Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2025

Administrator
Zumbrota Care Center
433 MILL STREET
ZUMBROTA, MN 55992

RE: CCN: 245376
Cycle Start Date: May 27, 2025

Dear Administrator:

On June 10, 2025, we notified you a remedy was imposed.

On July 7, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 30, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective June 24, 2025, be discontinued as of June 30, 2025. (42 CFR 488.417 (b))

In our letter of June 10, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 27, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered

August 22, 2025

Administrator
Zumbrota Care Center

433 MILL STREET
ZUMBROTA, MN 55992

Re: Reinspection Results
Event ID: 1TQ811

Dear Administrator:

On July 7, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
June 10, 2025

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: CCN: 245376
Cycle Start Date: May 27, 2025

Dear Administrator:

On May 27, 2025, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 23, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervision/Devices was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 25, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 25, 2025, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 25, 2025, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Zumbrota Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 27, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 27, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 10, 2025

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Re: State Nursing Home Licensing Orders
Event ID: 1TQ811

Dear Administrator:

The above facility was surveyed on May 19, 2025 through May 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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.

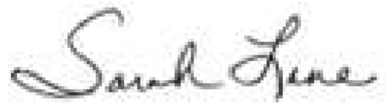
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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, 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	C 05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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
F 000	INITIAL COMMENTS On 5/19/25, 5/20/25, & 5/23/25 a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 5/8/25, when the facility failed to ensure the Wanderguard system was functioning properly and further failed to comprehensively assess elopement risk and needed level of supervision and develop and implement appropriate related interventions. The administrator and director of nursing (DON) were notified of the IJ on 5/20/25 at 3:50 p.m. The IJ was removed on 5/23/25 at 3:25 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 5/27/25. The following complaints were reviewed: H53764567C (MN112953), H53765068C (MN113161), and H53765469C (MN113272 & MN113279) with deficiencies cited at F609, F641, F689, F732, F836, F838, & F851. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2025

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.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 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.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		6/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 2 Based on interview and document review, the facility failed to report an elopement immediately to the administrator and to the State Agency within 2 hours for 1 of 1 resident (R1) who had eloped from the facility. Findings include: R1's face sheet dated 5/28/25, identified diagnoses of dementia (decline in mental ability and memory), delirium (a temporary state of mental confusion), and history of falling. R 1's Minimum Data Set (MDS) dated 2/6 /25, identified R1 needed supervision for transfers and had severe cognitive impairment. R1's elopement care plan focus dated 2/6/25, identified R1 was at risk for elopement related to history of attempts to leave the facility unattended. Interventions of wandergard on left wrist, encourage to attend activities during highest wandering times (late afternoon/evening), and distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. R1's progress note dated 5/8/25 at 7:45p.m., identified R1 had been observed wandering outside of the facility, R1 had a Wanderguard (a wander management system designed to help protect memory impaired residents from elopement) on her left wrist and worked properly, was alert and had intermittent confusion. R1's incident report dated 5/8/25 at 7:45 p.m., identified at R1 was found wandering outside of the building and R1 was orientated to person and time only. No predisposing environmental factors.	F 609	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The charge nurse was coached and counseled on the policies of elopement and maltreatment reporting on 05/09/25. How the facility will identify other residents having the potentioal to be affected by the same deficient practice. The maltreatment and elopement policies were reviewed with the entire staff, including a competency exam on 5/26/25. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. New hire orientation will now review a power point on maltreatment and elopement as part of their onboarding process prior to starting work on the floor. Maltreatment and elopement education will be part of the annual training. Incidents and grievances will be reviewed at daily stand-up meetings to determine if reportable. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits of 4 random staff members will take place monthly for three months starting in July of 2025. The audits will ask questions derived from the maltreatment policy, including what and when to report given 4 scenarios. The audit results will be shared at monthly and quarterly QAPI. Education on maltreatment reporting will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 3 Predisposing psychological factors included confusion and impaired memory. Door alarm/wandergard did not activate when R1 exited the building. Review of a report made to the state agency (SA) on 5/9/25 at 11:40 a.m., that R1 was found outside of the facility on the sidewalk in front of the building. R1 was brought back into the facility and reported that the Wanderguard alarm did not go off when R1 left the building, however the alarm did sound when R1 waw brought back in the building. The nurse did not report the elopement to the on-call nurse, administrator, or director of nursing to communicate R1's elopement. During an interview on 5/23/25 at 12:56 p.m., director of nursing (DON) stated that when R1 eloped from the facility it should have been reported to the administrator and the state agency immediately, but no later than two hours, but was not reported until the following day due to not being reported immediately after R1's elopement. Review of the facility's maltreatment reporting guidelines policy dated 11/26/24, identified any alleged maltreatment involving abuse neglect or financial exploitation injuries of unknown source or misappropriation a vulnerable adult property must be reported by the supervising employee of the building to the administrator of the care center immediately and to the state agency, but no later than two hours. Review of the facility's Elopement policy dated 8/1/22, identified when the resident who eloped is located:	F 609	be provided to all staff at one of two all-staff meetings held annually. After the three months, the QAPI team will determine if the audits need to continue. This deficiency was corrected 06/27/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 4 a. Complete a medical evaluation to identify potential injuries. b. Notify family and persons previously contacted. c. Notify the physician. d. Investigate to determine how the elopement occurred to correct any underlying contributing factors. e. Complete an "Incident Report" and document incident in the medical record. f. Report the 'elopement' incident to the state agency (MDH) as 'potential Neglect'.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F 641		6/20/25

