STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. Building B. Wing	10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moorhead Restorative Care Center	2810 Second Avenue North Moorhead, MN 56560

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to notify family following an incident of elopement for 1 of 1 residents (R1) reviewed who was found outside the facility without staff knowledge. Findings include: R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of orthostatic hypotension, depression and anxiety disorder and had moderate cognitive impairment. Further, MDS indicated R1 required extensive assistance from two staff for bed mobility, and transfers and utilized a wheelchair for mobility. Review of facility report submitted to the SA dated 10/7/22, at 1:29 p.m. indicated R1 had eloped from the building on 10/4/22, at approximately 12:00 a.m. R1's progress note dated 10/4/22, indicated R1 was last observed in facility at 12:00 a.m. and during rounds at 12:30 a.m. R1 was not in his room. R1 was found outside near the main entrance, sitting on the cement without his wheelchair, wearing sweatpants and no shirt. R1 was assessed for injuries and no injuries were noted. Further, the progress note indicated the nurse manager will notify family and provider during business hours. R1's record lacked evidence family was notified. On 10/11/22, at 11:27 a.m. family member (FM)-A indicated R1 had displayed mild confusion, anxiety, and delusional episodes since being admitted to the facility. FM-A confirmed they were unaware R1 had a WanderGuard implemented and R1 was found outside of the facility on 10/4/22, without staff knowledge. On 10/11/22, at 3:08 p.m. registered nurse (RN)-A indicated R1 was found outside of the facility sitting on the cement and leaning against a tree by the main entrance on 10/4/22, at approximately 12:00 a.m. and R1's WanderGuard did not alert staff. Further, RN-A indicated staff were expected to notify family immediately if an emergency other wise if an incident occurs in the middle of the night with no injury staff will report to the morning shift to update family. RN-A confirmed she did not update R1's family and was unsure if the family was updated. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/22, at 5:00 p.m. RN-B indicated staff are expected to notify family immediately if there was an injury or nonemergent updates staff can do during business hours. Further, RN-B was unsure if R1's family was notified following the elopement incident. On 10 /12/22, at 9:05 a.m. director of nursing (DON) indicated nursing staff were expected to update families immediately during an emergency or the following day during business hours if nonemergent. Review of facility policy titled Elopements dated 5/22, directed staff to notify the resident's legal representative once the resident returns to the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43083 Based on interview and document review, the facility failed to report an incident of elopement to the State Agency (SA), within 24 hours, as required for 1 of 1 residents (R1) reviewed for elopement. Findings include: R1's care plan dated 10/4/22, indicated R1 was at risk for elopement related to disoriented to place, impaired safety awareness, and aimless wandering. Review of facility report submitted to the SA dated 10/7/22, at 1:29 p.m. indicated R1 had eloped from the building on 10/4/22, at approximately 12:00 a.m. On 10/11/22, at 3:08 p.m. registered nurse (RN)-A indicated R1 required the use of a WanderGuard (WG) due to at risk for eloping from facility. Further, RN-A indicated R1 was found outside of the facility sitting on the cement and leaning against a tree by the main entrance on 10/4/22, at approximately 12:00 a.m. and R1's WG did not alarm staff. RN-A indicated R1's nurse manager RN-B was updated on the incident during the night but was unsure on time. On 10/11/22, at 5:00 p.m. RN-B indicated RN-A had called in the middle of the night on 10/4/22, and reported R1 was found outside and was last witnessed in the facility approximately 30 minutes earlier. Further, RN-B indicated she then notified director of nursing (DON) following the phone call with RN-A. In addition, RN-B indicated the incident was discussed at the manager meeting that morning and the administrator was notified then. RN-B was unsure on reporting requirement timeframe to the SA and stated, reporting is above my head. On 10/11/22, at 5:34 p.m. DON indicated on 10/4/22, R1 wandering into the therapy department due to the doors being unlocked and left open and was found outside the facility by the front entrance at approximately 12:30 a.m. DON confirmed R1's WG did not alert staff. Further, DON indicated facility policy for reporting elopements to the SA was within 5 days per administrators' guidance. Review of facility policy titled Elopements dated 5/22, directed staff all elopements will be reported to the Office of Health Facility Complaints (OHFC) and a full report with follow up and summary of incident and outcome as specified by state and federal regulations. Facility lacked timeframe for reporting elopements to the SA.