

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Gil-Mor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Third Street East Morgan, MN 56266	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38687</p> <p>The facility failed to comprehensively assess 1 of 1 resident (R15) annually, quarterly, and as needed for risk of elopement and need for a wander guard device when R15 went outside to sit on the patio and subsequently eloped off campus, across a busy highway and into a field where farmers with combines were working.</p> <p>Findings include:</p> <p>Review of the 1/26/24, Quality Assurance Performance Improvement (QAPI) meeting minutes identified the QAPI committee identified an elopement occurred. The unidentified resident went outside to sit with other residents. The WanderGuard was noted as functioning, however, the resident had taken it off. There was no date or name noted of the resident in the meeting minutes.</p> <p>Email correspondence reply on 6/10/24 at 7:01 p.m. and attached 10/9/23, incident report review identified R15 had eloped from the facility on 10/9/23 at 4:05 p.m., when R15 asked nursing staff if he could go outside. The unidentified nurse remarked R15 could. R15 was then seen by activity staff crossing the hi-way, going down into the ditch and into the field where tractors were busy in the field combining. R15 had wanted to get a closer look. When he was brought back into the facility. R15 remarked the nurse Didn't say he couldn't go across the road, or he wouldn't have. R15 reported he was going to check out the field work. After staff brought R15 back into the facility, and a WanderGuard was applied, R15 was upset as it would go off when he went to his spouse's room. Staff noted R15 understood he shouldn't have crossed the hi-way after the incident and was reported to be oriented to situation, person, place, and time and could ambulate without assistance but was to use a wheeled walker. Staff noted R15's care plan had been reviewed.</p> <p>Interview on 6/10/24 at 7:20 p.m., with trained medication aide (TMA)-A identified R15 has a Tabs alarm on his door and on his bed because his spouse tries to go in his room and transfer him and help him. He is a high fall risk. The tabs alarm is on his door at night because he gets up and wanders at night. Staff used to often find him on the floor in his room during the day and his spouse would be in there with him. During the night the Tabs alarm is on the outside of the door and during the day it's on the inside so R15's spouse can't get to it. She has been known to disarm the alarm and go in. R15 also has a bed sensor that shows on the LED display which also sounds in his room loudly enough for staff to hear it in the hallway. The bed alarm is the newest alarm. TMA-A was aware of the elopement when R15 walked outside and across the field. He thought R15's spouse shut the code off on the door but we are not sure. I know he had a WanderGuard.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 6/11/24 at 9:48 a.m., outside the facility identified adjacent to the facility front door and parking lot, was a hi-way where speeds were between 30-55 miles per hour (mph). Adjacent to the hi-way was a field with a tractor operating beside the road.</p> <p>R15's 9/8/23, Significant Change Minimum Data Set (MDS) identified he had moderately impaired cognition prior to the incident and had no behaviors noted of wandering. Section P-Restraints identified R15 had an alarm used daily.</p> <p>R15's last elopement assessment on 4/19/23, identified he had intact cognition at that time but had a previous attempt noted at leaving the facility. Staff stated he had no history of desires to go home or wandering. Staff decided to do a 3-day trial at that time and discontinue the WanderGuard if R15 had no concerns for wandering. There was no documentation to support R15 was reassessed for elopement risk with each quarter, annual, or Significant Change MDS.</p> <p>R15's current, undated care plan identified R15 had a focus for short term memory loss with a diagnosis of dementia. An entry was made that a WanderGuard had been placed on R15's walker after he was found wandering outside on 5/25/22. Since R15 had not attempted an elopement since 5/25/22, his WanderGuard was discontinued by the interdisciplinary team with family approval on 4/18/23. 15-minute checks were implemented on 4/18/23, then 30-minute checks on 4/19/23, then hourly on 4/20/23. Staff then permanently discontinued his WanderGuard. There was no mention if R15's physician (MD)-A was included in the discussion and had ordered the discontinuation of the WanderGuard device that had been previously ordered.</p> <p>Further review of R15's current, undated care plan identified R15 was noted to have been found wandering outside on 10/9/23 across the hi-way in front of the facility. Staff documented R15's WanderGuard was re-applied, and the family was updated. The WanderGuard had been discontinued as R15 had not wandered intentionally. R15 reported to staff he didn't know he wasn't allowed to go watch the farmers across the road into the field and is aware that this could be dangerous [due to] his vision and then he is aware now that he shouldn't leave the facility without assistance. R15 was noted to have a tabs alarm on his door to alert staff if he was wandering at night due to nightmares and confusion.</p> <p>R15's 7/26/23 Fax to his physician identified R15 reported he had lost his balance while out with his family. The family member caught him, so he did not fall. R15 wanted his physician to know he was getting weaker and had been using his wheelchair at times.</p> <p>R15's 10/9/23 faxed note to MD-A identified staff notified MD-A of R15's an elopement and noted they had placed a WanderGuard on R15 and his walker. MD-A replied back and agreed to the WanderGuard placement on 10/10/23 ok. Review of R15's physician progress notes after 10/9/23 identified there was no mention staff had alerted MD-A to R15's continued wandering in the facility or the 5/23/24 statement of wanting to leave the facility.</p> <p>Review of the facility reported incidents identified no report had been made to the State Agency of R15's elopement.</p> <p>R15's progress notes identified on:</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1) 10/9/23 a WanderGuard was placed on both his wheelchair and walker (not on his person), the incident reported, and the family updated.</p> <p>2) 10/10/23 at 3:24 p.m., staff noted R15's physician (MD)-A noted R15 was outside. Staff documented no new orders faxed.</p> <p>3) 11/28/23 at 2:30 p.m., staff noted R15 had episodes where he was confused and struggled to find the right words until assisted.</p> <p>4) 12/1/23 at 8:10 a.m., staff noted they were called to R15's room. He was found sitting on the bathroom floor with his back against the wall. R15 stated he did not hit his head or have any injuries noted. He was assisted up with 2 staff, was able to bear weight on his legs, and ambulate to his wheelchair without pain.