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	245376	A. BUILDING _____ B. WING _____	C 05/27/2025

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F 641	Continued From page 5 and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect wander/elopement alarm use for 1 of 2 residents (R1) reviewed for MDS accuracy. Findings include: R1's quarterly MDS assessment dated 2/6/25, included section "P0200: Alarms" with alarm type "wander/elopement alarm." The wander/elopement alarm was coded "0" indicating it was not used during the look-back period. R1's Elopement Risk assessment dated 2/6/25, indicated R1 had a Wanderguard placed on her right wrist. The analysis section noted for the assessment reference date (ARD) of 1/31/25 through 2/6/25, information was collected per review of documentation, observation, and interviews with direct care staff and resident. The analysis further noted, "is at risk to wander or elope from facility. Wanderguard in place right wrist. Placement and proper function checked daily." R1's elopement care plan dated 8/28/24, identified she was an elopement risk. Intervention dated 8/28/24, noted R1 had a Wanderguard on her left wrist.	F 641	F641 How corrective action wil be accomplished for those residents found to have been affected by the deficient practice. The resident's MDS was reviewed and modified to ensure accurate coding of the wanderguard by the MDS nurse. How the facility will identify other residents having the potential to be affected by the same deficient practice. An MDS audit of the residents who wear wanderguards was completed by the MDS nurse going back three months on 06/04/25. No other issues with the coding of wanderguards was found. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Our MDS nurse was educated on where to find the electronic list of residents who have wanderguards; she was also re-educated on where the information is located within the EHR. Prior to MDS submissions, the MDS Nurse will review the electronic list and EHR to ensure accurate coding of the wanderguard on the MDS. How the facility will monitor its corrective actions to ensure that the deficient	

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F 641	Continued From page 6 On 5/19/25 at 4:01 p.m., the facility's nurse manager, registered nurse (RN)-C, confirmed R1 was one of the residents with a Wanderguard device. At 4:16 p.m., RN-C tested R1's Wanderguard device which was observed to be in place on her left wrist. During an interview on 5/23/25 at 2:05 p.m., the MDS Coordinator (MDS-C) stated R1's quarterly MDS dated 2/6/25 should have identified R1 had a Wanderguard in place and was not accurate. MDS-C noted she must have missed adding this to the MDS and she would be doing a modification to R1's MDS to correct it. Facility MDS assessment policy requested but not received.	F 641	practice is being corrected and will not recur. Monthly MDS audits of a resident on a wanderguard will ne completed by MDS quality to ensure coding for wanderguards is accurate. This deficiency was corrected on 6/20/25.	
F 689 SS=J	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 maintain a functioning Wanderguard system and failed to comprehensively assess risk for elopement and appropriate interventions, resulting in elopement for 2 of 7 residents (R1, R2). R1's elopement occurred due to the failure of the Wanderguard system, which did not sound an alarm when R1	F 689	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: After elopement on 5/26/25, care conferences were held with family/ombudsman and facility to establish a safe plan of care. R2□s family was here 24/7 to provide 1:1 with her until more	6/30/25