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to ensure an elopement was thoroughly investigated and appropriate interventions were implemented to prevent future elopements for 1 of 1 residents (R1), whose WanderGuard failed to alert staff, was placed incorrectly and was not being tested per manufacturer's guidelines. Findings include: R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of orthostatic hypotension, depression and anxiety disorder and had moderate cognitive impairment. Further, MDS indicated R1 did not exhibit wandering behaviors but required the use of a WanderGuard (WG) daily. Review of facility reported incident submitted to the State Agency on 10/7/22, indicated R1 had eloped from the facility on 10/4/22, at approximately 12:00 a.m. R1 had self-propelled in his wheelchair to the therapy department exit door and was found outside the building near the main entrance. R1's WG was attached to metal frame of wheelchair at time of incident which was removed and a new WG placed on R1's leg as an immediate intervention. Review of 5-day investigation submitted to the State Agency dated 10/11/22, indicated the root cause of the incident to be therapy department door was left unlocked when all therapy staff left for the day. Further, R1 was noted to wander through facility with wheelchair and was not known to self-ambulate, so following the incident of R1 walking out of the therapy door and leaving his WG and wheelchair in the therapy department a new WG was placed on R1's left ankle along with implementing frequent checks. Interviews with R1's nursing assistants (NA-A and NA-B) on 10/11/22, who worked the night of the elopement, revealed confirmed the WG system alarm was sounding at the time of the incident when they found R1's wheelchair in the therapy department, however the alarm was faint and could not be heard from the residential care floor. NA-A and NA-B also confirmed they were not formally interviewed by the DON during the investigation. On 10/11/22, at 5:34 p.m. director of nursing (DON) indicated she completed the investigation which included interviewing the over night nurse on duty the night of 10/4/22, when the elopement occurred. DON stated the root cause of the elopement was due to therapy department failing to lock the door before leaving and due to R1 self ambulating out of the door leaving his wheelchair and WG behind the WG system did not alert staff of exit from the facility. DON confirmed she did not interview R1's nursing assistants that responded to the elopement and found R1 outside. On 10/11/22, at 9:05 a.m. DON confirmed the facility had completed their 5-day investigation and submitted the investigation to the State Agency. DON confirmed the WG manufacturer was not called to inquire about WG system malfunction, was not aware the alarm sounded or that the volume was low (though all doors were checked following the elopement), or R1's WG's was not placed according to manufacturer's guidelines.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 The 2567 for federal deficiencies has been revised as a result of an IIDR Based on observations, interviews, and document review, the facility failed to ensure to ensure safety checks were completed following an elopement and the appropriate use of a WanderGuard device to ensure staff are alerted when a resident elopes from the facility 1 of 3 residents (R1). In addition, the facility failed to follow manufacturer's guidelines for WanderGuard system use and testing for 4 of 4 residents (R1, R2, R3, R4) reviewed for elopement. Findings include: R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of orthostatic hypotension, depression and anxiety disorder and had moderate cognitive impairment. Further, MDS indicated R1 required extensive assistance from two staff for bed mobility, and transfers and utilized a wheelchair for mobility. R1's care plan dated 10/4/22, indicated R1 was at risk for elopement related to disoriented to place, impaired safety awareness, and aimless wandering. The care plan directs staff to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, identify [NAME] of wandering, wander alert bracelet (WanderGuard), and monitor location. R1's care plan lacked direction for staff on how often monitoring or visual checks on R1. R1's medical record lacked evidence R1's WanderGuard (WG) function was being monitored since placement on 9/23/22. R1's incident report dated 10/4/22, indicated nursing staff noted R1 was not in room at 12:30 a.m. during rounds. R1 was last seen