Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 19, 2026

Administrator
BIRCHWOOD HEALTH CARE CENTER
604 1ST STREET NE
FOREST LAKE, MN 55025

RE: CCN:245200
Cycle Start Date: May 6, 2026

Dear Administrator:

On May 6, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 6, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 6, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Administrator
BIRCHWOOD HEALTH CARE CENTER
604 1ST STREET NE
FOREST LAKE, MN 55025

Re: State Nursing Home Licensing Orders
Event ID: 230E15-H1

Dear Administrator:

The above facility survey was completed on May 6, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245200	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH CARE CENTER	604 1ST STREET NE , FOREST LAKE, Minnesota, 55025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 5/5/26 through 5/6/26 a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed. H52001688C (2995944) with a deficiency issued at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		05/20/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to thoroughly investigate and failed to comprehensively assess in an effort to	F0689	F689-Plan of Correction Deficiency: Failure to thoroughly investigate the object utilized to remove the resident's wander alert device following an elopement incident. How corrective action will be accomplished for the resident found affected: Resident R1 was immediately assessed upon return to the facility with no object identified for assisting in removal of the wander guard. The resident then attempted to remove the wander guard with a fork at a later time but was unsuccessful due to the increased supervision implemented. Order added to resident profile to assess resident after meals to ensure he does not attempt to take utensil with him. Order for wander guard placement every shift amended to include assess for signs of tampering with device.	06/10/2026

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 reverse for further 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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F0689 SS = D	Continued from page 1 identify risks and hazards associated with an elopement for 1 of 3 residents (R1) reviewed after R1 removed his wander alert bracelet and left the facility unsupervised by staff. In addition, the facility failed to ensure a system for all staff to identify who was at risk for elopement. Findings include: R1 quarterly Minimum Data Set (MDS) dated 1/23/26, indicated R1 had severe cognitive impairment and mental status had not acutely changed from baseline. No behaviors were indicated. R1 was independent with transfers and used a wheelchair. R1's diagnoses included hypertension, arthritis, aphasia (language disorder affecting ability to communicate effectively), CVA (stroke), Non-Alzheimer's dementia, and seizure disorder. Facility Incident Audit Report dated 4/12/26, indicated on 4/12/26, R1 had been seen around 4:00 p.m., by staff seated by the reception desk and had been observed again around 4:30 p.m. in the lobby. Staff noted R1 was missing around 4:45 p.m. R1 was located at 5:00 p.m., outside, just down from the assisted living. R1 stated he had been chasing the dead bodies in the ambulance. R1 was re-assessed for elopement, and a wander alert device was placed. IDT met and reviewed on 4/15/26. R1 had been exhibiting increased confusion, had gone outside and was on the sidewalk when staff found him. R1's progress note dated 4/12/26, indicated R1 was anxious and wandering, believed there were dead bodies being escorted out of the facility and he needed to help the police solve the crime. R1's Elopement Risk Evaluation dated 4/12/26, indicated R1 was ambulatory or able to self-propel his wheelchair, had a habit/history of wandering or attempts to leave the building and asked to go home or to other specific destinations. R1's care plan revised 4/13/26, identified cognitive loss/dementia and elopement/wander risk and identified the use of a wander alert bracelet. The care plan directed staff to check wander device function daily and ensure proper placement observe and document potential triggers to increased attempts at wandering/ elopement. The care plan identified limited physical mobility and indicated R1 required supervision/touching assistance for ambulation and required staff to propel him to and from all destinations in his wheelchair.	F0689	Continued from page 1 How the facility will identify other residents having the potential to be affected by the same deficient practice: All elopement attempts and wander guard removals, or attempted removals, will be assessed and investigated to appropriately identify any unique risk factors that could potentially to be used to remove the wander guard. The identified objects will be assessed for access of object and prevention of future use of said object. All residents at risk for elopement have amended orders to inspect device for signs of tampering. Measures or systemic changes put into place to ensure the deficient practice will not recur: The facility re-educated nursing staff and department management on requirements for comprehensive investigations following elopement or attempted elopement incidents. Education included: Identification and investigation of unique risk factors i.e. tools, objects, or environmental hazards that could contribute to removal of wander alert devices. Expectations for environmental room searches as permitted and documentation of findings The facility additionally implemented a standardized investigation checklist to ensure all potential contributing factors, including objects used to tamper with safety devices, are evaluated consistently. The facility also added additional ELOPMENT risk books to all departments with added education for those who speak ENGLISH as a second language. Inspection of device for signs of tampering added to wanderguard order set. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur: The Director of Nursing, designee, and/or Quality Assurance team will audit all wandering, attempted elopement, and elopement investigations weekly for	06/10/2026

