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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Village Care Center	719 Southeast 2nd Street Glenwood, MN 56334

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observation, interview and record review the facility failed to comprehensively assess and provide appropriate interventions to respect and promote resident rights and meet individual needs for 1 of 3 residents (R1) who had a Wander Guard placed on his wheelchair to restrict his access to the community despite his intact cognition, independent mobility with his electric wheelchair and the facility's failure to attempt least restrictive measures. Findings include: R1's Minimum Data Set, dated dated dated [DATE], identified intact cognition without behaviors. R1 felt little interest or pleasure in doing things and felt down, depressed, or hopeless 2 to 6 days out of 7 days and socially isolated himself. R1 felt it was very important to go outside to get fresh air when weather was good. R1 had functional limitation/impairment on both sides on upper and lower extremities. R1 used a electric motorized wheel chair for mobility. R1 required substantial/maximum assistance for toileting hygiene, shower/bathing, low body dressing, and application of footwear. R1 required supervision or touching assistance with sit to lying, lying to sitting, and partial/moderate assistance with sit to stand, chair/bed transfer, toilet transfers, and unable to ambulate. R1 was able to use motorized wheelchair independently once seated. R1 was occasionally incontinent of bowel and bladder. R1's diagnoses included stroke, aphasia (a brain disorder that affects speaking or understanding language), hemiplegia (one sided paralysis or weakness caused by brain or spinal cord problems), and seizure disorder/epilepsy, anxiety, and depression. No physical or electronic device (bed/chair alarms, wander guard, motion sensor) used to monitor and detect movement. R1's physician order dated 8/4/24, elopement-frequent checks (Note must be completed by a nurse). Follow paper form for frequent checks. Note on locations or attempts to leave facility every shift for one day. Order completed. R1's elopement risk assessment dated [DATE], BIMS score 0 and was identified as no wander risk. R1's elopement risk assessment dated [DATE], BIMS score 15 and was identified as no wander risk. (continued on next page)

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.

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

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F 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Facility elopement investigation notes dated 8/4/24, identified R1 had never gone anywhere other than the sitting area at the front of the facility before. R1 was alert, orientated, and able to make his needs known but had a history of poor safety awareness AEB (as manifested by) call pendent not used to request assistance with transfers. Facility staff member identified over the past week she had seen R1 on the west side of the building on the sidewalk with no signs of attempting to leave the facility grounds. R1's sister had told facility he had again requested family purse possible admission to the local AL facility, frequently looked for a different room more suitable for himself at current facility he resided at. He had attempted on once occasion to leave facility through doors located by the chapel, redirected, and moved back into facility without question. R1 was transported to ER for evaluation, placed on frequent checks for 24 hours. Wander guard was placed on R1's motorized scooter as he was unable to walk or move independently in a manual wheelchair.

R1's care area assessment (CAA) dated 6/12/24, identified recent change in mood; sad or anxious (e.g. crying, social withdrawal). R1's cognition was identified as having confusion, disorientation, and forgetfulness, and decreased ability to make self-understood or to understand others. R1 had a psychiatric or mood disorder and hearing or vision impairment that may have impacted his ability to process information (e. g. directions, reminders, and environmental cues). R1 had expressive communication (e.g. disruption in ability to speak, problems describing objects and events). R1 indicated he felt lonely and conditions identified that impede his ability to interact with others identified were: aphasia, depression, decline in functional abilities, and mood problems that impacted interpersonal relationships or that arises due to social isolation. R1's psychosocial change identified as recent move into a nursing home. R1 had little interest or pleasure in doing things and preferred group activities. Impairment on upper and lower extremity on one side.

