STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525397	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUPERIOR REHABILITATION CENTER LLC	1800 NEW YORK AVE SUPERIOR, WI 54880

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 -** 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** Based on interviews, record review, and policy review, the facility did not provide adequate supervision for 1 (R1) of 4 residents at risk for elopement. R1 was at risk for elopement as evidenced by successful elopements on 7/1/2020 and 8/14/2020. The facility did not identify individual resident centered interventions to prevent further elopement nor did they update the care plan to reflect these interventions after the elopement on July 1 2020. R1 eloped again on 8/14/2020 and the care plan remained without recognition of R1's elopements nor any interventions to prevent further elopement. This is evidenced by: The facility policy, entitled Elopement Guideline, dated 11/17, states, Assure that each resident is assessed on an ongoing basis and has appropriate safety precautions in place. and Care plan that addresses potential to wander or exit facility and the measures taken to prevent wandering/elopement. Example 1: R1 was admitted to the facility and protectively placed there on 3/25/2020. R1 has [DIAGNOSES REDACTED]. R1's care plan initiated on 4/2/2020 did address R1's mood and behaviors related to the [DIAGNOSES REDACTED]. The interventions from 4/2/2020 were to be alert to mood and behavior changes, and monitor and document mood state/behaviors upon occurrence. This portion of the care plan was not revised until 9/1/2020, these revisions included 15 minute checks for 72 hours that were initiated on 8/14/2020 and Social Services will speak with resident regarding any shopping as needed. There is no mention of R1 having had a wanderguard or that it had been removed due to not being effective in preventing wandering. There is no update to the care plan after the first elopement of 7/1/2020 and not until Surveyor was present on 9/1/2020 were any revisions made to the care plan regarding elopement. R1's Elopement Risk evaluation assessment was done on 7/2/2020 for the first time. This was after R1's first elopement. Interventions placed were 15 minute checks for 72 hours and placement of a wanderguard. There was no indication of interventions to address the reason for the elopement. Elopement Risk evaluation was done again on 9/1/2020, the day the Surveyor was in the building. This indicated that the interventions would be removal of the wanderguard and Social Services doing some resident shopping. Review of R1's protective placement papers state R1 is protectively placed at facility due to [MEDICAL CONDITION] brain disorder and other like incapacities. Review of investigation report indicates that R1 was capable of planning the elopement. R1 cut off wanderguard, made sure to bring walker and cane along to bus stop, got on the bus, called a cab and purchased desired items at a store. On 9/1/2020 Surveyor interviewed DON-B (Director of Nursing) regarding the R1 elopements and what interventions were done. DON stated that R1 came to the facility in March and was on the 3rd floor for two weeks, then moved to the first floor. On 7/1/2020 R1 took a cab to Super One Foods to get some groceries, this is when a wanderguard was placed. R1 was moved to the second floor but refused to stay there so came back to the first floor. On 8/14/2020 when staff took R1 their lunch tray R1 was not present in the room but the tray was left; this was at 11:30 AM. R1 was noted to be missing when another staff picked up the lunch tray at 12:30 PM and R1 was not in the room, nor had the tray been disturbed. The DON-B stated they had called R1's cell phone several times, that R1 had picked up the phone but could not hear what was being said so R1 hung up. The DON-B stated the facility and surrounding areas were searched and R1's walker was found at a nearby bus stop. Police and other authorities were notified along with family and MD. The bus driver had dropped R1 off at a Walmart and several staff members went to the Walmart to find R1, later a cab driver called the facility stating he had picked up a person that fit R1 description and taken them to a liquor store and then to a hotel, which is where R1 was found and brought back to facility. R1 was placed on 15 minute checks for the next 72 hours, no new wanderguard was applied. Per the DON-B, R1 was checked for alcohol on his return to facility but staff found an unopened water bottle and a container of Tylenol. Review of R1's comprehensive medical record showed that on 7/1/2020 R1 had eloped, gone to a Super One foods, and returned by cab with groceries which included a four pack of wine coolers of which two were missing. On 9/1/2020 at approximately 1:00 PM, Surveyor interviewed RN-E (Registered Nurse First Floor Manager) regarding interventions in place for R1. Surveyor requested documentation of interventions on care plan related to elopements. RN-E