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F0689 SS = D	Continued from page 2 R1's progress note dated 4/13/26, indicated IDT met and reviewed R1 exhibiting increased confusion. R1 went outside and was located on the sidewalk when staff located him. R1 had delusion thoughts and stated he was helping the police. R1 had cognitive impairment but had not previously displayed exit seeking behaviors. Past assessments indicated no risk for elopement. New assessment completed with increased risk. Wander alert device was placed. Facility resident sign out sheet indicated on 4/25/26, R1 signed himself out at 9:33 a.m. R1's Elopement Risk Assessment dated 4/25/26, indicated R1 was ambulatory or able to self-propel his wheelchair, had a habit/history of wandering or attempts to leave the building and asked to go home or to other specific destinations. Facility Incident Audit Report dated 4/26/26, indicated R1 eloped from the facility on 4/25/26. Nursing description written 4/26/26, indicated Dietary aide (DA)-A notified registered nurse (RN)-A he had seen R1 outside in the parking lot. RN-A alerted staff members who searched the parking lot. R1 was seen with a bystander with his vehicle. R1 was not wearing his wander alert bracelet. R1 was brought back to the facility and told facility staff he had been going to the farm and had signed himself out. When asked where his bracelet was, R1 stated he had removed it in his room and threw it away. Interdisciplinary team (IDT) met to review the incident 4/26/26. R1 was located across the street from the facility with a bystander who was placing R1 in his car for safety. Staff replaced R1's wander alert bracelet upon return to the facility and placed him on 15-minute checks. R1's quarterly MDS dated 4/27/26, identified severe cognitive impairment, indicated he was independent with the use of a manual wheelchair and indicated he displayed wandering behaviors. The MDS identified the use of a wander alarm. R1's progress note dated 5/4/26, indicated IDT met and reviewed R1's attempt to remove wander alert bracelet from wrist. R1 had been redirected and continued on 15-minute checks. R1 had a plan for what he wanted to do and where he wanted to go but was confused. During observation on 5/5/26 at 2:45 p.m., R1 was seated at the front entry in wheelchair talking with a visitor. R1 had a black wander alert bracelet on his right wrist.	F0689	Continued from page 2 4 weeks, then monthly for 2 months, to ensure investigations are comprehensive and include evaluation of unique risk factors, potential objects, environmental hazards, and contributing factors. Findings will be reviewed through the QAPI process, with additional education or corrective action implemented as indicated. Date of Compliance: The facility alleges compliance on June 10thth,2026.	06/10/2026

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F0689 SS = D	Continued from page 3 During interview on 5/5/26 at 4:20 p.m., licensed practical nurse (LPN)-A stated when she worked the station at the front of the facility, she did a lot of walking back and forth to monitor the residents. LPN-A said unless a resident was new, she knew who to watch and stated there was a binder at the front desk with the residents who were at risk for wandering. During interview on 5/5/26 at 4:51 p.m., RN-B stated they kept an eye on the residents who were known to wander. RN-B stated on the evenings and weekends it was really hard to keep an eye on the people going in and out of the facility but stated if a resident was wearing a wander alert bracelet the door would alarm if they were near the door. Video surveillance was viewed on 5/6/25 at 11:29 a.m., The surveillance video dated 4/25/26, showed R1 talking to another resident by the front door of the facility at 10:01 a.m. At 10:11 a.m., R1 left through the front door. R1 appeared again on the sidewalk at 10:16 a.m. and began propelling himself in his wheelchair to the parking lot on the south side of the building. At 10:20 a.m., R1 headed toward two dumpsters at the far end of the parking lot, stood up and left his wheelchair between the dumpsters and continued on foot. At 10:28 a.m., Staff headed to R1's location. R1 was observed on the video across the street and in front of an apartment building near an intersection of the street and the highway. Social services progress note dated 5/6/26, indicated social services spoke with R1's family regarding potential move to a facility with a secured unit due to increased wandering and attempts to remove wander alert device. During interview on 5/6/26 at 7:54 a.m., RN-B stated on 4/25/26, when R1 had left the facility he had been his usual self, wheeling around in his wheelchair. RN-A said DA-A had approached her and said he saw R1 outside by the apartments across the street. RN-A stated she went outside and R1 was with a bystander who had pulled over and was assisting R1 into his car. RN-A noted R1 did not have a wander alert bracelet on and when he was brought back to the building R1 told her he had taken it off and thrown it away and said he had signed out of the facility. RN-A stated the facility had discussed moving R1 to a facility with a secure unit because they didn’t feel the facility was appropriate due to R1 having a plan to leave and removed the wander alert bracelet. RN-A stated R1 broke the clasp off of the bracelet. RN-A said they	F0689		06/10/2026

