

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Littlefork Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 912 Main Street Littlefork, MN 56653	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082</p> <p>Based on observation, interview and document review, the facility failed to comprehensively assess for removing and placing a Wander Guard (WG- alarming device) and ensure the fenced in area for residents was secure for 1 of 3 residents (R1) reviewed for resident safety.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment, wandering behaviors occurred daily, verbally expresses needs to staff, independent with walking, wander/elopement alarm was used daily.</p> <p>R1's elopement risk assessment dated [DATE], indicated R1 was at risk for wandering/elopement from facility. Wander guard (WG) was in place.</p> <p>R1's care plan dated 7/11/24, identified R1 being at risk for elopement due to cognitive status as he was exit seeking, wander guard was placed and regular facility checks were to be completed.</p> <p>A report to the State Agency (SA) dated 9/17/24, indicated on 9/17/24, staff received an alert from a citizen R1 was walking outside on the facility grounds. R1 refused to return to the facility, staff walked with R1 until he was calm and ready to return.</p> <p>The facility 5 day report dated 9/24/24, indicated actions taken as a result of an investigation and included: staff educated on changes made to R1 care plan, Wander Guard (WG- alert system) placed, all door alarms and WG checked to ensure proper functioning, staff educated on the WG policy and need for assessment when placing and need for assessment when placing or removing a WG, educated staff on who has a WG and who should be accompanied when going outside for safety purposes. No systemic issues found, and no other recent elopements had occurred.</p> <p>R1's progress note dated 9/17/24 at 12:19 p.m., indicated a visitor told staff he saw R1 leaving the gated area. When staff went to check on R1, R1 was walking through the adjoining lawn out to the roadway. Staff called the front desk to alert staff and two other staff came and approached R1 to return back to the facility.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 9/25/24 at 2:48 p.m., R1 was outside sitting in a chair in a fenced in area on the East side of the facility. R1's chair was placed in front of the door which is mostly glass and R1 was easily supervised by staff. R1's Wander Guard was in place. The gate attached to the fence was secured by a bungee cord and a latch that was not locked.</p> <p>During interview on 9/25/24 at 2:52 p.m. nursing assistant (NA)-A stated R1 was able to be outside and was instructed to stay in front of the glass door so staff could supervise him, we check on him all the time. NA-A stated when staff cannot see R1 through the door they are to check the fence area to complete a visual check. NA-A was not aware if there were changes to the fenced area since R1 exited the fenced area; NA-A observed the bungee cord and latch on the gate and stated those had been there since R1 admission to the facility.</p> <p>During interview on 9/26/24 at 10:33 a.m. designated social worker (DSW) stated R1 was admitted to the facility and a WG was placed on R1 as he was an elopement risk. On 8/12/24, the WG was removed per families request as R1 had not attempted to elope. DSW was not aware if an assessment was completed prior to removing the WG. DSW confirmed R1 left the secured fenced area on 9/17/24.</p> <p>R1's medical record lacked an elopement risk assessment for removing the WG on 8/12/24, to ensure it was safe to remove the wanderguard. Further, the medical record lacked an elopement assessment for placing the WG back on after elopement incident on 9/17/24.</p> <p>During interview on 9/26/24 at 1:02 p.m., director of nursing (DON) stated there was not an elopement assessment completed to remove the WG or after the recent incident of leaving of the building and it should have been completed. The DON did not identify why the 5-day investigative report identified elopement assessment had been completed. DON confirmed the gate in the fence area had no changes and continued to use the bungee cord and latch on the gate since elopement. DON further stated staff were to keep doing frequent checks while R1 was outside and R1 was to sit in front of the door so staff can visually see R1.</p> <p>During phone call interview on 9/26/24 at 1:03 p.m. witness stated R1 was outside in the fenced area and was agitated and witness tried to distract R1 as he was wanting to leave. Witness said when R1 would not listen to not leave the area the witness then alerted staff. Witness recalled R1 was trying to use the fence gate to get out of the fenced area.</p> <p>During interview, via phone, on 9/26/24 at 2:14 p.m., case manager (CM) stated R1 left the building on 9/17/24 and did not have a WG at that time. CM stated family was contacted about trying to remove the WG and they agreed. CM did not recall an elopement assessment was completed when the WG was removed. CM stated the WG was removed due to not feeling there was a concern R1 would leave.</p> <p>During phone call interview on 9/26/24 at 2:37 p.m., family member (FM) stated she was aware R1 had eloped and the WG was put back on after this incident. FM stated she was notified when the facility wanted to try to remove the WG because R1 had not attempted to leave the facility.</p> <p>The facility policy Elopement dated 8/1/22, indicated all resident will be assessed on admission for risk of wondering or elopement. At any time, a resident is identified at risk for elopement, an elopement assessment will be completed, and a plan put into place.</p>		