</p> <p>5) 12/6/23 at 1:05 p.m., R15 was to have difficulty hearing. His eyesight was impaired. He was able to get around the facility on his own. Due to his poor eyesight, staff noted he would need assistance to read medical pamphlets and instructions. Staff assessed R15's cognition. R15 thought the year was 2030. R15 scored a 7 which identified sever cognitive impairment. Staff documented his cognition did go down, but it was a gradual decline over the past months and not an acute change. When staff left the room, R15 stated he had to go deliver eggs to his parent.</p> <p>Further review of his progress notes identified on:</p> <p>1) 12/24/23 at 9:22 p.m., R15 set off his door alarm and walked without a walker to the nurse's station. He reported he was going to the farm he had work to do,, he was going to let the cows out and help with farm work. Staff re-directed R15 and explained he had been retired. R15 was fed and then assisted to bed and went back to sleep.</p> <p>2) 12/28/23 at 8:32 a.m., Staff were called to R15's room. R15 stated he was walking to the bathroom and slipped and fell by his bathroom door, hitting his head. No injuries were noted.</p> <p>3) 1/13/24 at 10:11 p.m., staff heard R15 yelling for help. They found him on the floor bleeding from skin tear atop his head. R15 reported he was getting ready for his bath. A dressing was applied.</p> <p>4) 1/17/24 at 2:00 a.m., R15 was up wandering at times with his tabs alarm sounding.</p> <p>5) 2/4/24 at 5:38 a.m., R15 was confused and up wandering during the night, setting off his tabs alarm. He stated he wanted to out front and see who was here. That a.m., R15 reported he was in his car and stated he hit a dog then asked staff if he was up in their yard. Staff redirected R15.</p> <p>6) 2/27/24 at 2:27 a.m., R15 was found on the floor in his room, wearing socks in total darkness. R15 had no injuries. He was assisted back to bed.</p> <p>7) 3/3/24 at 8:05 a.m., R15 was found getting himself up off the floor in his room. R15's spouse had entered his room, woke him up, and took himself to the bathroom. Staff noted they failed to replace his door alarm after medications were given. Staff were to ensure his door alarm was placed and they placed a bed alarm to alert staff of his movement.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8) R15 was noted to have an unresponsive spell. He responded to a sternal rub and the MD was notified. Staff were to continue to monitor.</p> <p>9) 3/21/24, at 12:09 a.m., R15 was up to the bathroom. He said hey little guy looking down as if there was a dog or cat there. Later that evening at 9:00 p.m., R15 was again found on the floor in his room by his recliner. R15 was noted by staff to be left alone while brushing his teeth at 7:00 p.m., 50 minutes earlier. R15 was noted to be confused at times needing more assistance.</p> <p>10) 5/8/24 at 3:06 a.m., R15 was once again found sitting on his floor. R15 stated he was getting up to check out the fire .</p> <p>11) 5/23/24, R15 was documented as threatening a nurse aide and began pushing another resident stating he was going to leave. Staff redirected. There was no indication staff alerted MD-A to R15's elopement statement.</p> <p>There was no indication staff had re-assessed R15's supervision after frequent falls in his room, or while wandering or after threats to leave the facility to identify if he was a continued elopement risk or required increased supervision with the presence of gradual cognitive decline.</p> <p>Interview on 6/11/24 at 10:12 a.m., with the director of nursing identified after the 10/9/23 incident, the IDT team discontinued the WanderGuard that had been agreed upon as necessary by MD-A. The DON agreed staff failed to secure an order to remove the WanderGuard from MD-A or notify them they would like to remove it. She agreed if an MD ordered a WanderGuard the MD should be the one to discontinue it as it is an MD order. The DON was unaware of MDS assessments or lack thereof and deferred to the MDS nurse. The DON agreed R15 should have been fully re-assessed for Wandering with each MDS, and fully assessed for interventions and risk after his elopement on 10/9/23.</p> <p>Observation and interview on 6/11/24, by the Fire Marshall (FM) during his Life Safety Code tour with the maintenance supervisor (MS) between approximately 10:00 a.m. and 11:00 a.m., it was discovered the WanderGuard system had been shut off down the [NAME] Wing. The MS reported to the FM thought the hairdresser had shut it off as she is located down that same [NAME] wing. The MS reported the hairdresser would come in and out that door and it would have alarmed each time, so she was known to disengage the WanderGuard system to prevent it from alarming each time.</p> <p>Review of the current, undated WanderGuard list provided by the DON identified 2 residents (R8 and R23) resided down the [NAME] wing.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 6/11/24 at 12:05 p.m. with the MDS nurse (MDS)-A identified from what she recalls from incident, R15 went across street. His cognition at the time was a 12, indicating moderate cognitive impairment. A WanderGuard was initially placed on him, but since the previous DON who was working at that time felt R15 knew what he was doing as he wasn't aware he wasn't allowed to do that, she decided the WanderGuard was ok to be removed. MDS-A was unsure what policy was regarding the removal of WanderGuard and did not recall the facility having a Physician's Standing Order to apply or remove a WanderGuard device. The MDS nurse was unaware WanderGuard system was off down the [NAME] wing hall. She agreed anyone with a WanderGuard device would potentially be affected. MDS-A identified she only assessed residents upon admission for elopement if staff were made aware of previous elopements from other facilities or if staff report they see wandering behaviors. She agreed she should be doing assessments with the MDS scheduled assessments, after elopements or whenever needed. That was missed. She also agreed without an assessment done with the [DATE], Significant change MDS that occurred prior to the incident, she could not verify if he was or was not at increased risk for elopement prior to his incident as she had not assessed R15 with the MDS schedule or as needed.</p> <p>Interview on 6/11/24 at 12:21 p.m., with the DON identified she also wasn't aware of WanderGuard system being off down the [NAME] wing. She agreed that would affect any wanderer who happened to go down that hall.</p> <p>Observation on 6/11/24 at 12:25 p.m., of R15 in the dining room identified he was eating slowly at the assisted resident table. There was no Tabs alarm was present on his wheelchair or person.</p> <p>Interview on 6/11/24 at 12:27 p.m., with the administrator identified she was unaware R15's elopement was not reported to the SA. The old DON felt R15 knew what he was doing so she felt it wasn't an elopement. She agreed the definition of an elopement was when a resident leaves the premises or a safe area without the facility 's</p> <p>knowledge and supervision. She agreed R15 was known to have visual decline and it was unsafe for any resident to cross a busy hi-way and walk into a field. She reported an elopement assessment should be done upon admission, quarterly, with a change, or as needed. She wasn't aware R15 had not been assessed, especially after his elopement. Staff should have an MD order to discontinue a WanderGuard device usage. There were no notes to identify why that wasn't done. She was aware the hairdresser likely shut off the WanderGuard alarm as the alarm would go off a lot.