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F0689 SS = D	Continued from page 4 were keeping an eye on R1 but said “he’s definitely looking for stuff he can get it off with.” During interview on 5/6/26 at 8:52 a.m., LPN-B said R1 was on 15-minute checks and said it was hard because he was all over the place. LPN-B said if R1 was hanging out up front, she would go check on him. LPN-B said, “we have a lot of people.” During interview on 5/6/26 at 8:585 a.m., DA-A said on 4/25/26, he had been on break and when he returned to the facility he saw R1 by the stop sign at the highway. DA-A said he had recognized R1 but said he did not have a wander alert device, so DA-A was not sure if R1 was at risk or not. DA-A said he notified nursing and had gone with to get R1. DA-A said they found R1’s wheelchair in the parking lot by the trash. DA-A said if a resident was wearing a wander alert bracelet, that meant the resident was not safe to be outside unsupervised. DA-A said he was almost certain there was a list of residents who required supervision outside of the facility but did not know where to find it. During interview with the director of nursing (DON) and the administrator on 5/6/26, at 9:04 a.m., the DON said all staff were educated during monthly meetings regarding the missing resident protocol. DON said the wander alert bracelet alerted staff to who was at risk. The administrator said they had wander alert binders but said, “I would not think every staff would memorize everyone,” and said if a resident was new, staff may not know the person was at risk. During interview on 5/4/26 at 10:10 a.m., The DON stated on 5/5/26, when R1 was observed attempting to remove his wander alert bracelet, she did not know which staff had seen it. She said it may have been reported on one of the 15-minute check sheets but was not sure. The DON said R1 would try to find something to remove the wander alert bracelet and said he was on 15-minute checks because he was still actively trying to remove it. The DON said they did not know what he was using to attempt to remove the bracelet but said he has activities, pens, his own nail clipper, etc. in his room and said there were many different tactics R1 could take. The DON indicated they had not made any efforts to removed objects from R1’s room and not specified the need to staff to monitor R1 for removal of items accessed in the dining room or activities which could be used to remove the bracelet. The DON stated currently they felt the 15-minute checks were successful. DON stated R1’s case was different and said R1 had knowledge to know what to do. The DON said staff	F0689		06/10/2026

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F0689 SS = D	Continued from page 5 interviews were not a part of the investigation when R1 removed and/or attempted to remove the bracelet and said she did not know when he had last been seen prior to the elopement on 4/25/26. Facility policy Elopements and Wandering Residents dated 4/16/26, indicated the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements.	F0689		06/10/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH CARE CENTER	**604 1ST STREET NE , FOREST LAKE, Minnesota, 55025**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/5/26 through 5/6/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure. The following complaint was reviewed during the survey. H52001688C (2995944) with a licensing order issued at 0830. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		05/20/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**