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F 689	Continued From page 7 exited the building. R2's elopements occurred due to R2's risk of elopement was not accurately comprehensively assessed leading to insufficient supervision and lack of intervention, followed by a failure of the Wanderguard system. The facility's failures resulted in an immediate jeopardy (IJ). The immediate jeopardy began on 5/8/25, when R1 successfully eloped from the building without the alarm sounding and was found by staff outside, unharmed, approximately 15 minutes later, the facility failed to identify malfunctioning alarm system which resulted in subsequent elopements by R2. The administrator, Director of Nursing (DON), nurse manager, and social services director were notified of the immediate jeopardy on 5/20/25 at 3:50 p.m. The immediate jeopardy was removed on 5/23/25, but noncompliance remained at the lower scope and severity level of D, indicating no actual harm but the potential for more than minimal harm, which is not immediate jeopardy Findings include: R1 R1's facesheet dated 5/28/25, identified diagnoses of dementia, delirium, and history of falling. R 1's Minimum Data Set (MDS) assessment dated 2/6/25, identified R1 had severe cognitive impairment and required supervision or touches for transfers, used a wheelchair and/or walker for mobility with staff supervision or touching. R1's elopement care plan focus dated 2/6/25, identified R1 was at risk for elopement related to history of attempts to leave the facility	F 689	appropriate facility would be able to accept her for admission. Primary physician reviewed resident□s medications and provided suggestions on managing behaviors of agitation leading to elopement. Staff working were extensively educated on paying close attention to resident□s whereabouts and offering activities. Doors associated with the elopement are tested daily for compliance. Residents (R1 and R2) wanderguard bracelets were assessed for function and located to resident□s wrist instead of R2□s wheelchair and R1□s walker. Care conferences were held with R2□a family, ombudsman and facility staff to discuss safety. R2 discharged to a secured memory care facility on 6/3/25. How the facility will identify other residents having potential to be affected by the same deficient practice: All residents who currently have wanderguards have had new elopement assessments completed, identifying them as high medium or low risk based on diagnoses, medications, and elopement attempts. This was completed on 5/23/25. Once identifying the risk level, information was placed in the care plan, Kardex, and special instructions. The elopement book was reviewed and updated. Education was provided to all staff on where to locate information on elopements and what to do if an elopement occurs. All ZHS residents had elopement assessments completed by 5/21/25. Will continue to complete quarterly and PRN. Pertinent behaviors will be reviewed daily by IDT team. Examples of behaviors that	

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F 689	Continued From page 8 unattended. Interventions of Wanderguard on left wrist, and distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. R1's progress note dated 5/8/25 at 7:45p.m., identified R1 was observed wandering outside of the building, Wanderguard on left wrist and worked properly, was alert and had intermittent confusion. R1's incident report dated 5/8/25 at 7:45 p.m., identified R1 was observed wandering outside of the building and was orientated to person and time only. No predisposing environmental factors. Predisposing psychological factors included confusion and impaired memory. Door alarm/Wanderguard did not activate when R1 exited the building. R1's elopement care plan was revised on 5/9/25 to include encourage R1 to attend activities during highest wandering times (late afternoon/evening). During an interview on 5/20/25 at 1:21 p.m., registered nurse (RN)-A stated on 5/8/25 R1 had been observed in the facility about fifteen minutes earlier when around 7:30 p.m., staff observed R1 wandering outside of the facility near the gazebo, and then immediately brought back into the facility. The facility doors did not alarm when R1 left the facility, however, did go off when R1 was brought back into the facility. RN-A believed that the alarm not sounding may have been because the Wanderguard tag was on her left wrist and the door did not catch the signal. RN-A stated R1's Wanderguard was changed to a new one because it was due to expire soon. RN-A stated	F 689	we will discuss include residents having paranoid thoughts/actions, hallucinations, increased wandering, confusion, being found in other rooms hiding, psychotropic medication use(start, end, dose changes). Wanderguards located on residents are checked daily for function by nursing. Placement is checked every shift, and the doors are checked every day per manufacturers recommendations. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur: Elopement policy was reviewed and updated by our Quality team. All staff have been educated on our elopement policy and completed competency tests related to elopement. Nursing staff have been educated on what makes a resident high, medium or low risk for elopement. The guidance is in the elopement book for reference. All staff have been educated on who to call when a resident elopes and if there is a failure in our systems and what to do. All staff have been educated on reporting the timeline for elopements, behaviors that could indicate a resident is at higher risk for elopement and what to do. We added an elopement education for all new hires to complete. Nursing staff were all educated on how to complete the elopement assessments within (ehr) PCC. Maintenance has a newly revised, more detailed sheet for logging results while testing the doors. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and not recur: Maintenance is testing main doors in all	