R1's care plan last updated on 8/5/24, identified communication problem and directed staff to use simple, brief and consistent words/cue and yes/no questions, and communication tools such as communication board/book, writing pad, gestures, signs, and pictures. R1's speech communication was limited to yes, no, bye, grunts in different tones that corresponded with his facial expressions to express his mood, and hand gestures. R1 was identified as an elopement risk on 8/5/24, as evidenced by (EVB) was not identified on care plan. Staff were directed to monitor location for at least 24 hours after elopement, wandering behaviors, and attempted diversion interventions in behavior log. Wander guard was located on back of R1's motorized scooter. R1 was allowed to sit in courtyard by himself with call light pendent and staff or family was required to be with resident if he wanted to sit outside the main entrance. R1 had limited physical mobility and identified with independent scooter use after transfer assistance into his chair. R1 had diagnosis of depression related to loss of independence from stroke that resulted in hemiplegia, loss of independence, separation from family, unable to communicate with others, not wanting to come out of his room and admitted to being lonely. Staff were directed to monitor/document/report signs/symptoms of depression, hopelessness, anxiety, sadness, insomnia, verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness. R1's goal was to discharge to assisted living. Staff were directed to assist resident with tours of facilities and coordinate community services, and information about alterative living arrangements to R1 and representative.

R1's occupational therapy treatment note dated 7/12/24, identified R1 was classified as stable and uncomplicated decision making and deemed safe to operate power scooter.

R1's progress noted from 8/4/24, through 8/5/24, identified:

