted 8/26/19. A progress note from 8/27/19 at 6:11 p.m., reiterated the wandering behavior R1 exhibited and his fall in the stairwell. A late entry progress note dated 8/28/19 at 10:00 a.m., indicated the IDT reviewed R1's incident: "Resident has advancing dementia with a history of sun downing, poor safety awareness, falls and attempting to follow his wife back to attached Assisted Living." Interventions identified as in place to reduce potential falls and injury to resident were identified to include: "Resident has WanderGuard in place, and was verified to be functioning. ROOT CAUSE: Resident often becomes distressed when his wife leaves after evening visit and attempts to follow her back to assisted living. He uses FWW (front wheeled walker) for ambulation. Previous attempts to educate wife on effects of her late visits during sun downing were ineffective as they choose to enjoy their time together and it is within the resident's rights to allow these visits. NEW INTERVENTION: IDT met to discuss incident. Team verified resident's WanderGuard and key pads were functional in area of incident. Further	2 830		

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2 830	Continued From page 6 review of adding keypad entry to access these areas is underway at time of writing. Resident is currently in hospital; care plan will be evaluated upon planned return to address additional interventions. No caregiver misconduct is suspected." An nursing progress note from 8/30/19 at 10:56 a.m., indicated R1 was readmitted after a fall with multiple left sided rib fractures. R1's current care plan identified R1 as an elopement risk/wanderer, initiated 2/20/19. Interventions included: "Check placement of WanderGuard every shift and function every night shift, distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. The care plan indicated R1 preferred TV (television) or reading, and included: Identify pattern of wandering- Is wandering purposeful, aimless or escapist? Is the resident looking for something? Does it indicate the need for more exercise?" Additional care plan interventions included: provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Wander alert: WanderGuard on walker and check function nightly. The care plan also indicated R1 was at risk for falls related to dementia and use of an assistive device for mobility. The goal initiated 2/20/19 included: Will be free of falls. Interventions included: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance...	2 830		

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2 830	Continued From page 7 Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. In addition, the care plan identified the resident had a behavior problem related to dementia identified 4/2/19. The goal included: Will have fewer episodes of behavior. Interventions included: Monitor behavior episodes and attempt to determine the underlying cause. Consider: Location, time of day, persons involved, and situations. Document behavior and potential causes. R1's Elopement Assessment completed 7/12/19, identified the resident's risk for elopement with identification of behavior and mood. The assessment indicated R1 was resistive to long term care placement, and verbalized a desire or plan to leave the facility unauthorized/unsupervised and had cognitive impairment. The assessment also indicated R1 had a history of attempts to get to his wife's living place in the assisted living. The assessment indicated R1 had impaired safety awareness, made attempts made to take elevator and/or stairs to get to assisted living and does not notify staff. Wander guard in place, function checked every shift. Uses 4WW (four wheeled walker) to ambulate throughout the facility, and indicated "May be redirected at times, other times verbally confrontational with staff and threatens to run staff down with walker. Occasionally states he is going to throw his walker through the window. Believes male staff are having an affair with his wife, female staff are preferred during paranoid delusions about his wife."	2 830		

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2 830	Continued From page 8 Although the facility had identified R1's behaviors and risk for leaving the unit to go see his wife in the assisted living, the resident was not adequately supervised to prevent access to the stairwell. Post fall, R1 was assessed by Occupational Therapy (OT) 9/3/19. The OT assessment indicated R1 was a high fall risk and required one person assist for transfers and ambulation to ensure his safety. In addition, the assessment indicated R1 required assist with toileting, self-cares-do not leave unattended in bathroom, and for staff to anticipate needs such as offering assist for toileting, and walking to meals before he self-transferred. During an observation and interview on 9/5/19 at 11:40 a.m., dietary aide (DA)-A verified there were no physical barriers in front of the dining room exit door to prevent someone from walking through. Although there was a letter size posting which read, "stop, no residents beyond this point." DA-A opened the door to show the surveyor the stairwell. There was a steel pipe that appeared to be cemented into the floor which was not new. DA-A stated maintenance and kitchen are located downstairs. During an observation and interview on 9/5/19 at 1:00 p.m., family member (FM)-A was sitting in R1's room while R1 was sleeping in his recliner. FM-A said R1 had been in the hospital over the last week. FM-A said R1 had been trying to follow his wife back to the assisted living and had fallen down the steps and broke ribs. FM-A stated, "You have to take the elevator but can get to the assisted living from the steps, but it is a level down." FM-A stated R1 has dementia. FM-A said	2 830		