was not able to find this information. RN-E indicated there had been an Elopement Risk Evaluation done on 7/2/2020 and that is when wanderguard was placed. RN-E indicated that the guardian was contacted regarding the latest interventions which RN-E thought were not having a wanderguard and teaching R1 to sign in and sign out of the facility. Surveyor requested documentation of this conversation, RN-E was not able to find it. On 9/1/2020 at approximately 1:15 PM, Surveyor interviewed FM-F (Family Member) via telephone regarding R1's elopements and facilities updating and discussing interventions. FM-F indicated they were notified of both elopements, but that the facility had not contacted FM-F since 8/14 when they stated R1 would be on 15 minute checks for 72 hours and that R1 would not have a wanderguard as it was not effective. When Surveyor asked if facility had spoken to FM-F regarding intervention of teaching R1 to sign in and out of facility, FM-F indicated that they had not been contacted at anytime since 8/14/2020 and that this would not be acceptable to FM-F who has full guardianship of R1. FM-F indicated that they felt elopements were directly related to R1 seeking alcohol and that this has been a long standing problem. FM-F indicated to Surveyor a willingness and desire to help and participate with the facility in coming up with ways to prevent further elopements but that the facility had not contacted them. On 9/1/2020 at approximately 2:30 PM, the Surveyor met in a group interview, with NHA-A (Nursing Home Administrator), DON-B, SSD-C (Social Services Director), and RSSD-D (Regional Social Services Director) regarding interventions for R1's elopements and [MEDICAL CONDITION]. NHA-A indicated that the team had met on 8/17/2020 to discuss R1's elopements. A conversation was had and ideas were thrown around such as a ride with the bus driver to Kwik Trip or SSD-C doing shopping for R1. The shopping was initiated. Surveyor asked when the last time the team had met spoken to FM-F. RSSD-D indicated they spoke to FM-F on 8/14/2020 and this was to notify R1 was found and that 15 minute checks would be initiated. Also spoke about alternate placement. RSSD-D also indicated they had spoken to the Ombudsman at length about how to support R1 at the facility. RSSD-D was directed to a website regarding guardianship and protective placement. When asked to produce evidence of this conversation, RSSD-D did not. Although the team indicated there had been conversations regarding interventions for R1, there is no evidence that any action was taken to prevent further elopements from the facility. Review of R1's comprehensive medical record revealed that the facility did not update the care plan or put into place person centered interventions addressing R1's elopements and [MEDICAL CONDITION]. The facility did not keep the guardian updated on current interventions and resident care.
F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility did not provide medically-related social services for 1 of 4 residents

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

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 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) (R1,) in order to attain or maintain their highest practicable physical, mental and psychosocial well-being to prevent R1 from leaving the facility to obtain alcohol. Social Services did not provide services related to R1's alcohol use or identify and seek ways to support R1's individual needs through the care planning process, including soliciting ideas from R1's guardian. This resulted in R1 eloping from the facility twice to obtain alcohol and groceries. This is evidenced by: Example 1: R1 was admitted to the facility on [DATE], and had [DIAGNOSES REDACTED]. R1's care plan dated 4/2/2020 stated that Residents psychosocial needs will be met. Interventions are dated 4/2/2020 these included PHQ-9 will be conducted per regulation and PRN (as needed), will monitor mood state, will monitor safety concerns and evaluate PRN . There are no updates to this portion of the care plan since 4/2/2020. Care plan also has a focus area on mood and behavior due to residents [MEDICAL CONDITION]. Resident may become agitated, and state they want to leave facility. Interventions for this were 15 minute checks for 72 hours, be alert to mood and behavioral changes, Social Services will speak with resident regarding any needs for shopping as needed (initiated on 8/14/2020), and monitor and document mood state and behaviors upon occurrence. There are no person centered interventions addressing R1's alcohol use and elopement. There are no updates to the care plan since 4/2/2020 other than one on 8/14/2020 that was done after the second elopement that addresses shopping needs. There was no mention of a wanderguard being placed on R1 after the first elopement nor mention of it being removed on 8/14/2020 after the second elopement. R1's Elopement Risk Evaluation Assessment was done on 7/2/2020 after R1's first elopement on 7/1/2020. It stated 