STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

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 observation, interview and document review, the facility failed to provide adequate supervision to 1 of 1 resident (R1) at risk for elopement, who eloped from the facility. Findings include: R1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE], indicated that R1 had severe impaired cognition and that R1 was independent to be off the unit. R1's care plan dated 6/13/19, indicated that R1 preferred independent activities, which included going on health walks. R1's care plan also identified that R1 had depression and that staff are to encourage and provide opportunities for exercise and physical activity. On 5/21/20, at 8:00 a.m. R1 was observed in the common area eating breakfast, and at 10:36 a.m. R1 was observed to be in his room, which was located on the second level of the home. Review of a Progress Note dated 5/19/20, identified that R1 was reminded to go out on the deck if he wanted fresh air and not to go outside. At 2:15 p.m. the note identified that R1 had attempted to go outside the front door and was reminded that he should use the deck for health walks and not to go out the doors because he may get lost. Another progress note dated 5/19/20, indicated that R1 was reminded that he needs someone to go with him outside to prevent him from getting lost, as he is new to the neighborhood. A Progress Note dated 5/18/20, indicated that staff went to get R1 from his room for lunch at 11:30 a.m. and he was unable to be found anywhere in the facility or on facility grounds. The Life Enrichment coach and Administrator went out to look for him. After an hour the police were notified that R1 was missing. The police called a short time later indicating that R1 was located at the tennis courts just a few blocks away. Staff approached R1, who was sleeping under the park bench. Upon return to the facility R1 was reminded that if he leaves he needs to sign out, but more importantly he needs to not go out alone because he is not familiar with the area and easily gets turned around and lost. R1 indicated that he wanted to go out on a health walk and get some fresh air, as well as do some shopping. R1 indicated that he got turned around and was not able to find his way back so decided to take a nap. On 5/21/20, during an interview at 8:03 a.m. the director of nursing (DON) indicated R1 had a Keruve watch, (a GPS tracking system), placed on him last June or July. The DON further indicated that the watch was set for a two or three block radius and the system alarms a tablet that sends a text message to the DON and Administrator if R1 goes out of the two or three block range. The DON explained that R1's routine was to come down for breakfast in the mornings, then after breakfast he would take a nap or work on a crossword, and that a lot of times R1 wouldn't come back down until lunch. DON further indicated that they did not notice R1 was gone until they went to get him for lunch. The DON then indicated there were alarms on the doors and that she checked the cameras but could not see the outside camera on the front door because a tree had overgrown and partially blocked the view. The DON stated that a female resident was entering the house and she assumed R1 must have left the house around 10:30 a.m. The DON stated that both the therapeutic rec and administrator must have driven passed R1, because he was laying under a park bench. DON explained that when R1 was brought back to the facility every 30 minute checks were initiated. When the watch company (Keruve) was called to find out why the GPS was not working, the DON was told that money needed to be put into the account every six months. When asked if the DON was aware of this, the DON stated, I don't recall that it needed money every six months. At 8:36 a.m., the DON was holding the GPS watch, tapping on the screen and stated the tablet had just quit working that morning. When asked what the plan was, if they could not get the Keruve watch to work, the DON indicated that she would go to the store to see what options they had and that they would continue every 30 minute checks for R1. When asked if R1 had made any other attempts to leave the house, the DON stated last September or October the housekeeper came to me and asked if R1 was supposed to be going for a walk, I said no, he's not we found him walking to the end of the block and back. The DON stated that a second watch was purchased at that time. At 8:49 a.m. when asked about R1 taking walks on his own, DON stated I would say he's not safe to be out alone because he gets turned around and lost. When asked if an elopement assessment had been completed for R1, the DON stated, no I have not done a formal elopement assessment on him. During an interview at 9:35 a.m. nursing assistant (NA)-A was asked about the incident of R1 eloping from the facility on the 18th. NA-A indicated that R1 came downstairs for breakfast, then he went upstairs to his room around 8:45 a.m. NA-A further indicated that around 11 o'clock maybe 11:30 they went to get R1 for lunch and he was gone. NA-A stated there were alarms on the front and back door, and explained that when they hear the alarms the doors are checked. NA-A went on further to explain that when showers are performed upstairs, the door alarms are hard to hear and assume the nurse's check the doors. When asked if a head count was done to assure a client hasn't left the house when the alarms go off, NA-A stated no. NA-A indicated that R1 is allowed to go for walks when he has his watch on, and that there was a limited distance that R1 could go. NA-A then indicated there is an alert if R1 goes too far and stated the GPS system was not working properly when R1 eloped. NA-A further indicated that R1 is allowed to go for walks, and that he is to sign himself out prior to leaving. When asked if R1 would remember to sign out, NA-A stated, No. During interview at 9:43 a.m. the DON said the therapeutic recreational person has asked R1 to go for walks with her but he declined the walks. The DON stated when the door alarm goes off we check to see who it is, if I can't see on the camera, then I will go to the door. The DON explained that there was a tree blocking the camera to the front door and stated if I can't see anyone then I go outside to look around. When asked if clients were accounted for after alarms go off to see if anyone was missing, the DON stated, no. R1 was interviewed at 10:29 a.m. When asked how he was feeling, R1 stated, feeling mixed up right now. My mood is very bad, I got nothing to be happy about. When R1 was asked what helps with his mood, R1 stated I go for health walks, the walks go for a half hour, sometimes it's a certain route or destination. R1 stated, just recently I went out and got confused and couldn't remember how to get back, somehow I was not able to get back. They say I should have someone with me, I don't go outside by myself anymore. It's kinda special to do something with another person instead of by myself. Policies for elopement and managing the door alarms was requested but not provided.

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