STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 Based on interview and document review, the facility failed to ensure resident identified as elopement risk had a functioning WanderGuard unit or other interventions were implemented to prevent elopements for 1 of 3 residents (R1) reviewed for elopements. This resulted in an immediate jeopardy (IJ) for R1. The IJ began on 12/1/21 when R1's WanderGuard was tested and determined to not be functioning but was not replaced, nor was additional interventions put in to place to keep R1 safe until the WanderGuard could be replaced. Then on 12/8/21 R1 eloped out of the building and was found by a visitor/contractor lying in a snowbank unharmed. The facility failed to place immediate interventions to prevent a future elopement when it was again determined R1's WanderGuard was not functioning, which resulted in R1 eloping out of the building again an hour later (on 12/8/21), and was found by another visitor outside (on campus) unharmed. In addition, there were no immediate interventions placed after the second elopement. On 12/15/21, at 3:30 p. m. administrator, director of nursing (DON), and consultant were notified of the IJ. The IJ was removed on 12/16/21, at 1:46 p.m. but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of facility report number 345259 to the State Agency (SA) dated 12/8/21, indicated R1 went outside wearing 2 tee-shirts and sweatpants. He subsequently fell on the ice as he tried to stand and into the snow bank. Staff was notified that the resident was outside in the snow bank by a pharmacy tech that was delivering medications to the facility. Review of the 5-day investigation to the SA dated 12/9/21, indicated replaced wanderguard bracelet as his was not in working condition as the action taken to prevent reoccurrence to resident. R1's annual Minimal Data Set (MDS) dated [DATE], indicated R1's diagnoses included Alzheimer's, dementia and had severe cognitive impairment. R1 required extensive assistance from one staff for activities of daily living, however, was able to utilize wheelchair independently for mobility. Further review of MDS, indicated R1 had delusions but did not exhibit any wandering behaviors. R1's Elopement Risk assessment dated [DATE], identified R1 as an elopement risk related to decreased motivation and cognitive status, has attempted to leave in the past. However, assessment lacked information related to interventions in place to prevent a future elopement. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's care plan dated 12/8/21, indicated R1 displayed paranoid behaviors and would accuse people of stealing his car and that staff were lying to him. R1's care plan directed staff to provide one on one attention, distractions, and offer food and beverages. R1's care plan lacked information on R1 being an elopement risk and interventions for staff when resident was displaying wandering or exit seeking behavior. However, on 12/14/21, after survey entrance, R1's care plan was revised to include R1 had a history of elopement and directed staff to observe for wandering behaviors, offer activity when restless, redirect as able, replace WanderGuard every 85 days, and check WanderGuard for placement and functioning located on R1's left wrist. Review of R1's progress notes lacked evidence of the two elopements occurring on 12/8/21. Further review of R1's progress notes dated 12/10/21, indicated R1 was seen by the nurse practitioner who observed and spoke with resident. The following order was received: Collect UA [urinary analysis] for increased confusion. However, R1's progress notes lacked evidence that a UA was attempted or obtained with the results. R1's Incident Details report dated 12/8/21, indicated, Resident has been fixated on his glasses getting fixed. He did come to the dining room but was too fixated on his glasses to eat any supper. He wheeled himself out of the dining room. At [6:05 p.m.] this writer went to the door for medication delivery. The delivery person said something about a man in a wheelchair outside. The delivery man assisted with resident getting into the wheelchair and back into the facility. I did bring him down to his room so he could use the bathroom. He is sitting at the nursing station with me now. He has no bruises or scratches from falling sideways into snowbank. Further review of incident report, lacked evidence of immediate interventions placed to prevent future elopements for R1. Review of a second incident report dated 12/8/21, at 7:15 p.m. indicated R1 was fixated on his car when he self- propelled in his wheelchair down the hallway. It was noted by a nursing assistant another visitor had seen him outside and helped him back in through the front doors. This incident report indicated staff reoriented R1, offered food and R1 went to his room. Review of licensed nurses' 24-hour report sheet dated 12/1/21, indicated R1's WG [WanderGuard] not working. In addition, review of the 24-hour report sheets lacked evidence of R1's WanderGuard being addressed. On 12/14/21, at 1:50 p.m. R1 was observed to be sitting at the edge of his bed and a WanderGuard bracelet was on his left wrist. R1 stated he had just woken up from a nap and appeared to be mildly confused when responding to surveyors questions. On 12/14/21, at 3:18 p.m. licensed practical nurse (LPN)-A indicated R1 was known to get agitated and concerned about things and he won't forget about it. Further, LPN-A indicated prior to R1's two elopements on 12/8/21, R1 required a WanderGuard bracelet, however, it hasn't been working for a week if not more. Everybody knew it wasn't working so we were watching him closely. In addition, LPN-A indicated R1 was noted to wander nearly every day and has attempted to exit the building in the past. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/14/21, at 3:51 p.m. registered nurse (RN)-A indicated R1 had no short-term memory and will often get fixated on something and there is only so much you can do. On 12/8/21, R1 was noted to be fixated on his glasses and would not eat the supper meal. R1 left the dining room and ended up outside in a matter of minutes. R1 fell out of the wheelchair and into a snowbank with no injuries noted. RN-A brought R1 back into the facility and assessed R1 for injuries. RN-A indicated she re-orientated R1 and notified the DON. RN-A then noted R1 fixated on finding his car and wheeling past the nursing station in the hallway and called for a CNA to get R1. By the time the CNA reached R1, R1 was being brought back into the facility by a visitor. RN-A then indicated she re-orientated R1 once again and the staff got him ready for bed. RN-A indicated R1 had a WanderGuard on, however, after the first and second incident RN-A did not check the WanderGuard, but it did not sound the alarm for both incidents. RN-A stated, I didn't put any extra monitoring in place. I just passed it on in the 24-hour