15 minute checks would be done for 72 hours and that a wanderguard was placed. The next Elopement Risk Evaluation was not done until 9/1/2020 when the Surveyor was in the facility. It stated the wanderguard was removed, and that Social Services would be assessing resident shopping needs. Review of R1's guardianship papers dated 5/5/2020 showed that a permanent guardianship was in place with all rights transferred to the guardian. Surveyor review of R1's comprehensive record does not show a root cause analysis of why R1 has made attempts to leave the building, nor any person centered interventions to prevent further elopements. There is no indication in R1's medical record that R1's alcohol use is being addressed. On 9/1/2020 at approximately 1145 AM Surveyor interviewed SSD-C (Social Services Director). SSD-C indicated to Surveyor that R1 had been protectively placed at the facility by the county. Surveyor asked SSD-C what that meant, SSD-C stated that meant the resident would be residing at the facility until permanent guardianship went through. SSD-C indicated to Surveyor that at present there was only a temporary guardianship in place. Surveyor asked SSD-C to show Surveyor the Protective Placement and Guardianship papers. The Surveyor noted there was a Protective Placement and that there was a permanent guardianship in place. The Surveyor asked SSD-C if they had sought counseling or any other intervention regarding R1's history of [MEDICAL CONDITION]. SSD-C indicated that they thought nursing was doing that and that the SSD-C thought R1 had refused these services. The Surveyor asked for documentation of the offering of these services and the refusal. No documentation was given to the Surveyor. On 9/1/2020 at approximately 1230 PM Surveyor interviewed RN-E (Registered Nurse First Floor Manager) regarding R1's alcohol use. Surveyor asked about treatment for [REDACTED]. Surveyor asked RN-E if they had contacted the guardian regarding interventions for his [MEDICAL CONDITION] history and elopement. RN-E stated that they had updated and spoken to the guardian. Surveyor requested RN-E print up any documentation there might be on the care plan indicating that a wander guard had been placed and removed or any other interventions that may have been done including speaking with R1's guardian. RN-E did not produce any of the requested documentation On 9/1/2020 at approximately 110 PM the Surveyor telephoned R1's guardian, FM-F (Family Member) for an interview regarding R1's recent elopements. Surveyor asked FM-F if the facility had contacted them regarding interventions related to R1's elopements. FM-F stated to the Surveyor that they had not heard from the facility since 8/14/2020 and that was regarding the elopement and that R1 would be put on 15 minute checks through the weekend and that the wanderguard was not going to be put back on as R1 had stated they would cut it off again. Surveyor inquired as to the facility informing FM-F of intervention of teaching R1 to sign in and sign out of facility as this was a plan that had been discussed by the interdisciplinary team. FM-F stated that she had not been updated and that this was not something that they would agree to. FM-F stated that they felt all of R1's elopements were related to seeking alcohol as this had been a long standing problem. FM-F stated they were not opposed to R1 having supervised alcohol in the facility. FM-F stated to the Surveyor that they were very open to working with the facility to find person centered ways to prevent any further elopements but that the facility has not sought input or updated them. On 9/1/2020 at approximately 230 PM Surveyor met with NHA-A (Nursing Home Administrator), DON-B (Director of Nursing), SSD-C, and RSSD-D (Regional Social Services Director) for a group interview regarding R1's recent two planned elopements that appeared to be related to alcohol seeking. Surveyor asked team what was done to address R1's history of [MEDICAL CONDITION] and ongoing alcohol seeking attempts. NHA-A stated that the team had met on 8/17/2020 and that R1 was a topic of conversation. NHA-A stated that many ideas were thrown around, including for the bus driver to take R1 to Kwik Trip periodically, to teach R1 to sign in and out of the facility, and for the SSD to do some shopping for the R1. It was decided to initiate the shopping. During this interview all members of the team did indicate they did feel that R1 was seeking alcohol when the elopements occurred. When Surveyor asked the team to produce any sort of documentation that indicated that R1's history of [MEDICAL CONDITION] was being addressed by the Social Services and that the guardian had agreed to these interventions and been brought into discussions, they did not do so. There is no evidence in R1's comprehensive medical record or R1's care plan that R1's psychosocial needs related to history of [MEDICAL CONDITION] are being addressed by the facility. There is no evidence that the facility has sought guardian input into the care planning process.