STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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 **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 observation, interview, and document review, the facility failed to ensure 3 of 3 alarm systems were appropriately maintained, tested and monitored which resulted in the elopement of 1 of 1 resident (R2). Additionally, 2 other residents who exhibited wandering behaviors were R1 and R3. Due to the system failure all resident with wander guards are at risk for the immediacy The facility's lack of monitoring, testing and maintenance of the alarm systems resulted in an Immediate Jeopardy (IJ), with the potential for serious harm, injury, or death. The IJ began on 2/23/20, when R2 exited the building, crossing a major hi-way, tripped on a curb and sustained minor injuries before being seen by an off duty staff person. The facility's administrator (A) and director of nursing (DON) were notified of the IJ on 3/12/20 at 3:07 p.m. The was removed on 3/14/20 at 3:30 p.m., but non-compliance remained at the lower scope and severity of D, isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R2's 2/7/20, baseline care plan identified she was confused, walked independently, had no behaviors of wandering or at risk for elopement as identified on the baseline care plan. R2's progress noted identified the following: 1) 2/8/20 at 6:19 a.m., R2 was up from her bed and wandering into other resident's rooms. 2) 2/8/20 at 5:02 p.m., R2 up walking frequently and wandered into other resident's rooms. Had gone past doors a couple of times setting off the alarm. 3) 2/10/20 at 5:05 a.m., staff had a difficult time with R2 wanting to go outside to find her car and go home. R2 had wandered into other resident's rooms and used the bathroom in one of the rooms. 4) 2/13/20 at 1:08 p.m., identified R2 exhibited wandering behaviors in the halls often looking for a restroom or her room and showed confusion. R2's 2/13/20, admission Minimum Data Set (MDS) identified R2 had severe cognitive impairment with [DIAGNOSES REDACTED]. R2 required supervision of one staff for walking in her room and in the corridor. R2 had no wandering behaviors noted on her assessment even though the nursing notes identified wandering behaviors. There was no indication an elopement assessment had been completed. R2's 2/13/20, comprehensive care plan completed the same day as the MDS, identified R2 had behavioral symptoms of wandering. Interventions currently in place at the time of the assessment included a WanderGuard bracelet to R2's right ankle related to wandering. R2's 2/14/20, physician's progress report identified nursing staff reported R2 continued to wander but was easily redirected. There were no other interventions implemented by the physician at that time. Further review of R2's progress notes identified on: 1) 2/20/20 at 6:06 p.m., R2 was confused and wandered into other resident's rooms. 2) 2/22/20 at 5:26 p.m., R2 had exited out door 6 (D6). R2 was outside on the sidewalk looking for her car. R2 was redirected back into building. The standard door alarm system had audibly sounded however there was no mention if the R2's WanderGuard bracelet she was wearing had sounded. R2's 2/22/20, Event Summary Report identified the D6 door had alarmed at the time of the elopement, with standard door alarm heard by staff. R2 had the newer style WanderGuard bracelet was on her person, however, that bracelet did not activate that door as that door had not been wired to work with the new style WanderGuard. There was no mention additional 1:1 supervision was implemented, staff were educated on what alarms worked on what doors, nor had they identified appropriate testing, monitoring, and maintenance of the alarm systems by the manufacturer. R2's 2/23/20 at 3:16 p.m., progress note identified the facility received a call at 3:00 p.m. from the local convenience store at R2 was at their store. They identified R2 had a cut on her head from a fall after tripping on the curb crossing the hi-way to the store. EMS was called, and R2 was elevated at the convenience store, had no injuries and needed no medical attention and was brought back to the nursing home. Upon return to the facility, R2 complained of right wrist pain and had a small laceration by left eye which was cleansed and adhesive Steri-Strips applied. Staff noted a small scrape to her left hand and a small bruise on her left knee. The report also identified R2 was last seen when staff had toileted her at 2:00 p.m., 1 hours and 16 minutes before she was seen at the convenience store. There were no alarms that sounded per staff interviews even though R2 had the newer style WanderGuard bracelet on. Review of R2's 2/23/20, Event Summary Report identified R2 eloped out of facility to a convenience store and tripped on curb causing her to fall. R2 exited through D6. Staff had not remembered hearing either alarm system sounding (door alarm, or WanderGuard). R2 was assessed by EMS and returned to facility. The care plan was updated to offer activities such as sitting and visiting with other residents. The Medical director (MD) discussed the possible need for alternative placement with a more secured facility. There was no mention staff had tested the door alarm system or the newer-style WanderGuard system bracelet R2 was wearing to ensure these alarms were functioning appropriately. Review of R2's progress notes identified on: 1) 2/25/20 at 1:18 p.m., staff added new intervention to the care plan to be aware of R2's presence. If R2 was not in sight staff were to start a search right way. Staff identified the newer-style WanderGuard bracelet R2 had worn since shortly after admission was not wired to all the doors including D6. As a result, a second older-style WanderGuard system bracelet was placed on R2's left ankle for the old alarm system. The older system was wired on D6 along with the standard door alarm. There was no indication the facility had contacted the alarm system manufacturer to ensure it was functioning properly, nor had the facility performed any routine maintenance or consistent monitoring as identified by the manufacturer of the 3 alarm systems; door alarm, old and new WanderGuard system. 