STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. Building B. Wing	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of St Cloud	1717 University Drive Southeast Saint Cloud, MN 56304

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** 44645 Based on observation, interview and document review, the facility failed to identify possible elopement behaviors and develop interventions for 1 of 1 residents (R1) who was cognitively impaired, wandered and left the building without staff knowledge. This resulted in an Immediate Jeopardy (IJ). The IJ began on [DATE], when R1 left the building without staff knowledge and was found at the bottom of a steep hill, near a busy street. The administrator and director of nursing (DON) were notified of the IJ on [DATE], at 6:50 p.m. The immediate jeopardy was removed on [DATE], at 4:26 p.m. and the non-compliance remained at the lower scope and severity of a D, no actual harm with a potential for more than minimal harm. Findings include: R1's significant change Minimum Data Set (MDS), dated [DATE], indicated R1 had severe cognitive impairment, non-traumatic brain dysfunction, traumatic brain injury (TBI), and no wandering behaviors. Additionally, R1 needed supervision with locomotion on and off the unit, was not steady walking, needed a walker, and had two or more falls since prior assessment. R1's care plan printed [DATE], identified R1; had limited physical mobility related to dementia, impaired cognitive function related to history of head injury (resident required cues and reminders for Activities of daily living), unsteady gait/balance, high risk for falls, impaired visual function, poor decision making, and exhibited delusions about her husband that was deceased . There was no indication R1 was at risk for wandering. A progress note dated [DATE], at 12:03 p.m. stated R1 ambulated around the building as she looked for her mother and father-in-law, (who were deceased), and at 9:08 p.m. R1 wandered the building as she searched for Santa [NAME], and wanted to go to [NAME] to see her husband. A progress note dated [DATE], at 11:08 p.m. RN-A documented at approximately 8:00 p.m. nursing assistant (NA)-C was unable to find R1. RN-A went to foyer, where she had seen R1 earlier, and noted the front maglock system was disarmed. R1 was found outside standing at the bottom of a the hill with her walker. R1 told staff she went outside to get some fresh air. (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	Although progress notes of [DATE] identified R1 was wandering around the building, and left the building without staff knowledge on [DATE], the facility had not completed a wander risk assessment until after the [DATE] event. R1's Wander Risk Scale assessment, dated [DATE], identified risk factors included history of wandering, mental status, diagnosis, and mobility. The assessment indicated R1 has no reported episodes of wandering in past 6 months and no diagnosis of dementia; which resulted in a score of 4 (a score chart indicated , d+[DATE] Low Risk). The assessment, indicated R1 was not at risk and did not need a new care plan or interventions even though the progress notes identified R1's wandering behavior. On [DATE] R1's care plan indicated R1 left the faciity on [DATE]. Interventions were initiated for 15-minute checks, monitor resident for tailgating (follow close behind) when visitors are in the building, and wander risk assessment per facility policy. R1's care plan was updated on [DATE] and identified R1 was safe and removed 15-minute check intervention. Although the facility removed the 15-minute checks, they did not implementy any interventions to prevent R1 from going outside unsupervised, even though she continued to have wandering behaviors. Review of facility's investigation as of [DATE], indicated video footage was reviewed and it appeared NA-B may have disarmed the door at 6:30 p.m. R1 was sitting in the lobby area then seen going out the front door and was outside for 10 minutes before staff assisted her back in the facility. NA-B was re-educated on the importance of making sure the door is armed for alarm. On [DATE], at 2:09 p.m. RN-A stated she had been alerted by NA-C on [DATE], at approximately 8:00 p.m. that he could not locate R1. RN-A had seen R1 less than 20 minutes earlier sitting in the foyer of the facility. She noticed the front door was disarmed, so she walked out of the building, and saw R1 at the bottom of the hill with her walker. RN-A stated R1's had impaired cognition and she [R1] is not somebody I would be willing to just send outside on her own. On [DATE], at 3:27 p.m. interim director of nursing (DON) stated the entry door had a maglock system and was kept locked to make sure people that entered the facility were screened for COVID-19, not to keep any residents from getting out of the facility. DON stated she had not yet completed the investigation, but video from [DATE], revealed R1 did not leave facility grounds. Therefore, the incident was not an elopement. The facility grounds where R1 ambulated down the hill in her walker was observed on [DATE], at 9:20 a.m. was steep and adjacent to a busy city street that had 2 apartment complexes on one side and the facility on the other side of the street. On [DATE], at 10:32 a.m. nursing assistant (NA)-A stated the facility kept an Elopement Book at the front desk with photos of residents at risk for elopement. NA-A further stated that she knows R1's abilities and even though it was not on R1's plan of care (POC), R1 would need to be supervised or she could wander outside the facility. On [DATE], at 10:46 a.m. NA-B stated that after the incident, she was educated to make sure the door was locked every time the alarm was turned off. NA-B further stated R1 wandered in the building but could not go outside without supervision because of R1's impaired cognition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 2:05 p.m. assistant director of nursing (ADON) stated after R1 was found outside without supervision, 15-minute checks were initiated, but had been discontinued on [DATE]. ADON stated after the incident, a history of wandering should have been identified on the updated wandering risk assessment. She stated, R1 was not safe to go outside without supervision due to her impaired cognition and mobility. On [DATE], at 3:29 p.m. DON stated R1 had a purpose and was very clear about her purpose to go outside. Therefore, she would not call it wandering, and R1's care plan had not been updated to have her supervised when outside. DON acknowledged she did not ask direct care staff about supervision of R1. Further, she was not aware if family had been contacted. DON stated Wandering Risk assessments were completed on [DATE], and [DATE], and R1 was a low risk for wandering/eloping. DON stated, I consider her to be safe to be outside unsupervised. On [DATE], at 4:22 p.m. Regional Director of Clinical Services (RN)-B stated going outside with the intent to get fresh air would not be wandering. It was a purposeful choice. RN-B clarified you can be high risk, but not necessarily an elopement risk. RN-B stated it was case-by-case, provider and family directed. Further, RN-B stated her expectation was staff would follow the process which was to notify provider and family. Additionally, RN-B stated she would expect the front-line staff would be asked for their observations and comments when determining resident safety to be outside unsupervised. R1's physician progress notes, dated [DATE], [DATE], [DATE], [DATE], all indicated R1's diagnoses included dementia with moderate-advanced impairment level. The facility's Elopement Risk and Prevention Policy, revised [DATE], indicated all residents were afforded adequate supervision to provide the safest environment possible, and all residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. The policy defines wandering as random or repetitive locomotion that may be goal-directed, or non-goal-directed or aimless. The immediate jeopardy began on [DATE], when R1 was unsupervised when exiting the building. The immediacy was removed [DATE], at 4:26 p.m. Audit of facility documents verified the facility updated the elopement risk and prevention policy, created a new elopement risk assessment, and conducted facility-wide elopement and maglock system education. Staff interviews on [DATE], confirmed training had been completed regarding updated elopement policy, and R1's wandering/elopement risk interventions. Audit of R1's documents verified a new elopement risk assessment was completed and care plan was updated on [DATE]. R1's photo and wandering interventions were placed in the Elopement Book.