</p> <p>Interview on 6/11/24 at 2:40 p.m., with nurse aide (NA)-E regarding R15's wandering noted R15 was confused at times. Sometimes he comes out and wanders (walks) and says he needs to get his car. He can walk around the unit but the tabs alarm on his door alerts staff he was coming out. Staff put the Tabs alarm on his door whenever he goes in his room. He doesn't get farther than the hallway. To her knowledge staff have never forgotten his tabs and he has never gotten off the unit (East wing).</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 6/11/24 at 4:19 p.m., with MD-A identified he was made aware of R15's elopement on 10/9/23. He agreed to staff placing the WanderGuard on R15's person. He was unaware staff discontinued the WanderGuard without first acquiring an MD order to do so. He expected an elopement assessment be performed on admission, quarterly and with any changes. He also was unaware the hairdresser was disabling the WanderGuard alarm and stated that was a risk to any residents but especially any who resided down that wing who wore a WanderGuard. He agreed staff should have assessed R15 and others who may be at risk and follow facility policies and procedures for reporting, assessing, monitoring, and perform a root cause analysis to identify potential areas of improvement or interventions to keep residents safe.</p> <p>Observation and interview on 6/11/24 at 4:40 p.m., with R15 in the day room identified he was alert and oriented x 2. He remarked he had some forgetfulness but could not account for recent events. R15 was seated in a wheelchair and made no attempts at self-ambulating in the wheelchair. He gave no indication of reporting he wanted to go outside to potentially elope or showed any behaviors of wanting to elope.</p> <p>Review of the 2/20/24, Elopement Risk Assessment procedure identified elopement occurs when a resident who isn't permitted to leave the facility does so with intent, or when a resident is incapable of adequately providing self-protection departs unsupervised or undetected. Elopement causes an increased risk of harm or death in certain situations. Effective assessment was essential to ensuring safety. Staff were to:</p> <ol style="list-style-type: none"> 1) Review the resident's medical record. 2) Assess the resident's ambulation status. 3) Use the facility's assessment tool. 4) complete assessment for agitation, mental capacity. 5) Notify the MD so they can evaluate the resident and order appropriate interventions. <p>Review of the 2/20/24, Elopement Precautions, Long Term Care policy identified staff were to:</p> <p>Before an elopement</p> <ol style="list-style-type: none"> 1) Review the medical record. 2) Assess the resident upon admission and regularly thereafter. 3) Make sure the resident wears an electronic safety device that alerts staff of an attempted elopement if the facility has such a system in place. 4) Assign a resident to a room that is properly located, away from exits, close to a nurse's station, etc 5) Develop a care plan with safety goals. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>38687</p> <p>The facility failed to acquire a physicians order prior to discontinuing a WanderGuard device for 1 of 1 resident (R15) who eloped, had a WanderGuard ordered to be implemented by staff, and was discontinued without a physician order or knowledge the next day.</p> <p>Findings include:</p> <p>Review of the 1/26/24, Quality Assurance Performance Improvement (QAPI) meeting minutes identified the QAPI committee identified an elopement occurred. The unidentified resident went outside to sit with other residents. The WanderGuard was noted as functioning, however, the resident had taken it off. There was no date or name noted of the resident in the meeting minutes.</p> <p>Email correspondence reply on 6/10/24 at 7:01 p.m. and attached 10/9/23, incident report review identified R15 had eloped from the facility on 10/9/23 at 4:05 p.m., when R15 asked nursing staff if he could go outside. The unidentified nurse remarked R15 could. R15 was then seen by activity staff crossing the hi-way, going down into the ditch and into the field where tractors were busy in the field combining. R15 had wanted to get a closer look. When he was brought back into the facility. R15 remarked the nurse Didn't say he couldn't go across the road, or he wouldn't have. R15 reported he was going to check out the field work. After staff brought R15 back into the facility, and a WanderGuard was applied, R15 was upset as it would go off when he went to his spouse's room. Staff noted R15 understood he shouldn't have crossed the hi-way after the incident and was reported to be oriented to situation, person, place, and time and could ambulate without assistance but was to use a wheeled walker. Staff noted R15's care plan had been reviewed.</p> <p>Observation on 6/11/24 at 9:48 a.m., outside the facility identified adjacent to the facility front door and parking lot, was a hi-way where speeds were between 30-55 miles per hour (mph). Adjacent to the hi-way was a field with a tractor operating beside the road.</p> <p>R15's 9/8/23, Significant Change Minimum Data Set (MDS) identified he had moderately impaired cognition prior to the incident and had no behaviors noted of wandering. Section P-Restraints identified R15 had an alarm used daily.</p> <p>R15's current, undated care plan identified R15's current, undated care plan identified R15 was noted to have been found wandering outside on 10/9/23 across the hi-way in front of the facility. Staff documented R15's WanderGuard was re-applied, and the family was updated. The WanderGuard had been discontinued as R15 had not wandered intentionally. R15 reported to staff he didn't know he wasn't allowed to go watch the farmers across the road into the field and .is aware that this could be dangerous [due to] his vision and then he is aware now that he shouldn't leave the facility without assistance. R15 was noted to have a tabs alarm on his door to alert staff if he was wandering at night due to nightmares and confusion.</p> <p>R15's 10/9/23 faxed note to MD-A identified staff notified MD-A of R15's an elopement and noted they had placed a WanderGuard on R15 and his walker. MD-A replied back and agreed to the WanderGuard placement on 10/10/23 ok. There was no indication MD-A was notified of the discontinuation of R15's WanderGuard device.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R15's progress notes identified on:</p> <p>1) 10/9/23 a WanderGuard was placed on both his wheelchair and walker (not on his person), the incident reported, and the family updated.</p> <p>2) 10/10/23 at 3:24 p.m., staff noted R15's physician (MD)-A noted R15 was outside. Staff documented no new orders faxed.</p> <p>Interview on 6/11/24 at 10:12 a.m., with the director of nursing identified after the 10/9/23 incident, the IDT team discontinued the WanderGuard that had been agreed upon as necessary by MD-A. The DON agreed staff failed to secure an order to remove the WanderGuard from MD-A or notify them they would like to remove it. She agreed if an MD ordered a WanderGuard the MD should be the one to discontinue it as it is an MD order. The DON was unaware of MDS assessments or lack thereof and deferred to the MDS nurse. The DON agreed R15 should have been fully re-assessed for Wandering with each MDS, and fully assessed for interventions and risk after his elopement on 10/9/23.