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20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to thoroughly investigate and failed to comprehensively assess in an effort to identify risks and hazards associated with an elopement for 1 of 3 residents (R1) reviewed after R1 removed his wander alert bracelet and left the facility unsupervised by staff. In addition, the facility failed to ensure a system for all staff to identify who was at risk for elopement. Findings include: R1 quarterly Minimum Data Set (MDS) dated 1/23/26, indicated R1 had severe cognitive impairment and mental status had not acutely changed from baseline. No behaviors were indicated. R1 was independent with transfers and used a wheelchair. R1's diagnoses included hypertension, arthritis, aphasia (language disorder affecting ability to communicate effectively), CVA (stroke), Non-Alzheimer's dementia, and seizure disorder. Facility Incident Audit Report dated 4/12/26, indicated on 4/12/26, R1 had been seen around 4:00 p.m., by staff seated by the reception desk and had been observed again around 4:30 p.m. in the lobby. Staff noted R1 was missing around 4:45 p.m. R1 was located at 5:00 p.m., outside, just down from the assisted living. R1 stated he had been chasing the dead bodies in the ambulance. R1 was re-assessed for elopement, and a wander alert device was placed. IDT met and reviewed on 4/15/26. R1 had been exhibiting increased confusion, had gone outside and was on the sidewalk when staff found him. R1's progress note dated 4/12/26, indicated R1 was anxious and wandering, believed there were dead bodies being escorted out of the facility and he	20830	Corrected	06/10/2026

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20830	Continued from page 2 needed to help the police solve the crime. R1's Elopement Risk Evaluation dated 4/12/26, indicated R1 was ambulatory or able to self-propel his wheelchair, had a habit/history of wandering or attempts to leave the building and asked to go home or to other specific destinations. R1's care plan revised 4/13/26, identified cognitive loss/dementia and elopement/wander risk and identified the use of a wander alert bracelet. The care plan directed staff to check wander device function daily and ensure proper placement observe and document potential triggers to increased attempts at wandering/ elopement. The care plan identified limited physical mobility and indicated R1 required supervision/touching assistance for ambulation and required staff to propel him to and from all destinations in his wheelchair. R1's progress note dated 4/13/26, indicated IDT met and reviewed R1 exhibiting increased confusion. R1 went outside and was located on the sidewalk when staff located him. R1 had delusion thoughts and stated he was helping the police. R1 had cognitive impairment but had not previously displayed exit seeking behaviors. Past assessments indicated no risk for elopement. New assessment completed with increased risk. Wander alert device was placed. Facility resident sign out sheet indicated on 4/25/26, R1 signed himself out at 9:33 a.m. R1's Elopement Risk Assessment dated 4/25/26, indicated R1 was ambulatory or able to self-propel his wheelchair, had a habit/history of wandering or attempts to leave the building and asked to go home or to other specific destinations. Facility Incident Audit Report dated 4/26/26, indicated R1 eloped from the facility on 4/25/26. Nursing description written 4/26/26, indicated Dietary aide (DA)-A notified registered nurse (RN)-A he had seen R1 outside in the parking lot. RN-A alerted staff members who searched the parking lot. R1 was seen with a bystander with his vehicle. R1 was not wearing his wander alert bracelet. R1 was brought back to the facility and told facility staff he had been going to the farm and had signed himself out. When asked where his bracelet was, R1 stated he had removed it in his room and threw it away. Interdisciplinary team (IDT) met to review the incident 4/26/26. R1 was located across the street from the facility with a bystander who was placing R1 in his car for safety. Staff replaced R1's wander alert bracelet upon return to the facility and placed him	20830		06/10/2026

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20830	Continued from page 3 on 15-minute checks. R1's quarterly MDS dated 4/27/26, identified severe cognitive impairment, indicated he was independent with the use of a manual wheelchair and indicated he displayed wandering behaviors. The MDS identified the use of a wander alarm. R1's progress note dated 5/4/26, indicated IDT met and reviewed R1's attempt to remove wander alert bracelet from wrist. R1 had been redirected and continued on 15-minute checks. R1 had a plan for what he wanted to do and where he wanted to go but was confused. During observation on 5/5/26 at 2:45 p.m., R1 was seated at the front entry in wheelchair talking with a visitor. R1 had a black wander alert bracelet on his right wrist. During interview on 5/5/26 at 4:20 p.m., licensed practical nurse (LPN)-A stated when she worked the station at the front of the facility, she did a lot of walking back and forth to monitor the residents. LPN-A said unless a resident was new, she knew who to watch and stated there was a binder at the front desk with the residents who were at risk for wandering. During interview on 5/5/26 at 4:51 p.m., RN-B stated they kept an eye on the residents who were known to wander. RN-B stated on the evenings and weekends it was really hard to keep an eye on the people going in and out of the facility but stated if a resident was wearing a wander alert bracelet the door would alarm if they were near the door. Video surveillance was viewed on 5/6/25 at 11:29 a.m., The surveillance video dated 4/25/26, showed R1 talking to another resident by the front door of the facility at 10:01 a.m. At 10:11 a.m., R1 left through the front door. R1 appeared again on the sidewalk at 10:16 a.m. and began propelling himself in his wheelchair to the parking lot on the south side of the building. At 10:20 a.m., R1 headed toward two dumpsters at the far end of the parking lot, stood up and left his wheelchair between the dumpsters and continued on foot. At 10:28 a.m., Staff headed to R1's location. R1 was observed on the video across the street and in front of an apartment building near an intersection of the street and the highway. Social services progress note dated 5/6/26, indicated social services spoke with R1's family regarding potential move to a facility with a secured	20830		06/10/2026