report, so everyone knew what was going on with him [R1]. On 12/15/21, at 8:16 a.m. LPN-B indicated R1 will persistently ask where he should be or what he should be doing and we [staff] use a lot of reassurance but its very difficult to redirect and reorient due to poor short-term memory. Further, LPN-B indicated she checked R1's WanderGuard for functioning a week or week and a half ago and it was not functioning, so I passed it through report, and I believe we didn't have it [new WanderGuard] in the building. I believe we ordered some. On 12/15/21, at 8:43 a.m. nursing assistant (NA)-A indicated R1 was not identified as an elopement risk and did not wear a WanderGuard. NA-A indicated staff are made aware of elopement risk and interventions through report, however some aids are not good at communicating and NAs are also able to look at the nursing care guide sheets. On 12/15/21, at 9:47 a.m. RN-B indicated R1is not orientated and getting worse. RN-B indicated R1 was identified as an elopement risk with interventions that included 1-1, offer food, drink, and distractions. RN-B indicated all of the interventions are in R1's care plan, however, they were just added to the care plan on 12/14/21. RN-B indicated, Staff know by word of mouth and interventions are placed on the care guide sheets, however, as of 12/15/21, the care guide sheets did not identify R1 as an elopement risk nor provide staff with interventions. RN-B indicated she was aware that R1's WanderGuard was not working but was unable to give a date when she was made aware. RN-B indicated she updated maintenance to order some when she found out R1's was not working and stated, I didn't put anything in place because he wasn't exit seeking to be honest with you. RN-B was unsure what was implemented following R1's incidents on 12/8/21, as well. When asked what the process is once staff identify the WanderGuard is not working, RN-B stated, I can't answer what the process is. On 12/15/21, at 10:15 a.m. environmental services director (ESD) indicated he was not aware of R1's WanderGuard not functioning properly prior to his two elopements on 12/8/21. Further, ESD stated, Prior to that we didn't have any extras because that is when they told me they were out. I think it's a lack of communication. I should check to make sure they don't run out. In addition, ESD stated, She [RN-B] said one was outdated and I think that was [R1]'s. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/15/21, at 10:48 a.m. director of nursing (DON) indicated WanderGuards were being monitored on the overnight shift but after R1's incidents was changed to be checked on days and evenings due to they were either not being done or not being communicated that they were no longer working. When asked what the process is when the WanderGuards are identified as not working and no extras are found, DON stated, communicate to the am staff so that they can get more. There is nothing in place at this time to be [NAME] with you. DON indicated staff know who an elopement risk is by knowing who has a WanderGuard on and the licensed nursing staff are able to look in the care plans to identify and what interventions are in place. However, DON confirmed R1's care plan was updated on 12/14/21, with elopement risk and interventions. DON indicated on 12/8/21, R1 eloped outside looking for his glasses and he tried to stand and fell on the ice. There was no injury noted. DON indicated she was aware R1's WanderGuard was not working that night, so DON directed staff to keep eyes on him until he went to bed. DON left for the evening and was not aware of the second incident until the following morning on 12/9/21. DON was unsure what was put into place after the second incident. Once DON was aware of the second incident on 12/9/21, DON stated, I asked [Maintenance] for a WanderGuard to replace it and we found out we didn't have any so then they were ordered. When asked what was put into place until the new WanderGuard arrived, DON stated, check on him more frequently and to know where R1 is at every hour. DON indicated she verbally updated staff but, I didn't document it anywhere looking back I should have done a one-hour safety check. Further, DON indicated she was not aware that the WanderGuard was not working on 12/1/21, and you can assume that it was not working from 12/1/21 through 12/8/21. On 12/15/21, at 11:14 a.m. administrator was not aware that there were no WanderGuard's available for R1 nor was she aware the WanderGuard was not working on 12/1/21. In addition, administrator indicated when staff identify a WanderGuard is not functioning they were expected to change it and if there were no WanderGuards available they should call maintenance. He has back ups in his office. Further, administrator indicated if there were no WanderGuard's available in the building at that point they would need to do safety checks. On 12/15/21, at 1:14 p.m. RN-C indicated staff were to check on the overnight shift for Wanderguard functioning. RN-C indicated if a WanderGuard is identified as not working, I will report it to the next shift. I don't know where to find the new ones. I just report it to the next shift and let them know. RN-C confirmed prior to R1's incident she knew his WanderGuard was not functioning and I heard it wasn't working probably weeks before that. I can't tell you the exact date but I had known it wasn't working. RN-C stated, The night before he got out I was working and I don't believe it was working. I don't know if it was reported. It was reported so many times I think I just gave up on it. Review of facility policy titled, Elopement revised 10/23/17, indicated all residents will be assessed for risk of wandering or elopement and if the resident is identified to be at risk for elopement interventions will be in place to prevent an elopement, and the nurse will enter these into the resident's care plan. Further review of policy indicated nursing will test the notification bracelet (WanderGuard) daily for proper signaling and damage to the bracelet. However, the policy lacked direction for staff if the WanderGuard bracelet is checked and is not functioning correctly and what they are supposed to implement to protect the resident from an elopement. The IJ which began on 12/1/21, was removed on 12/16/21, at 1:46 p.m. after the facility successfully implemented a removal plan which included the following: - All resident's requiring a WanderGuard were reviewed and checked for functioning (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Audits on WanderGuard supply - Modified charting procedure to include the functional status in the resident's treatment record - Updated elopement policy - Updated maltreatment policy to include steps to take when a WanderGuard is not functioning and - All staff/ nurses were to review both policies prior to working next shift; but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.