</p> <p>Interview on 6/11/24 at 12:05 p.m. with the MDS nurse (MDS)-A identified from what she recalls from incident, R15 went across street. His cognition at the time was a 12, indicating moderate cognitive impairment. A WanderGuard was initially placed on him, but since the previous DON who was working at that time felt R15 knew what he was doing as he wasn't aware he wasn't allowed to do that, she decided the WanderGuard was ok to be removed. MDS-A was unsure what policy was regarding the removal of WanderGuard and did not recall the facility having a Physician's Standing Order to apply or remove a WanderGuard device.</p> <p>Interview on 6/11/24 at 12:27 p.m., with the administrator identified staff should have an MD order to discontinue a WanderGuard device usage. There were no notes to identify why that wasn't done.</p> <p>Interview on 6/11/24 at 4:19 p.m., with MD-A identified he was made aware of R15's elopement on 10/9/23. He agreed to staff placing the WanderGuard on R15's person. He was unaware staff discontinued the WanderGuard without first acquiring an MD order to do so. He expected staff to notify him of their intentions to discontinue a WanderGuard device.</p> <p>There was no specific policy related to WanderGuard provided by the end of the survey.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Gil-Mor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Third Street East Morgan, MN 56266	
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** 38687</p> <p>Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R15) with a history of elopement was appropriately assessed and supervised when R15 went outside to sit on the patio and subsequently eloped off campus, across a busy highway and into a field where farmers with combines were working. Furthermore, the facility failed to ensure 1 of 1 WanderGuard system remained active on the [NAME] wing at all times.</p> <p>Findings include:</p> <p>Review of the 1/26/24, Quality Assurance Performance Improvement (QAPI) meeting minutes identified the QAPI committee identified an elopement occurred. The unidentified resident went outside to sit with other residents. The WanderGuard was noted as functioning, however, the resident had taken it off. There was no date or name noted of the resident in the meeting minutes.</p> <p>Email correspondence reply on 6/10/24 at 7:01 p.m. and attached 10/9/23, incident report review identified R15 had eloped from the facility on 10/9/23 at 4:05 p.m., when R15 asked nursing staff if he could go outside. The unidentified nurse remarked R15 could. R15 was then seen by activity staff crossing the hi-way, going down into the ditch and into the field where tractors were busy in the field combining. R15 had wanted to get a closer look. When he was brought back into the facility. R15 remarked the nurse Didn't say he couldn't go across the road, or he wouldn't have. R15 reported he was going to check out the field work. After staff brought R15 back into the facility, and a WanderGuard was applied, R15 was upset as it would go off when he went to his spouse's room. Staff noted R15 understood he shouldn't have crossed the hi-way after the incident and was reported to be oriented to situation, person, place, and time and could ambulate without assistance but was to use a wheeled walker. Staff noted R15's care plan had been reviewed.</p> <p>Interview on 6/10/24 at 7:20 p.m., with trained medication aide (TMA)-A identified R15 has a Tabs alarm on his door and on his bed because his spouse tries to go in his room and transfer him and help him. He is a high fall risk. The tabs alarm is on his door at night because he gets up and wanders at night. Staff used to often find him on the floor in his room during the day and his spouse would be in there with him. During the night the Tabs alarm is on the outside of the door and during the day it's on the inside so R15's spouse can't get to it. She has been known to disarm the alarm and go in. R15 also has a bed sensor that shows on the LED display which also sounds in his room loudly enough for staff to hear it in the hallway. The bed alarm is the newest alarm. TMA-A was aware of the elopement when R15 walked outside and across the field. He thought R15's spouse shut the code off on the door but we are not sure. I know he had a WanderGuard.</p> <p>Observation on 6/11/24 at 9:48 a.m., outside the facility identified adjacent to the facility front door and parking lot, was a hi-way where speeds were between 30-55 miles per hour (mph). Adjacent to the hi-way was a field with a tractor operating beside the road.</p> <p>R15's 9/8/23, Significant Change Minimum Data Set (MDS) identified he had moderately impaired cognition prior to the incident and had no behaviors noted of wandering. Section P-Restraints identified R15 had an alarm used daily.</p> <p>(continued on next page)</p>		

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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>R15's last elopement assessment on 4/19/23, identified he had intact cognition at that time but had a previous attempt noted at leaving the facility. Staff stated he had no history of desires to go home or wandering. Staff decided to do a 3-day trial at that time and discontinue the WanderGuard if R15 had no concerns for wandering. There was no documentation to support R15 was reassessed for elopement risk with each quarter, annual, or Significant Change MDS.</p> <p>R15's current, undated care plan identified R15 had a focus for short term memory loss with a diagnosis of dementia. An entry was made that a WanderGuard had been placed on R15's walker after he was found wandering outside on 5/25/22. Since R15 had not attempted an elopement since 5/25/22, his WanderGuard was discontinued by the interdisciplinary team with family approval on 4/18/23. 15-minute checks were implemented on 4/18/23, then 30-minute checks on 4/19/23, then hourly on 4/20/23. Staff then permanently discontinued his WanderGuard. There was no mention if R15's physician (MD)-A was included in the discussion and had ordered the discontinuation of the WanderGuard device that had been previously ordered.</p> <p>Further review of R15's current, undated care plan identified R15 was noted to have been found wandering outside on 10/9/23 across the hi-way in front of the facility. Staff documented R15's WanderGuard was re-applied, and the family was updated. The WanderGuard had been discontinued as R15 had not wandered intentionally. R15 reported to staff he didn't know he wasn't allowed to go watch the farmers across the road into the field and .is aware that this could be dangerous [due to] his vision and then he is aware now that he shouldn't leave the facility without assistance. R15 was noted to have a tabs alarm on his door to alert staff if he was wandering at night due to nightmares and confusion.</p> <p>R15's 7/26/23 Fax to his physician identified R15 reported he had lost his balance while out with his family. The family member caught him, so he did not fall. R15 wanted his physician to know he was getting weaker and had been using his wheelchair at times.</p> <p>R15's 10/9/23 faxed note to MD-A identified staff notified MD-A of R15's an elopement and noted they had placed a WanderGuard on R15 and his walker. MD-A replied back and agreed to the WanderGuard placement on 10/10/23 ok. Review of R15's physician progress notes after 10/9/23 identified there was no mention staff had alerted MD-A to R15's continued wandering in the facility or the 5/23/24 statement of wanting to leave the facility.</p> <p>Review of the facility reported incidents identified no report had been made to the State Agency of R15's elopement.</p> <p>R15's progress notes identified on:</p> <ol style="list-style-type: none"> 1) 10/9/23 a WanderGuard was placed on both his wheelchair and walker (not on his person), the incident reported, and the family updated. 2) 10/10/23 at 3:24 p.m., staff noted R15's physician (MD)-A noted R15 was outside. Staff documented no new orders faxed. 3) 11/28/23 at 2:30 p.m., staff noted R15 had episodes where he was confused and struggled to find the right words until assisted. <p>(continued on next page)</p>		