in the facility at 12:00 a.m. by nursing staff. R1 had self-propelled in wheelchair and exited the door in the therapy room. R1 was found outside sitting on the cement without his wheelchair by the front entrance (this door is approximate 15-20 ft from therapy door). R1 was assessed for injuries and no injuries were noted. Review of facility reported incident submitted to the State Agency on 10/7/22, indicated R1 had eloped from the facility on 10/4/22, at approximately 12:00 a.m. R1 was found outside the building near the front entrance. R1 had a new WG placed on R1's leg as an immediate intervention. On 10/11/22, at 11:27 a.m. R1 was observed sitting in his recliner in his room. R1 had a circle shaped WG on left ankle. During continuous observation until 12:04 p.m. an unidentified nursing assistant visually checked on R1. (37 minutes). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/22, at 3:08 p.m. registered nurse (RN)-A indicated all residents who are at risk for eloping have a WG and interventions in their care plans directing staff what to do when they are exhibiting exit seeking or wandering behaviors. RN-A indicated R1 appeared to be confused and exhibited wandering behaviors but was unaware if R1 required visual safety checks. Further, RN-A indicated on 10/4/22, at approximately 1:00 a.m. RN-A observed two nursing assistants (NA) outside with R1. R1 was sitting on the cement by the main entrance leaning against a tree without his wheelchair. R1's wheelchair was found at the therapy department exit door and his WG had not alerted staff. Following the incident R1 was placed on 15-minute visual safety checks, but RN-A was unsure if R1 continued to be on the safety checks at that time. On 10/11/22, at 3:35 p.m. nursing assistant (NA)-A indicated residents who are at risk for elopement were identified in each resident's care plan and frequent visual safety checks are in place to ensure the resident was still in the facility. NA-A indicated R1 had confusion and exhibited exit seeking and wandering behaviors more in the evenings. NA-A stated interventions used when R1 was exhibiting these behaviors included redirection and frequent visual checks but was unsure how often stated at least hourly. NA-A stated NA-B was R1's care staff on the night of 10/4/22, and R1 was last observed attempting to exit the front entrance in his wheelchair at approximately 12:30 a.m. when staff redirected R1 back to his room and into bed. At approximately 1:00 a.m. during rounds NA-A stated R1 was not in his room and they began to search for R1 in the facility. NA-A and NA-B heard a faint alarm in the therapy department where R1's wheelchair with the WG attached was found next to the exit door, so staff exited outside and found R1 sitting on the cement by the main entrance. Further, NA-A indicated following the incident R1 was placed on 15-minute visual safety checks but was unsure if those safety checks were still in place. (time noted in interview was different than time indicated in facility incident reported to State Agency) On 10/11/22, at 3:54 p.m. interview with regional services manager (RSM) at RF Technologies (WG manufacturer) indicated if there was a malfunction with the facility's WG system, the facility would be expected to contact RF Technologies to work through the problem. On 10/11/22, at 4:01 p.m. NA-C indicated R1's cognition varied each day and R1 exhibited wandering and exit seeking behaviors. NA-C indicated interventions for R1's behaviors included a WG placement and checking on R1 regularly but was unsure if R1 required scheduled visual safety checks. On 10/11/22, at 4:16 p.m. NA-B indicated needs assistance with all activities of daily living due to R1's low blood pressure and fall risk. NA-B stated R1 was disorientated and exhibits wandering and exit seeking behaviors and NA-B was unsure what interventions were in place for R1's behaviors. Further, NA-B indicated on 10/4/22, at approximately 11:00 p.m. R1 began exhibiting wandering and exit seeking behaviors and while beginning rounds at approximately 12:00 a.m. R1 was not in his room. NA-B indicated NA-B checked in the therapy department and heard the WG system alarm but it was very faint. NA-B observed R1's wheelchair at the door with the WG attached and R1 was outside by the main entrance. In addition, NA-B indicated following the incident 15- minute visual checks were implemented for R1, but was unsure if they were still in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/22, at 5:00 p.m. nurse manager (NM) indicated residents are assessed for elopement risk on admission and interventions were determined by the providers and nursing staff. NM was not aware of interventions for R1's wandering and exit seeking behaviors other than a WG placed and reorientation or redirection. NM indicated R1 had an elopement