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/4/24 at 10:24 a.m., Late entry: Received a call from community member lived at a local assisted living (AL) facility Estates at approximately 11:10 and reported to charge nurse believed one of our residents [R1] was outside of her place of residence and stuck in a ditch. When questioned how she knew it was [R1] she indicated she visited a family member at this facility and was familiar with him. She indicated had called the police department but was told they were unable to assist her. The charge nurse checked and confirmed [R1] was missing. Community member called again and stated the police department was at the scene. The police department called charge nurse requested the residents full name and date of birth (DOB). After confirmation [R1] returned to facility at 11:25 a.m. with emergency medical EMT's and police. He was then sent to evaluation to ER (emergency room) at 12:27 p.m. to ensure resident was safe after being out of the facility. POA (power of attorney) was notified by staff nurse and facility administrator notified at 11:48 am by charge nurse. [R1] returned from the ER with orders for antibiotics d/t (due to) urinalysis suggestive of a UTI (urinary tract infection). -8/4/24 at 3:47 p.m., Returned to facility via ambulance from hospital. -8/4/24 at 4:10 p.m., Change wander guard: please document initials, date, and serial number of new wander guard. Placed on back of electric scooter. Reason for placement explained to wife and [R1]. -8/5/24 at 2:59 p.m., Health Status Note: Elopement follow-up: Effective Date: 08/05/2024 14:59 Type: Health Status Note. Elopement Follow-up: Resident left building via motorized w/c (wheelchair) after breakfast. [R1] did not communicate to any staff he left facility. Destination was local assisted living facility to look inside facility at room availability. [R1's] wheelchair got stuck in a ditch on the way to the assisted living. Was assisted by local law enforcement and EMT and returned to facility. Was then taken to ER for evaluation. diagnosed with UTI (urinary tract infection). Started on Cipro 250 mg (milligrams) BID (two times a day) x (times) 3 days. Interventions: BIMS (brief interview for mental status) score was 15.0 (intact cognition). Wander guard- placed on motorized w/c. [R1] must have someone sit with him when wanting to sit outside at the main entrance. Must inform staff when leaving facility with any family member by himself after . Be sure resident has call pendant on self when going in the courtyard. Resident is aware of the plan and in agreement. During an observation on 8/15/24 at 10:20 a.m., R1's door was closed to his room. R1 laid across his bed with feet placed on electric wheelchair. R1 woke up after surveyor knocked at the door and entered. Wander guard was noted attached to the electric wheelchair on the back side located just below the head rest. During an observation on 8/15/24 at 11:11 a.m. staff nursing assistant (NA)-A stopped by R1's room and checked to see how he was doing. Additionally, at 11:12 a.m. female staff stopped by R1's room checked on him and left room. During an observation on 8/15/24 at 11:20 a.m., R1 came out of his room fully dressed in electric wheelchair, went down hallway and made a loop around the facility independently. Wander guard intact on back side of wheelchair located just below the head rest. During an observation on 8/15/24 at 4:00 p.m. R1 sat in his room alone in silence and looked out of window. Wander guard intact on back side of wheelchair located just below the head rest. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/16/24 at 9:25 a.m., R1's room door was open and he sat in motorized wheel chair alone at his desk and painted on a ceramic duck. Wander guard intact on back side of wheelchair located just below the head rest. During an observation on 8/16/24 at 2:30 p.m., and 4:00 p.m. R1 laid on top of his bed with door open to room, eyes closed in silence. Wander guard intact on back side of wheelchair located just below the head rest. During an interview on 8/15/24 at 10:20 a.m., R1 stated had left facility over one week ago in the electric wheelchair to cruise around the neighborhood and check on an AL facility. R1 stated he wanted to move so he would have more independence. R1 stated was aware of his surroundings and felt safe leaving the facility grounds in the electric wheelchair. R1 stated most of the time when he left the grounds in the past had a family member with him. R1 stated staff had informed him he was unable to leave the facility grounds independently. During a follow up interview/observation on 8/16/24 at 9:30 a.m., R1 sat in electric wheelchair with wander guard attached to the bar located on the backside below the head rest of the wheel chair. R1 was positioned at a table and pained a ceramic duck. R1 stated felt more restricted after the placement of the wander guard and isolated more in his room than before. R1 stated staff do not have the time to take him outside, they were so busy. R1 was aware he could go out into the courtyard but had been closed recently due to dug up ground. R1 stated hardly ever went out in the front of building anymore unless family visited. R1 stated he felt sad, isolated, and very much restricted. R1 stated felt his depression had gotten worse since staff placed the wander guard and restricted his independence going outside. R1 confirmed he had no thoughts of hurting himself and he talked to his sister, and she listened. During an interview on 8/15/24 at 2:25 p.m., nursing assistance (NA)-A stated R1 preferred to be independent, and cognition intact with no confusion or forgetfulness. NA-A stated R1 was independent with use of electric wheelchair allowed to go outside independently but due to recent elopement wander guard was applied to wheelchair and R1 was restricted as to where he could go. NA-A stated R1 was allowed to go out to the courtyard independently but area was closed off to residents, due to