2) 2/27/20 at 3:34 p.m., progress note identified R2 attempted to leave out D6. An alarm sounded and staff were able to redirect before exiting to outside. Review of the facility 2/27/20, Elopement Risk Assessment identified R2 had previous successful elopements. The current interventions in place were identified as appropriate. There was no mention staff had identified the need for any routine maintenance or consistent monitoring of the three alarm systems as identified by the manufacture to ensure they worked appropriately. Interview on 3/10/20 at 11:15 a.m., with nursing assistant (NA)-A identified the standard alarm at D6 will sound approximately 30 seconds at the door if no keypad door code is entered to bypass the system. The standard alarm system also has an audible alarm that sounded at the nurse station. The alarm at the nurse's station must be manually turned off in order to stop the alarm. NA-A identified there were 3 residents who exhibited wandering behaviors, R1, R2, and R3. Interview on 3/10/20 at 11:25 a.m., with activities assistant (AA)-A identified when a door alarm sounds staff are to immediately check for potential elopement of residents. AA-A identified the 3 residents who exhibited wandering behaviors were R1, R2, and R3. Interview on 3/10/20 at 11:31 a.m., with NA-B identified the 3 residents who exhibited wandering behaviors were R1, R2, and R3. R2 had a history of [REDACTED]. NA-B was made aware recently by administration D6 was not alarmed with the newer WanderGuard system. Interview on 3/10/20 at 1:34 p.m., with licensed practical nurse (LPN)-A identified after R2's 2/23/20 elopement, staff were to have direct observation of R2 to prevent future elopement. NA-B identified the 3 residents who exhibited wandering behaviors were R1, R2, and R3. NA-B was unsure if Wander guard bracelets were to be checked every 2 weeks or monthly and was not educated on any manufactures inspection of the system. R2 was known to only attempt elopement through D6 and was unaware of any other doors R2 attempted to elope. On 2/23/20, LPN-A received a call from the convenience store alerting her R2 had eloped. None of the alarm system had sounded from door D6 to alert staff of her elopement. At approximately 7:00 p.m., staff identified the

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	**03/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVINE PROVIDENCE HEALTH CENTER	**312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142**

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 **Residents Affected -** Few	(continued... from page 1) standard door alarm had been disarmed at the nurse's station so it was not functioning, and they were unsure how long it was disarmed. LPN-A was unsure where staff were to document wanderguard checks. Interview on 3/10/20 at 1:39 p.m., with the DON identified after R2's elopement on 2/25/20, the D6 door did not have the newer WanderGuard system wired into the alarm system. They then added the older-style WanderGuard bracelet to R2's ankle in addition to the newer-style WanderGuard. R2 had two bracelet alarms, one for each of the two WanderGuard systems. The DON instructed staff on duty to provide direct observation of R2 to prevent future elopements. Interview and document review on 3/11/20 at 8:15 a.m., with plant operation manager (POM) identified there was no system for preventative maintenance performed on any of the 3 alarm systems. The POM was unaware door D6 did not have the newer WanderGuard system until the DON told him this on 2/25/20. The POM identified none of the 3 alarm systems were tested for functionality on any of the facility's 6 exit doors at that time. The POM identified the manufacturer required weekly WanderGuard checks and monthly maintenance. The POM had not performed any preventative maintenance or monitoring of the 3 alarm systems. He agreed the alarm systems had not been maintained per manufacturer's guidelines and had no knowledge if they functioned appropriately. Further interview on 3/11/20 at 9:40 a.m., with the DON identified she had contacted the manufacturer of the alarm systems. The facility was unable to get bracelets for the older-style WanderGuard system. The manufacturer identified the system was too old and bracelets are no longer available. Both the older and newer styled WanderGuard systems were considered antiquated. When staff placed the older-system WanderGuard on R2, the bracelet was located in the medication room in a cup, labeled DO NOT USE. Staff took the bracelet and tested it next to door D6 and it had worked at that time. She agreed, staff should have checked with the manufacturer prior to placing the older style WanderGuard bracelet on R2. The older-style bracelet was placed on R2's ankle in addition to the current newer-styled bracelet. The DON had been informed the standard alarm system had been disabled at