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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>4) 12/1/23 at 8:10 a.m., staff noted they were called to R15's room. He was found sitting on the bathroom floor with his back against the wall. R15 stated he did not hit his head or have any injuries noted. He was assisted up with 2 staff, was able to bear weight on his legs, and ambulate to his wheelchair without pain.</p> <p>5) 12/6/23 at 1:05 p.m., R15 was to have difficulty hearing. His eyesight was impaired. He was able to get around the facility on his own. Due to his poor eyesight, staff noted he would need assistance to read medical pamphlets and instructions. Staff assessed R15's cognition. R15 thought the year was 2030. R15 scored a 7 which identified sever cognitive impairment. Staff documented his cognition did go down, but it was a gradual decline over the past months and not an acute change. When staff left the room, R15 stated he had to go deliver eggs to his parent.</p> <p>Further review of his progress notes identified on:</p> <p>1) 12/24/23 at 9:22 p.m., R15 set off his door alarm and walked without a walker to the nurse's station. He reported he was going to the farm he had work to do,, he was going to let the cows out and help with farm work. Staff re-directed R15 and explained he had been retired. R15 was fed and then assisted to bed and went back to sleep.</p> <p>2) 12/28/23 at 8:32 a.m., Staff were called to R15's room. R15 stated he was walking to the bathroom and slipped and fell by his bathroom door, hitting his head. No injuries were noted.</p> <p>3) 1/13/24 at 10:11 p.m., staff heard R15 yelling for help. They found him on the floor bleeding from skin tear atop his head. R15 reported he was getting ready for his bath. A dressing was applied.</p> <p>4) 1/17/24 at 2:00 a.m., R15 was up wandering at times with his tabs alarm sounding.</p> <p>5) 2/4/24 at 5:38 a.m., R15 was confused and up wandering during the night, setting off his tabs alarm. He stated he wanted to out front and see who was here. That a.m., R15 reported he was in his car and stated he hit a dog then asked staff if he was up in their yard. Staff redirected R15.</p> <p>6) 2/27/24 at 2:27 a.m., R15 was found on the floor in his room, wearing socks in total darkness. R15 had no injuries. He was assisted back to bed.</p> <p>7) 3/3/24 at 8:05 a.m., R15 was found getting himself up off the floor in his room. R15's spouse had entered his room, woke him up, and took himself to the bathroom. Staff noted they failed to replace his door alarm after medications were given. Staff were to ensure his door alarm was placed and they placed a bed alarm to alert staff of his movement.</p> <p>8) R15 was noted to have an unresponsive spell. He responded to a sternal rub and the MD was notified. Staff were to continue to monitor.</p> <p>9) 3/21/24, at 12:09 a.m., R15 was up to the bathroom. He said hey little guy looking down as if there was a dog or cat there. Later that evening at 9:00 p.m., R15 was again found on the floor in his room by his recliner. R15 was noted by staff to be left alone while brushing his teeth at 7:00 p.m., 50 minutes earlier. R15 was noted to be confused at times needing more assistance.</p> <p>(continued on next page)</p>		

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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>10) 5/8/24 at 3:06 a.m., R15 was once again found sitting on his floor. R15 stated he was getting up to check out the fire .</p> <p>11) 5/23/24, R15 was documented as threatening a nurse aide and began pushing another resident stating he was going to leave. Staff redirected. There was no indication staff alerted MD-A to R15's elopement statement.</p> <p>There was no indication staff had re-assessed R15's supervision after frequent falls in his room, or while wandering or after threats to leave the facility to identify if he was a continued elopement risk or required increased supervision with the presence of gradual cognitive decline.</p> <p>Interview on 6/11/24 at 10:12 a.m., with the director of nursing identified after the 10/9/23 incident, the IDT team discontinued the WanderGuard that had been agreed upon as necessary by MD-A. The DON agreed staff failed to secure an order to remove the WanderGuard from MD-A or notify them they would like to remove it. She agreed if an MD ordered a WanderGuard the MD should be the one to discontinue it as it is an MD order. The DON was unaware of MDS assessments or lack thereof and deferred to the MDS nurse. The DON agreed R15 should have been fully re-assessed for Wandering with each MDS, and fully assessed for interventions and risk after his elopement on 10/9/23.</p> <p>Observation and interview on 6/11/24, by the Fire Marshall (FM) during his Life Safety Code tour with the maintenance supervisor (MS) between approximately 10:00 a.m. and 11:00 a.m., it was discovered the WanderGuard system had been shut off down the [NAME] Wing. The MS reported to the FM thought the hairdresser had shut it off as she is located down that same [NAME] wing. The MS reported the hairdresser would come in and out that door and it would have alarmed each time, so she was known to disengage the WanderGuard system to prevent it from alarming each time.</p> <p>Review of the current, undated WanderGuard list provided by the DON identified 2 residents (R8 and R23) resided down the [NAME] wing.</p> <p>Interview on 6/11/24 at 12:05 p.m. with the MDS nurse (MDS)-A identified from what she recalls from incident, R15 went across street. His cognition at the time was a 12, indicating moderate cognitive impairment. A WanderGuard was initially placed on him, but since the previous DON who was working at that time felt R15 knew what he was doing as he wasn't aware he wasn't allowed to do that, she decided the WanderGuard was ok to be removed. MDS-A was unsure what policy was regarding the removal of WanderGuard and did not recall the facility having a Physician's Standing Order to apply or remove a WanderGuard device. The MDS nurse was unaware WanderGuard system was off down the [NAME] wing hall. She agreed anyone with a WanderGuard device would potentially be affected. MDS-A identified she only assessed residents upon admission for elopement if staff were made aware of previous elopements from other facilities or if staff report they see wandering behaviors. She agreed she should be doing assessments with the MDS scheduled assessments, after elopements or whenever needed. That was missed. She also agreed without an assessment done with the [DATE], Significant change MDS that occurred prior to the incident, she could not verify if he was or was not at increased risk for elopement prior to his incident as she had not assessed R15 with the MDS schedule or as needed.</p> <p>Interview on 6/11/24 at 12:21 p.m., with the DON identified she also wasn't aware of WanderGuard system being off down the [NAME] wing. She agreed that would affect any wanderer who happened to go down that hall.</p> <p>(continued on next page)</p>