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2 830	Continued From page 9 R1 had followed his wife over to the assisted living before but had not previously fallen. FM-A verified staff had asked R1's wife not to come visit as often in the evenings. During a phone interview on 9/5/19 at 1:36 p.m., nursing assistant (NA)-C said R1 had experienced an unwitnessed fall and stated she (NA-C) was the first to see R1. NA-C said she'd been in the common area when the alarm sounded. NA-C said she'd thought to go in the stair well to check the entrance because, "R1 has gone there before." NA-C said no one saw R1 go by the dining room. NA-C said when she went through the closed door, she saw R1 laying on the second landing, ran down to assist him, and the left alarm sounding until other staff arrived. NA-C said R1's wife uses the door off the common room when she goes back to the assisted living. NA-C said R2 had previously gone through the doors to the stairwell, but had not fallen. NA-C said the keypad was protected and a person had to punch in a code to open the outside exit door, but the doors from the hallway and dining room do not have that feature, so a person could walk through. NA-C stated, "There is a wheelchair (WC) stopper to prevent WC from going down the stairs, but R1 used a walker and is independent to walk around the facility." NA-C said R1's wife had left about 20 minutes prior to R1 going into the stairwell. On 9/5/19, at 2:15 p.m. registered nurse (RN)-A stated, "Nurses were sitting at the nurse's station (overlooks the common area) and were in the middle of a shift change report at the time of the incident." RN-A said, "[NA-C] told us (the nurses) [R1] was by the stairs, but we did not hear the alarms." RN-A stated he'd checked the stairwell	2 830		

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2 830	Continued From page 10 and observed R1 lying on the floor with NA-C by him holding his head. RN-A said they decided to send the resident to the ER [emergency room]. RN-A was asked again if the alarm was sounding. RN-A said he had not heard any alarm adding the shift report occurs at the nurses' station. RN-A said if an alarm was sounding we should have heard the alarm. RN-A stated there are two accesses to the stair well. One off the common room and the other from the main dining room. RN-A said R1 was independent before the incident happened but now requires assistance. RN-A added he really didn't know how R1 got on the other side of the door. RN-A said the facility was working on a plan following the incident, and the director of nursing (DON) was working on care plan updates after the incident. RN-A also verified R1's wife uses the door off the common area to go back to the assisted living, and that they'd placed a sign on the door that reads STAFF ONLY. However, RN-A verified R1 has dementia and may not be able to, or understand, the sign on the door. During the interview, RN-A reviewed the notes in the computer and reiterated the incident occurred on 8/27/19 about 6:11 p.m. RN-A verified R1 had been looking for his wife prior to the incident. During interview with the maintenance director on 9/5/19 at 3:10 p.m., the maintenance director explained the alarm system in the common room, and stated the dining room door was the same type of system stating, "Residents with a WanderGuard will sound the alarm if close to the sensor and the door is opened. The facility is having the alarm company give an estimated for making the two doors lock." When the maintenance director opened the door, it was noted the alarm was faint at the nursing station.	2 830		

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2 830	Continued From page 11 At that time, DON-A was asked about the alarm sounding. DON-A verified the faint beeping alarm coming from the door. The maintenance director said the alarm continues to sound until manually shut off and stated a warning "name" is announced on the walkie-talkie the staff carry with them. The maintenance director stated after the incident, maintenance was told to get an estimate to have the automatic doors be key padded like the other outside exit doors. This would ensure if someone with a WanderGuard got close to the doors, it would lock to prevent the resident from opening and going through the door. On 9/6/19, at 5:30 a.m. RN-B said he recalled R1's incident. RN-B said the nurses were at the nurses' station having shift report and heard a faint sound. The sound was faint because the doors were closed to the main dining room. RN-B verified R1 had been found on the floor in the stairwell with complaints of his left side hurting. RN-B said prior to the fall, R1 had been exhibiting inappropriate behaviors towards an NA. RN-B also said R1 was likely looking for his wife who lives in the assisted living. RN-B said R1 must have used the side door to the dining room. RN-B was unable to recall any other instances of R1 getting out that door, but stated, "He is a wanderer and sets off the other alarmed doors. He used to be independent to move around the facility but he now needs assistance." RN-B verified they'd called 911 to get emergency transport for R1 due to the resident's pain. During a phone interview with DON-B and the administrator on 9/20/19 at 2:05 p.m., DON-B verified R1 had previously been found in the stairwell 7/12/19. DON-B verified she is part of	2 830		

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2 830	Continued From page 12 the IDT meeting and was unsure why there had been no follow to the 7/12/19 incident documented 7/14/19. The administrator stated staff training had been completed on 9/5/19. The administrator said they had already put interventions in place, such as contact with the wireless alarm company to get a quote on an updated system which would lock if someone wearing a WanderGuard came close to the door. However, the administrator stated the quote is $5800 and had not yet been initiated. The administrator verified they'd previously posted a sign indicating Staff Only and NO Resident Beyond this Point. The administrator also stated staff now walk with R1's wife and the resident when the wife is getting ready to leave the facility to deter the resident from following his wife back to the assisted living. The DON stated additional safety interventions put in place included additions to the new hire education plan including more dementia training to describe methods for how to deescalate/redirect resident behaviors. The administrator verified their alarm system could generate reports of data on the time the alarms were set off and how long they were on for. However, reports were not available for the surveyor. The administrator also said the previous DON had been working on the issue with R1 and his attempts to go through the stairwell doors to get to the assisted living in July. He said it was unclear whether the previous DON had reviewed the reports from the computer for alarm data from the July incident. The facility's 8/2014 policy Wandering, Unsafe Resident, included: The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will identify	2 830		

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2 830	Continued From page 13 residents who are at risk for harm because of unsafe wandering (including elopement). The policy also included; the staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure appropriate, comprehensive nursing care is provided in accordance with assessed resident needs.. The DON or designee could audit progress notes and incidents reports to ensure ongoing compliance. The DON could report the audit results to the quality assurance group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		