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20830	Continued from page 4 unit due to increased wandering and attempts to remove wander alert device. During interview on 5/6/26 at 7:54 a.m., RN-B stated on 4/25/26, when R1 had left the facility he had been his usual self, wheeling around in his wheelchair. RN-A said DA-A had approached her and said he saw R1 outside by the apartments across the street. RN-A stated she went outside and R1 was with a bystander who had pulled over and was assisting R1 into his car. RN-A noted R1 did not have a wander alert bracelet on and when he was brought back to the building R1 told her he had taken it off and thrown it away and said he had signed out of the facility. RN-A stated the facility had discussed moving R1 to a facility with a secure unit because they didn't feel the facility was appropriate due to R1 having a plan to leave and removed the wander alert bracelet. RN-A stated R1 broke the clasp off of the bracelet. RN-A said they were keeping an eye on R1 but said "he's definitely looking for stuff he can get it off with." During interview on 5/6/26 at 8:52 a.m., LPN-B said R1 was on 15-minute checks and said it was hard because he was all over the place. LPN-B said if R1 was hanging out up front, she would go check on him. LPN-B said, "we have a lot of people." During interview on 5/6/26 at 8:585 a.m., DA-A said on 4/25/26, he had been on break and when he returned to the facility he saw R1 by the stop sign at the highway. DA-A said he had recognized R1 but said he did not have a wander alert device, so DA-A was not sure if R1 was at risk or not. DA-A said he notified nursing and had gone with to get R1. DA-A said they found R1's wheelchair in the parking lot by the trash. DA-A said if a resident was wearing a wander alert bracelet, that meant the resident was not safe to be outside unsupervised. DA-A said he was almost certain there was a list of residents who required supervision outside of the facility but did not know where to find it. During interview with the director of nursing (DON) and the administrator on 5/6/26, at 9:04 a.m., the DON said all staff were educated during monthly meetings regarding the missing resident protocol. DON said the wander alert bracelet alerted staff to who was at risk. The administrator said they had wander alert binders but said, "I would not think every staff would memorize everyone," and said if a resident was new, staff may not know the person was at risk. During interview on 5/4/26 at 10:10 a.m., The DON	20830		06/10/2026

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20830	Continued from page 5 stated on 5/5/26, when R1 was observed attempting to remove his wander alert bracelet, she did not know which staff had seen it. She said it may have been reported on one of the 15-minute check sheets but was not sure. The DON said R1 would try to find something to remove the wander alert bracelet and said he was on 15-minute checks because he was still actively trying to remove it. The DON said they did not know what he was using to attempt to remove the bracelet but said he has activities, pens, his own nail clipper, etc. in his room and said there were many different tactics R1 could take. The DON indicated they had not made any efforts to removed objects from R1's room and not specified the need to staff to monitor R1 for removal of items accessed in the dining room or activities which could be used to remove the bracelet. The DON stated currently they felt the 15-minute checks were successful. DON stated R1's case was different and said R1 had knowledge to know what to do. The DON said staff interviews were not a part of the investigation when R1 removed and/or attempted to remove the bracelet and said she did not know when he had last been seen prior to the elopement on 4/25/26. Facility policy Elopements and Wandering Residents dated 4/16/26, indicated the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for elopement to ensure comprehensive assessment to determine unique risk factors related to elopement amd implement resident specific interventions. The director of nursing or designee, could conduct random audit to ensure care planned interventions and adequate supervision is implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	20830		06/10/2026