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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>Observation on 6/11/24 at 12:25 p.m., of R15 in the dining room identified he was eating slowly at the assisted resident table. There was no Tabs alarm was present on his wheelchair or person.</p> <p>Interview on 6/11/24 at 12:27 p.m., with the administrator identified she was unaware R15's elopement was not reported to the SA. The old DON felt R15 knew what he was doing so she felt it wasn't an elopement. She agreed the definition of an elopement was when a resident leaves the premises or a safe area without the facility ' s</p> <p>knowledge and supervision. She agreed R15 was known to have visual decline and it was unsafe for any resident to cross a busy hi-way and walk into a field. She reported an elopement assessment should be done upon admission, quarterly, with a change, or as needed. She wasn't aware R15 had not been assessed, especially after his elopement. Staff should have an MD order to discontinue a WanderGuard device usage. There were no notes to identify why that wasn't done. She was aware the hairdresser likely shut off the WanderGuard alarm as the alarm would go off a lot.</p> <p>Interview on 6/11/24 at 2:40 p.m., with nurse aide (NA)-E regarding R15's wandering noted R15 was confused at times. Sometimes he comes out and wanders (walks) and says he needs to get his car. He can walk around the unit but the tabs alarm on his door alerts staff he was coming out. Staff put the Tabs alarm on his door whenever he goes in his room. He doesn't get farther than the hallway. To her knowledge staff have never forgotten his tabs and he has never gotten off the unit (East wing).</p> <p>Interview on 6/11/24 at 4:19 p.m., with MD-A identified he was made aware of R15's elopement on 10/9/23. He agreed to staff placing the WanderGuard on R15's person. He was unaware staff discontinued the WanderGuard without first acquiring an MD order to do so. He expected an elopement assessment be performed on admission, quarterly and with any changes. He also was unaware the hairdresser was disabling the WanderGuard alarm and stated that was a risk to any residents but especially any who resided down that wing who wore a WanderGuard. He agreed staff should have assessed R15 and others who may be at risk and follow facility policies and procedures for reporting, assessing, monitoring, and perform a root cause analysis to identify potential areas of improvement or interventions to keep residents safe.</p> <p>Observation and interview on 6/11/24 at 4:40 p.m., with R15 in the day room identified he was alert and oriented x 2. He remarked he had some forgetfulness but could not account for recent events. R15 was seated in a wheelchair and made no attempts at self-ambulating in the wheelchair. He gave no indication of reporting he wanted to go outside to potentially elope or showed any behaviors of wanting to elope.</p> <p>Review of the 2/20/24, Elopement Risk Assessment procedure identified elopement occurs when a resident who isn't permitted to leave the facility does so with intent, or when a resident is incapable of adequately providing self-protection departs unsupervised or undetected. Elopement causes an increased risk of harm or death in certain situations. Effective assessment was essential to ensuring safety. Staff were to:</p> <ol style="list-style-type: none"> 1) Review the resident's medical record. 2) Assess the resident's ambulation status. 3) Use the facility's assessment tool. <p>(continued on next page)</p>		

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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>4) complete assessment for agitation, mental capacity.</p> <p>5) Notify the MD so they can evaluate the resident and order appropriate interventions.</p> <p>Review of the 2/20/24, Elopement Precautions, Long Term Care policy identified staff were to:</p> <p>Before an elopement</p> <p>1) Review the medical record.</p> <p>2) Assess the resident upon admission and regularly thereafter.</p> <p>3) Make sure the resident wears an electronic safety device that alerts staff of an attempted elopement if the facility has such a system in place.</p> <p>4) Assign a resident to a room that is properly located, away from exits, close to a nurse's station, etc</p> <p>5) Develop a care plan with safety goals.</p> <p>6) participate in a hallway monitoring program for 30-minute rounds per shift.</p> <p>After elopement</p> <p>1) Perform a comprehensive assessment</p> <p>2) Notify the MD of findings.</p> <p>3) Monitor the resident closely for 72 hours after elopement.</p> <p>4) Participate in a de-briefing 72 hours after the event to review the incident, and perform a root cause analysis to gain insight into the system failures that led to the elopement and initiate measures to improve processes.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38687</p> <p>Based on observation, interview, and document review, the facility failed to ensure all 20 nurse aides (NA)-A, NA-B, NA-C, NA-D, NA-E, NA-F, NA-G, NA-H, NA-I, NA-J, NA-K, NA-L, NA-M, NA-N, NA-O, NA-P, NA-Q, NA-R, NA-S, and NA-T), and all 3 trained medication aides/NA's ((TMA)-A, TMA-B, and TMA-C) of 37 total nursing staff, were appropriately trained to manufacturer's instructions for the cleaning and disinfection of 1 of 1 whirlpool tub. This had the ability to affect residents who utilized the whirlpool tub for bathing.</p> <p>Findings include:</p> <p>Observation, interview and manufacturer's guideline review on 6/11/24 at 10:19 a.m., with NA-C and NA-D during a whirlpool tub cleaning and disinfection identified staff began the process by placing the plug into the bottom of the tub. NA-C then moved the knob to disinfectant and ran the disinfectant for 20 seconds. There was less than a half inch of the solution in the well of the tub. She then switched the knob to rinse to fill the remainder of the well and or ensure the jets were covered with the appropriate amount of disinfectant. The jets were observed heavily soiled with dirt-like debris. NA-C stated they used to remove the jets and scrub and disinfect those jets, however, they stopped by order of management as they were going through jets too fast. NA-C has been employed at the facility for 3 years, and NA-D has been employed for approximately 6 months and was being trained by NA-C. NA-C stated they follow the posted guidelines and had been trained to follow those by another NA when she began employment. NA-C was unsure how much disinfectant was required to be in the tub to ensure the correct amount of solution was placed per gallon of water. Staff failed to perform the cleaning process prior to the disinfectant process as described below to ensure dirt and debris were effectively removed prior to the disinfecting process.