from facility on 10/4/22, due to the WG system alarm did not sound because R1 left his wheelchair inside the facility. Further, NM confirmed R1 had a WG placed on his ankle following the incident rather than on his wheelchair and NM was unsure if R1 was on visual safety checks following R1's elopement incident. NM indicated placement of a WG is determined by the least restrictive placement which is typically the wheelchair unless the resident is ambulatory then it would be placed on their ankle. NM confirmed R1 did not have WG daily function monitoring and placement check in his record and indicated the nurse practitioner typically puts in an order for staff to complete this. On 10/11/22, at 5:34 p.m. director of nursing (DON) indicated since R1's elopement on 10/4/22, R1's WG was placed on his ankle and 15-minute safety checks were implemented to prevent future elopements. DON confirmed R1's care plan was not revised with new interventions and the interventions were only communicated verbally to nursing care staff. In addition, DON indicated the 15-minute checks were being completed by paper form by R1's nursing care staff. At 6:02 p.m. DON confirmed the 15-minute checks were not being implemented due to not being able to find the documentation at either nursing stations. Review of facility policy titled Elopements dated 5/22, indicated all residents shall be screened during admission and annually reviewed or with significant change for potential for elopement on the elopement assessment. Further, policy directed staff to implement the following safety measures for residents who are identified to be at risk for elopement: WanderGuard bracelets for each resident will be tested weekly, WanderGuard doors will be tested monthly, a log of residents with WanderGuard bracelets will be kept by nursing with expiration dates of the WanderGuard, and if the WanderGuard system is down visual checks of the residents with WanderGuard bracelets would be done every 30 minutes. R2's quarterly MDS dated [DATE], indicated R2's diagnoses included depression, psychotic disorder and had moderate cognitive impairment. Further, R2 did not exhibit behaviors but required the use of a WG alarm daily. R3's quarterly MDS dated [DATE], indicated R3 had a diagnosis of delirium and moderately impaired cognition. R3 did not exhibit wandering behavior but required the use of a WG alarm daily. R4's quarterly MDS dated [DATE], indicated R4's diagnoses included stroke, anxiety and had severely impaired cognition. R4 did not exhibit wandering behavior but required the use of a WG alarm daily. On 10/11/22, at 2:53 p.m. LPN-B stated there are currently four residents in the facility who are considered high risk for elopement, and they all have a WG in place. Further, LPN-B indicated WGs are monitored daily for placement and functioning by bringing each resident to the door that is alarmed. On 10/11/22, at 3:08 p.m. RN-A indicated placement of a WG was determined by assessing each resident and place the WG in a least restrictive area, typically on their ankle or wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/22, at 5:00 p.m. NM indicated nursing staff are expected to monitor each resident's WG functioning and placement daily by bringing each resident to the door to ensure the alarm will sound. On 10/12/22, at 9:15 a.m. R2 was observed laying in bed in room with a circle WG on left ankle, confirmed by DON. On 10/12/22, at 9:17 a.m. R3 was observed in his room in bed with a circle WG on left ankle and a second WG placed on the back of his wheelchair on the metal frame, confirmed by DON On 10/12/22, at 9:19 a.m. R4 was observed self-propelling in hallway in his wheelchair with a circle WG on his ankle, confirmed by DON. On 10/12/22, at approximately 9:19 a.m. DON indicated staff were expected to monitor each resident's WG daily by bringing each resident to the door to ensure it is functioning and in place daily. On 10/12/22, at 9:42 a.m. RSM at RF Technologies (WG manufacturer) indicated the circle WG should be placed on the resident's wrist only due to less transmission and placing the circle WG on an ankle it is further from the receiver which places the resident at greater risk of getting out of the facility. Further, RSM indicated testing the WGs should be completed using a tester provided by RF technologies and not bringing the resident to the door due to inconvenience to the resident as well as safety concerns with showing the resident the exits and functioning. Review of WG manual titled, Wander Management Transmitters User Guide dated on page 10 directs a CodeWatch (circle WGs) was smaller than a transmitter and is placed on the wrist of a resident. Further, WG User Guide directed to test operation of transmitters using the transmitter tester and never take a resident to a door to test their transmitter.