STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	03/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARMLY ON THE LAKE LLC	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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 interview and document review the facility failed to ensure adequate supervision for 1 of 1 cognitively impaired resident (R1) at risk for elopement. Findings include: R1's quarterly minimum (MDS) data set [DATE], indicated he was moderately cognitively impaired and required supervision for all activities of daily living. An Elopement Risk Evaluation dated 12/14/19, indicated R1 had made no attempts to leave the facility, was fully ambulatory and wore a Wanderguard bracelet. The evaluation indicated R1 was at little risk for elopement but had wandering tendencies of walking to places he was not familiar with and unable to find his way back. R1's care plan dated 3/7/20, identified an alteration in cognition related to Alzheimer's, dementia and [MEDICAL CONDITION]. The care plan was updated on 3/23/20, to include risk for elopement related to a a history of exit seeking/elopement and indicated on 3/20/20, R1 asked to go outside for fresh air and walked away from the facility. The care plan further indicated R1 continued to make statements about going home and identified the use of a Wanderguard bracelet. An Elopement Risk Evaluation dated 3/20/20, indicated R1 had a history of [REDACTED]. The evaluation indicated R1 continued to be at risk for elopement due to asking to go out for fresh air and walking away from the facility, exit seeking and statements about wanting/needing to go to his old town home. The evaluation indicated R1 was aware how close his previous residence was to the facility but forgot he no longer lived there. Wanderguard remained appropriate. Review of R1's facility Progress Notes indicated the following: 12/15/19, R1 used a Wanderguard and utilized frequent cues and re-direction. 1/11/20, R1 walked with a rolling walker and had a Wanderguard as he got confused and may become exit seeking. 3/15/20, R1 was exit seeking and trying to get home to his apartment. R1 set off the alarm by the chapel doors. Review of documentation identified that on 3/20/20, a writer identified that at 5:45 a.m., a nursing assistant (NA) trainer doing screenings at the front entry asked, Do you have a resident named (R1)? Staff coming in for day shift had recognized him in the parking lot and eventually inquired as to why he was outside. Writer stated yes, and immediately left the front exit with another NA to search for R1. Another staff who worked a the facility but not directly with R1 had let him out the front door not knowing he was a resident, therefore his wanderguard was not activated. After searching the immediate vicinity on foot and not successfully locating R1, writer initiated missing persons emergency protocol. 911 was called to report R1 missing and gave his description. After speaking to R1's daughter she gave two addresses where she thought he may go, one of which was his previous town home. The search party was alerted to this address and subsequently found R1 near this location behind a storm door in an entryway to one of the town homes. He was located at approximately 6:15 a.m. 30 minutes or so after going missing. Search was then ended and R1 was brought back to facility by police. He was wearing a sweater, a vest over it, and a baseball cap but no coverings on his hands or ears which were red and waxy in appearance. R1 was wrapped in warm blankets immediately and vitals taken. Both of his knees reddened, but R1 stated he did not fall. A facility Verification of Investigation report dated 3/20/20, indicated R1 was asked if he got out for some fresh air and he responded, yes he did. R1 stated he went out because he wanted to surprise his daughter and said he and his daughter owned a town home nearby. R1 stated he did make it there, but barely and said he got tired and cold. The report indicated the Wanderguard was tested and found to be functioning properly but had been disabled by the staff member who let him out the door. During interview on 3/24/20, at 9:34 a.m. family member (FM) -A stated she was told that R1 had asked to go outside. FM-A stated he was wearing an ankle bracelet that should have locked the door but someone had let him go out. FM-A stated R1 had gone to the town home he used to live in and was found 45 minutes later between a door and a screen door on his knees. FM-A said staff believed he was crouched down trying to warm up and stated it was 23 degrees when they called her. FM-A said R1 was not dressed appropriately and said he had on a long sleeve shirt, a ball cap and sweat or pajama pants. FM-A stated she was aware the person doing screenings at the desk had let R1 out and stated, why anyone would let him out, I can't guess, it could have ended much worse. FM-A further stated R1 had previously lived further away down the highway and said she wouldn't put it past him to try to go to that house. On 3/24/20, at 10:07 a.m. licensed practical nurse (LPN)-A stated R1 had eloped from the facility the previous week. LPN-A stated he went to the front desk and asked if he could go out to get some fresh air. LPN-A stated the staff member at the desk did not know R1 and let him out the doors. She stated another staff member walking in had seen R1 and asked if he was supposed to be outside and the staff member who let him out said she wasn't sure so she contacted the nurse manager on R1's unit, called 911 and began searching for him. LPN-A stated R1 was found approximately 45 minutes later. At 10:21 a.m. LPN-B stated the morning R1 eloped from the facility, she came in right before 6:00 a.m. and saw people outside. LPN-B said she was told they did not know where R1 was. LPN-B stated she put her stuff down and began searching. LPN-B said it was kind of a cold day, windy. It was so dark, I was worried, it was so dark we couldn't see anything. LPN-B stated she was so cold she had to come back in and people got in their cars to look for R1. LPN-B got in a car with another staff member and they checked the town home area where R1 had lived previously. LPN-B said she noticed the shape of a person by a glass door on his right knee trying to open the door to get in and said it was R1. LPN-B stated they were able to get him up and called for help. LPN-B stated when R1 returned to the facility they tried to check his vital signs but could not get them because he was so cold so they wrapped him in warm blankets. At 10:30 a.m. the wellness director (WD) stated she arrived at the facility at 5:00 a.m. to do screening on the day R1 eloped. The WD said R1 approached her at 5:30 a.m. and asked to go outside for some fresh air. The WD said she used the key pad to unlock the doors which prevented R1's Wanderguard from activating and stated she was not aware he wore a Wanderguard. The WD said she opened the door for him and it was a little chilly out so she told him to knock on the door when he wanted to come in. She stated at some point, a girl from the kitchen asked about R1 being outside, then another staff walked up. The WD asked that staff member if R1 should be outside and the other staff member did not know so she went to find the nurse. She said at that point R1 must have been going toward the road because he was not outside the doors. She said herself and other staff got in their cars and started driving around and stated it was dark and R1 was wearing all black. The WD stated she should have asked someone before letting R1 out the doors. She stated she was unaware there was a book at the desk to check for residents who were at risk for elopement, but since had received Additonal training. At 11:02 a.m. the administrator stated R1 had admitted to the facility in December and had a history of [REDACTED]. The administrator stated R1 had recently been talking more about gong home and had approached the front door about a week prior and stated he was aware R1 had set off the alarm on March 15th. The administrator stated after R1 set off the alarm, they discussed it in their clinical meetings and the nurse manager had conversations with staff. He stated at that point they just kind of increased monitoring. The administrator stated the wellness staff had initially received just general education related to elopement but have now received more training. A facility policy titled Elopement Guideline dated November 2017, indicated elopement is defined as that situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety, needs and therefore at risk for

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) injury outside the confines of the facility, has left the facility without knowledge of staff. The policy indicated a specific system has been developed to notify staff that an external door has been opened in an area accessible to residents and indicated only the administrator (or designee) may authorize disabling the alarm system and is responsible for the method of monitoring for residents safety and resetting the alarm.