</p> <p>Review of the posted [NAME] Advantage Seated Bathing System manufacturer's guidelines identified 2 vertical columns:</p> <p>A) The 1st column described the bath cleaning process as follows to clean the tub and remove dirt and debris:</p> <ol style="list-style-type: none"> 1) Place the chair in the tub and close the drain. 2) Turn knob to TUB CLEANER and the control knob to ON. 2) Turn the whirlpool on. A homemade label was placed over the next step to say Turn knob to rinse after 10 seconds). 3) Lift the seat bottom off chair. Use the cleaning solution to scrub the tub, chair, and underneath seat bottom. Open the tub drain, turn the selector knob to RINSE and the Control knob to ON. 4) Turn the whirlpool on. When the clear water comes out of all the jets, turn the whirlpool off. 5) Turn the control knob to OFF. Use the shower wand to rinse the tub and chair. <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At the bottom of this section was a handwritten note that lists the cleaning procedure to be done Between each resident!</p> <p>B) The 2nd column described the bath disinfection process as follows to ensure complete disinfection:</p> <ol style="list-style-type: none"> 1) Place the chair in the tub, release the carrier from the tub, release the carrier from the tub, and close the door. 2) Turn the selector knob to DISINFECTANT and the control knob to ON. 3) Turn the whirlpool on. When there is about 2 inches of disinfectant in the well, turn the whirlpool off. 4) A sticker was placed over part of the manufacturer's instructions to TURN KNOB TO RINSE. then it continues to state to use the disinfectant solution to scrub the tub, chair, and underneath the seat bottom. 5) Leave wet for 10 minutes. After 10 min, open the tub drain. Turn the selector knob to RINSE and the control knob to ON. 6) Turn the whirlpool on. When clear water comes out of all jets, turn the whirlpool off. 7) Turn the control knob to OFF. Use the shower wand to rinse the tub and chair. <p>At the bottom of this section was a handwritten note that lists the disinfecting procedure to be done After last bath of the day!</p> <p>Interview on 6/11/24 at 10:52 a.m., with the director of nursing (DON) identified the IP should be doing environmental rounds and competencies on whirlpool tub cleaning and disinfection as part of her role. She was unaware staff were not cleaning and disinfecting according to manufacturer's guidelines. She performed no competencies herself as she has not been at the facility very long and was just overhauling the IP surveillance as a whole.</p> <p>Observation and interview on 6/11/24 at 11:17 a.m. with the infection preventionist (IP) of the whirlpool tub room identified she performed no environmental rounds, nor did she do training or competencies of the whirlpool tub cleaning and disinfection. She agreed the jets still had visible dirt-like debris on them. She also was unsure what the process was for cleaning and disinfecting the whirlpool tub, nor that each was required to be done per manufacturer's instructions between each resident use. She thought perhaps the director of nursing (DON) did staff training and competencies on the tub cleaning and disinfection. She agreed it was a risk to all residents who bathed and without appropriate cleaning and disinfection, cross contamination was likely to occur. The IP noted the posted procedure identifying cleaning only occurred between resident use and disinfection after last resident of the day had been there since she had started some 3 years.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Gil-Mor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Third Street East Morgan, MN 56266	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 6/11/24 at 11:23 a.m. wit the maintenance supervisor (MS) identified he had no documented preventative maintenance he performs on the whirlpool tubs. Sometimes the company would come out and service the machine, but agreed they looked at the mechanical issues and they don't perform routine cleaning of parts etc.</p> <p>There was no policy specific to cleaning the WP tubs except for manufacturer instructions nor was there any policy related to staff competencies provided by the end of survey.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336</p> <p>Based on observation, interview and document review, the facility failed to ensure staff had not stored in-use medication with expired medication in 1 of 1 narcotic medication box and ensure that expired medication was not administered to 1 of 1 resident (R3).</p> <p>Findings include:</p> <p>Observation and interview on [DATE] at 6:49 p.m., with registered nurse (RN)-A of he locked narcotic box medication identified 1 blister pack of oxycodone (narcotic pain medication) ,d+[DATE] milligrams (mg) belonging to R3 with 12 remaining tablets in a bubble pack and had an expiration date of [DATE]. The individual narcotic record identified R3 had received 2 of the expired tablets on [DATE] at 5:00 p.m. RN-A confirmed Oxycodone had been administered as recorded in the log book. He stated nurses routinely count narcotics at the beginning and end of their shifts and would sign off on the count every shift. RN-A agreed expired meds should be discarded as soon as possible and not stored with in-use medication.</p> <p>R3's, [DATE] at 6:20 p.m., progress noted identified R3 had been administered the expired oxycodone pain medication.</p> <p>Interview on [DATE] at 6:12 p.m., with director of nursing (DON) identified her expectations would be for nursing to appropriately discard expired narcotics once discovered and not store those medications with in-use medications. the medication should have been detected during the narcotic medication count and verified as one of the 5 medication rights before medication would be administered. Staff should have called the pharmacy and informed them the medication was soon to expire so they could have had medication on-hand to use for R3 when it was needed.</p> <p>Review of undated, current Dispensing, Storage & Labeling of Medications policy identified the facility would not use medications after the date of expiration.</p> <p>Review of undated, Controlled Substances policy identified the facility would detect outdated Class II, III, IV, and V drugs that are no longer needed, and would destroy or dispose of those medications according to the State and Federal law.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>47497</p> <p>Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 2), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS.</p> <p>Findings include:</p> <p>Review of the payroll based journal (PBJ) report identified the facility did not have 24 hour nursing coverage on 1/6/24, 1/27/24, 2/17/24, and 3/9/20. Review of the staffing schedules and time punches identified the facility had 24 hour licensed staffing for the previously mentioned dates.</p> <p>Interview on 6/11/24 at 2:00 p.m., with administrator identified that the hours worked by agency staff during those dates were not being reported from the staffing company correctly, she reports this has caused the inaccurate data submission to PBJ.