the ground being dug up and not safe to enter. NA-A verified R1 was allowed to sit out front of building but only if accompanied by a family member or staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 8/16/24 at 8:11 a.m., R1's family member (FM) stated they knew R1 left the facility not to long ago to check out the AL next door. FM indicated R1 had told her he was the youngest resident in the facility and felt out of place. FM stated R1 had also told her he was not aware he had to sign out of the building prior to leaving and felt he told the truth. FM also stated there were times when she had taken R1 out of the facility, staff had her sign him out, but sometimes they would just say ok and not ask where they were going or when we would return. FM verified they had found R1 on the on the back side of the AL facility, that he wanted to move, and had gone there to check out the area. FM stated the facility had informed her prior to R1 leaving the facility he could go out and about and that would not be a problem. FM stated R1 had left the facility by himself for a stroll around that side of town by the facility about two months ago without any problems. FM indicated she had planned on finding R1 a cell phone to carry with him while outside in case he needed assistance. FM stated R1's cognition had improved in the past year 90%, was severely impaired and now his cognition was intact. FM stated R1 told her he felt totally isolated at this facility and she was afraid he would get more depressed. FM verified she had seen sadness in R1 the past few days, gave her the shrug of his shoulders and indicated he could just as well lay in bed, unable to go outside anymore unless someone had time. FM stated R1 loved the lake, sensory, and needed fresh air. FM stated, thank God he had his painting he can do in his room, that was most likely what was saving him from getting too down on things until he moved. During an interview on 8/16/24 at 9:53 a.m., licensed practical nurse (LPN)-B stated R1 valued his independence, drove his electric wheelchair well, and was important to offer R1 choices. LPN-B stated they had not completed an assessment for application of a wander guard since she started work at the facility (three months ago). LPN-B also stated R1 had no history of elopement, loved the outdoors, sat out in the front of building, and did not wander aimlessly without a purpose. LPN-B confirmed R1 was unable to leave facility without family or someone with him. During a telephone interview on 8/16/24 at 11:18 a.m., registered nurse (RN)-A stated a wander guard had been placed by another staff on R1's wheelchair and management team decided the following day (Monday) R1 would be allowed to go outside in the courtyard by himself unsupervised. The courtyard door (a contained area) would set off the wander guard, R1 was ok with that and happy to have the ability to go out there alone. RN-A verified no assessment for a wander guard was required and was a nursing judgement call. RN-A stated after R1's initial elopement risk assessment was completed upon admission; had been an ongoing thing an assessment was not required prior to the application of the wander guard. RN-A stated when a resident lacked safety awareness, it was a motherly instinct that indicated a safety issue. RN-A indicated staff completed 15-minute checks for 24 hours once R1 returned from ER but no other interventions were tried prior to the placement of the wander guard, adding she was not sure what else could have been done. During an interview on 8/16/24 at 11:54 a.m., LPN-A stated they worked the day R1 left the facility. LPN-A indicated R1 was alert and oriented that morning and no signs of confusion were noted. LPN-A stated R1 had told her upon his return that day he just wanted to check things out at the local AL facility. LPN-A stated it appeared to be an isolated incident. LPN-A stated R1's cognition was intact, was forgetful at times, and should have signed out when he left facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/16/24 at 12:45 p.m., social worker (SW) stated the facility courtyard was closed to residents and most likely will be for the next two weeks. SW stated R1 was independent in his electric wheelchair on and off the unit (to other units within the facility), not real clear in R1's care plan as to where he could go independently prior to the elopement. SW stated R1 had a wander guard applied to the backside of his wheelchair and unable leave the facility until next review date without staff or family. SW stated the courtyard had not been torn up yet so he was allowed to go out there independently so that he would not feel like he had a babysitter with him. SW stated R1 had intact cognition, speech therapy attempted a SLUMS (St. Louis University Mental Status) (screening tool designed to detect early signs of mild cognition impairment and dementia) however because he was non-verbal the test was unable to be completed. SW stated R1 had not left the facility prior to his elopement, two assessments were completed upon admission 6/17/24, and annual review on 7/11/24 and identified no risk for elopement. SW stated a wander guard was applied to R1's wheelchair and he was made aware of it and was ok with it. SW stated R1 and his family asked if wander guard was a permanent thing and were told we do not want to take away his freedom and planned on getting back to where he will not need it. SW stated the wander guard was placed for a testing period so that staff were made aware when he exited the building. SW verified no assessment was completed prior to the application of the wander guard on 8/4/24, once he returned from the emergency room visit (ER). SW stated an assessment should have been completed on R1's safety level outside beyond the building. SW stated the wander guard will lock the exit doors (included the courtyard door) when the resident was positioned five feet in front of it and would restrict R1 from going outside. SW stated R1 would be