the master switch at the nurses station on 2/23/20, and was discovered at 7:00 p.m The DON speculated staff were tired of the alarm systems sounding and turned it off. There was no indication the DON had re-educated staff on the importance of not disabling the master control switch at the nurses station. The DON identified facility staff checked the WanderGuard bracelets monthly. But they only tested these bracelets at 2 doors, D1 and D5, which were only alarmed with the standard and newer style WanderGuard alarm systems. She agreed if bracelets to either system were not checked at every exit door, staff had no way of knowing if the bracelets worked at each door. Also they would not know if the resident was wearing the correct bracelet for that specific door alarm or if the door alarms were functioning properly. The DON agreed if the facility had educated staff and performed routine monitoring and maintenance as identified by the manufacture, R2 would not have eloped without staff knowledge. She agreed they were not performing preventative maintenance or testing according to manufacturer's guidelines. Interview on 3/11/20 at 10:15 a.m., with R2's family member (FM)-D identified he was made aware by facility staff of R2's elopement on 2/23/20. FM-D was advised staff were unsure when or how R2 eloped without the alarm systems sounding. Observation and interview on 3/11/20 at 10:33 a.m., with the POM and DON identified there were 3 alarm systems in the facility. An older-style WanderGuard, a newer style WanderGuard, and a standard door alarm system. The standard door alarm system alarmed at all exit doors except D1 and the nurses station. This alarm can be silenced by a master shut off switch at the nurses station. The older-styled WanderGuard alarm system only alarmed at door D6, and the nurses station. This alarm can only be silenced at the door using the keypad. The nurses station alarm must be silenced separately. The newer-styled WanderGuard system was to have alarmed at doors D1 and D5. Doors D2, D3 and D4 have no WanderGuard system in place but was alarmed with the standard door alarm. Those doors lead directly outside the facility and would not alarm if the standard alarm had been disabled at the master switch at the nurses station. During this time, the facility doors were checked and identified D1 alerted with the newer system, but there was no standard door system alarm. D6 failed to alarm with the standard door alarm. Both the DON and POM agreed the alarm systems identified the lack of a standard alarm on D1 and failure of that alarm on D6. R1's 3/11/20, face sheet identified she was admitted to the facility with [DIAGNOSES REDACTED]. R1's undated, current care plan identified a WanderGuard was added to R1's ankle on 11/8/19, related to confusion and wanting to go out front of the facility to see where the people are. R1 was confused as to where she was at. R1's Treatment Administration Reports (TAR) identified in January February and March 2020, staff had not documented any wanderguard checks they reportedly were to have completed monthly. R1's 12/11/19 through 3/5/20 progress notes identified on 1/8/20, staff noted R1 wore a wanderguard but made no mention this was tested per manufacture's guidelines. There was no progress note to identify R1's wanderguard had been tested for functionality. R3's 3/11/20, face sheet identified she was admitted to the facility with [DIAGNOSES REDACTED]. In January, 2020, R3's wanderguard was documented as checked on 1/7/20. In February, 2020, R3's wanderguard was checked on 2/3/20. There is no documentation how staff checked the wanderguard for functionality. Interview on 3/11/20 at 12:29 p.m., with administrator identified the 3 alarm systems were antiquated and was unaware how the systems worked and the systems had not been maintained appropriately. The alarm system needed to be fixed, but due to budgeting, that was not addressed. Interview on 3/11/20 at 4:07 p.m., with medical director (MD) identified R2 had severe dementia. He understood from staff, they were to have had direct observation of R2 in addition to the WanderGuard. The MD was not aware the system had not been monitored, maintained or tested according to manufacturer recommendations. The MD expected staff to follow the manufacture's guidelines for maintenance, monitoring, and testing of all alarm systems in the facility. Review of the June 2019, Elopement or Unsafe Wandering Policy & Procedure identified through the admission MDS process new residents were to be evaluated for the risk of wandering and elopement. An Elopement Risk Assessment (ERA) was to be completed on any resident determined to be at risk for wandering and/or elopement. The ERA was to have been completed within 24 hours of an elopement to determine if appropriate interventions were in place. All immediate exits from the nursing unit were equipped with an alarm system. There was no mention the doors were not all equipped with all 3 alarm systems. Review of the June 2010, Accutech (WanderGuard) LC 1200 Manual Version 1.05 identified Accutech bracelets operate by an internal battery. The battery is not replaceable. For maximum protection bracelets needed to be tested on a weekly basis. Preventative maintenance testing were to be performed at the minimum on a monthly basis. The IJ that began on 2/23/20, was removed on 3/14/20 at 3:30 p.m. when the facility re-assessed all residents for potential elopement, placed R2 on continuous 1:1 monitoring, contacted the alarm manufacturer for servicing, and educated staff.