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38687</p> <p>Based on observation, interview, and document review, the facility failed to ensure 2 of 2 staff (nurse aide (NA)-C and NA-D) appropriately cleaned and disinfected 1 of 1 whirlpool tub according to manufacturers guidelines and failed to provide baseline screenings and/or testing for 2 of 5 sampled staff (NA-A and trained medication aide (TMA)-B) and 3 of 5 sampled residents (R4, R17, and R11) for tuberculosis (TB) prevention and identification.</p> <p>Findings include:</p> <p>WHIRLPOOL TUB CLEANING</p> <p>Observation, interview and manufacturer's guideline review on 6/11/24 at 10:19 a.m., with NA-C and NA-D during a whirlpool tub cleaning and disinfection identified staff began the process by placing the plug into the bottom of the tub. NA-C then moved the knob to disinfectant and ran the disinfectant for 20 seconds. There was less than a half inch of the solution in the well of the tub. She then switched the knob to rinse to fill the remainder of the well and or ensure the jets were covered with the appropriate amount of disinfectant. The jets were observed heavily soiled with dirt-like debris. NA-C stated they used to remove the jets and scrub and disinfect those jets, however, they stopped by order of management as they were going through jets too fast. NA-C has been employed at the facility for 3 years, and NA-D has been employed for approximately 6 months and was being trained by NA-C. NA-C stated they follow the posted guidelines and had been trained to follow those by another NA when she began employment. NA-C was unsure how much disinfectant was required to be in the tub to ensure the correct amount of solution was placed per gallon of water. Staff failed to perform the cleaning process prior to the disinfectant process as described below to ensure dirt and debris were effectively removed prior to the disinfecting process.</p> <p>Review of the posted [NAME] Advantage Seated Bathing System manufacturer's guidelines identified 2 vertical columns:</p> <p>A) The 1st column described the bath cleaning process as follows to clean the tub and remove dirt and debris:</p> <ol style="list-style-type: none"> 1) Place the chair in the tub and close the drain. 2) Turn knob to TUB CLEANER and the control knob to ON. 2) Turn the whirlpool on. A homemade label was placed over the next step to say Turn knob to rinse after 10 seconds). 3) Lift the seat bottom off chair. Use the cleaning solution to scrub the tub, chair, and underneath seat bottom. Open the tub drain, turn the selector knob to RINSE and the Control knob to ON. 4) Turn the whirlpool on. When the clear water comes out of all the jets, turn the whirlpool off. 5) Turn the control knob to OFF. Use the shower wand to rinse the tub and chair. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At the bottom of this section was a handwritten note that lists the cleaning procedure to be done Between each resident!</p> <p>B) The 2nd column described the bath disinfection process as follows to ensure complete disinfection:</p> <ol style="list-style-type: none"> 1) Place the chair in the tub, release the carrier from the tub, release the carrier from the tub, and close the door. 2) Turn the selector knob to DISINFECTANT and the control knob to ON. 3) Turn the whirlpool on. When there is about 2 inches of disinfectant in the well, turn the whirlpool off. 4) A sticker was placed over part of the manufacturer's instructions to TURN KNOB TO RINSE. then it continues to state to use the disinfectant solution to scrub the tub, chair, and underneath the seat bottom. 5) Leave wet for 10 minutes. After 10 min, open the tub drain. Turn the selector knob to RINSE and the control knob to ON. 6) Turn the whirlpool on. When clear water comes out of all jets, turn the whirlpool off. 7) Turn the control knob to OFF. Use the shower wand to rinse the tub and chair. <p>At the bottom of this section was a handwritten note that lists the disinfecting procedure to be done After last bath of the day!</p> <p>Interview on 6/11/24 at 10:52 a.m., with the director of nursing (DON) identified the IP should be doing environmental rounds and competencies on whirlpool tub cleaning and disinfection as part of her role. She was unaware staff were not cleaning and disinfecting according to manufacturer's guidelines. She performed no competencies herself as she has not been at the facility very long and was just overhauling the IP surveillance as a whole.</p> <p>Observation and interview on 6/11/24 at 11:17 a.m. with the infection preventionist (IP) of the whirlpool tub room identified she performed no environmental rounds, nor did she do training or competencies of the whirlpool tub cleaning and disinfection. She agreed the jets still had visible dirt-like debris on them. She also was unsure what the process was for cleaning and disinfecting the whirlpool tub, nor that each was required to be done per manufacturer's instructions between each resident use. She thought perhaps the director of nursing (DON) did staff training and competencies on the tub cleaning and disinfection. She agreed it was a risk to all residents who bathed and without appropriate cleaning and disinfection, cross contamination was likely to occur. The IP noted the posted procedure identifying cleaning only occurred between resident use and disinfection after last resident of the day had been there since she had started some 3 years.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 6/11/24 at 11:23 a.m. wit the maintenance supervisor (MS) identified he had no documented preventative maintenance he performs on the whirlpool tubs. Sometimes the company would come out and service the machine, but agreed they looked at the mechanical issues and they don't perform routine cleaning of parts etc.</p> <p>There was no policy specific to cleaning the WP tubs except for manufacturer instructions nor was there any policy related to staff competencies provided by the end of survey.</p> <p>TB</p> <p>Review of the immunizations for R4, R17, and R11 identified :</p> <p>1) R4 was admitted to the facility in January 2024 and R17 was admitted in April 2023 There was no baseline screenings for TB provided for either resident.</p> <p>2) R11 was admitted in May 2024. R11 had a baseline screening, however, there was no TB testing performed by facility staff.</p> <p>Review of the immunizations for NA-A and TMA-B identified NA-A had a baseline screening, but had not been tested for TB. TMA-B had no baseline screening or testing performed for TB.</p> <p>Email correspondence on 6/12/24, from the director of nursing (DON) identified she could not find the above verifications that baseline screening and/or testing had been completed for the above mentioned residents or staff. The DON was aware of a lack of TB screening and testing, however, no steps had yet been completed to ensure this identified concern had been corrected.</p> <p>Review of the 2020, TB Exposure Control Plan identified measures to reduce the risk of exposure to residents and staff included screening and testing. The infection preventionist was responsible for oversight, in collaboration with the administrator and DON</p>		