required wait until staff swiped badge to have allowed R1 out of building. SW stated the first 24 hours after the elopement supervision was increased but after the 24 hours no other interventions or non-restrictive options were tried prior to the application of the wander guard. SW indicated R1 had not tired to exit the building alone since the elopement and the use of the wander guard should have be reassessed and possibly removed. During an interview on 8/16/24 at 2:00 p.m., case manager RN-C stated R1's cognition was intact. RN-C stated unable to identify in R1's care plan if he had been assessed and/or if he was able to leave the facility grounds safely prior to the elopement. RN-C indicated a wander guard was placed on the back of R1's wheelchair on Sunday (day after elopement) and unsure if less restrictive options were attempted prior to that. RN-C stated the last elopement risk assessment completed was 6/11/24. RN-C stated the wander guard alerted staff R1 had entered the area by an exit door and required staff to swipe badge to open the door. RN-C stated the use of the wander guard on R1 restricted his movement outside the building. RN-C stated they had not discussed with R1 how he felt about the wander guard yet and hoped that someone explained it to him and what it was used for. RN-C stated after review of R1's medical record did not see any monitoring being completed for mood and hoped staff would have reported if there were any changes. RN-C stated R1's care plan was changed after the elopement and he was now required to have staff or family member outside the facility main entrance and courtyard independently. RN-C stated the court yard had been torn up and no residents were allowed to be in that area. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/16/24 at 2:36 p.m., director of nursing (DON) stated R1 had intact cognition was aware of what he was doing, and was able to communicate with people out in the community to yes and no questions. DON indicated R1 was not an elopement risk, had no previous elopement attempts, and could have left the building if he wanted to. DON verified an elopement risk assessment was not completed after the 8/4/24 elopement and should have been, it would have triggered R1 was an elopement risk. DON stated a wander guard was placed on R1's wheelchair to prevent another elopement. DON indicated the wander guard alert system was used to alert staff R1 tried to exit the building. DON stated if R1 really wanted to get out of the facility he would just wait a few seconds then hold door handle down, would open, and then exit the building. DON stated the wander guard was used to alert staff he was at the door. DON stated she would have expected staff to have attempted other interventions such as checked on R1 more frequently after the 24 hours were up before the application of the wander guard. DON the use of the R1's wander guard should have been reviewed weekly. During an interview on 8/16/24 at 3:13 p.m. floor manager RN-B stated R1's BIMS (brief interview for mental status) indicated cognition was intact. RN-B stated SLUMS or MoCA (Montreal Cognitive Assessment) (used to identify impairment of cognition) was not completed due to R1's deficits and inability to write and answer questions easily. RN-B stated assumed R1 was independent on and off the unit and independent outside prior to the elopement but hard to determine that after review of care plan. RN-B stated R1 had communication barriers, wanted out of this facility, felt like he did not fit in, no dementia, and younger than the residents that resided in the facility. RN-B stated R1 had made staff aware he wished to be moved to AL for more independence and family indicated he wanted to go over there to be re-evaluated. RN-B stated prior to elopement R1 had been outside with family, during activities, and had been safe without issues. RN-B stated she had applied a wander guard to R1's wheel chair after he returned fromER on [DATE]. RN-B stated no assessment was completed to the application of the wander guard and should have been. RN-B also stated every 15 minute checks were started and completed 24 hours later. RN-B indicated the wander guard would restrict R1's mobility for going outside and staff would have to open the door for him. RN-B stated anyone could open the door 15 seconds after the wander guard alarmed, door lock would have released, and R1 was not prompted for that. RN-B stated R1 used an electric wheelchair, moved rather fast, found the wander guard was the only option, unable to have someone at all the exit doors when staff assisted other residents. RN-B stated R1 and family asked how long would the wander guard be used and informed unsure of the plan. RN-C indicted R1 had not attempted to exit the facility building since the wander guard was applied and an assessment had not been completed to identify if it was still needed. Facility policy Elopement assessment dated [DATE], revealed a safe environment would be expected to be provided for each resident of the facility. Elopement would be defined as leaving the facility without following the facility's policies and procedures for leave of absence. A thorough elopement risk assessment would be completed during admission, annually, and with any significant change in condition to identify if a resident was at high risk for elopement. Residents identified as high risk for elopement would have preventive interventions initiated on the resident's care plan, direct care staff informed of resident's risk, and when actively exit seeking would have a wander guard placed to ensure residents' safety. Facility policy Wander Guard Blue Devices dated 4/27/22, revealed resident(s) identified to wear a wander guard: assessed to be a potential wanderer, assessed for safety risks and had be determined little or no regard for their own safety, and new admits whose behaviors suggested they maybe a wandering risk. Consider monitoring the new admits until actual risk can be determined.