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F 689	Continued From page 9 staff tested the doors and R1's Wanderguard when R1 returned and they both were working properly, however did not notify maintenance that the door failed to alarm when R1 had exited the building. During an interview on 5/20/25 at 1:27 p.m., director of nursing (DON) stated R1 eloped on 5/8/25 and R1 left the building without the Wanderguard system door alarm going off. R1 should have had a repeat elopement assessment completed at that time and all nurses were able to complete the assessment. DON indicated staff did not notify maintenance the alarm had not sounded and stated when R1 eloped staff should have notified maintenance "immediately". In addition, staff should have assessed all resident Wanderguard devices to ensure proper function, check all doors with Wanderguard sensors to ensure proper function, and provide education to all staff in the building at the time about testing the system. DON stated, "None of that was done." DON's expectation was for all doors to be tested for proper functioning if a resident eloped. DON was not aware of the manufacturer's recommendations for testing and did not know how the doors were being tested. R2 R2's facesheet dated 5/28/25, identified R2 had diagnoses including urinary tract infection (can cause confusion in the elderly), Parkinson's disease (progressive neurological disorder that affects movement), altered mental status, unspecified convulsions (sudden involuntary muscle contractions and spasms), unspecified dementia (condition causing loss in ability to think, remember, learn, make decisions, and problem solve and symptoms including	F 689	key points as per manufacturer manual. Revised their form for tracking. Audits are being completed reviewing elopement assessments and reviewing in IDT any behaviors that could put someone at increased risk for elopements. Will review elopements at QAPI. This will be an on-going opportunity to monitor to ensure we are continuing to ensure resident safety. Will discuss any behaviors in morning IDT and come up with interventions. Completed elopement assessments on other residents who had wanderguards updated on risk level, this was completed on 5/23/25. Identified residents as high-medium-low risk for elopements, communicated it on special instructions for all residents who have wanderguards- this was completed 5/23/25. We have identified 2 residents who are at medium risk for elopement since and completed all the proper steps to ensure their safety including elopement assessment, wanderguard placement and monitoring. One of those 2 residents has since been discharged from the facility. The other one remains with a wanderguard on for safety. Will complete Elopement assessment upon day 1 of admission, along with the 5 day/ admit assessments, quarterly, and PRN. Elopement policy was reviewed and updated by the Quality Team and all staff were educated on new policy. The elopement binder was updated. The DON and NM will keep up to date. This will be on-going.	

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F 689	Continued From page 10 personality changes and emotional problems), abnormalities of gait and mobility, amnesia (memory loss), rapid eye movement (REM) sleep behavior disorder (a disorder where people act out their dreams during REM sleep), macular degeneration (progressive eye disease of damage to the retina causing loss of central vision), dystrophies involving the retinal pigment epithelium (eye disease involving deposits of pigment in the retina that can cause central vision loss), vitreous degeneration (degeneration of the vitreous fluid in the eye leading to floaters and vision changes), hypermetropia (far-sightedness causing blurry close-up vision), and presbyopia (decline in eyes' ability to focus on nearby objects). R2's Minimum Data Set (MDS) assessment dated 5/7/25, identified she admitted to the facility on 4/30/25. R2 had moderate cognitive impairment, delusions and verbal behavioral symptoms directed toward others, and had no wandering behaviors. R2 required substantial staff assistance with toileting hygiene, mobility in bed, and transfers. R2 used a wheelchair and was dependent on staff for wheelchair mobility. R2 was not independent with any self-cares or mobility. R2's physician orders dated 4/30/25, included: - Observe for side effects of antipsychotic medication. Side effects listed included disorientation or confusion, increased agitation, and restlessness. - Melatonin (supplement to treat sleep problems like insomnia) 5 milligram (mg) tablet, give 10 mg by mouth as needed (PRN) at bedtime for restlessness/insomnia.	F 689	DON will review information weekly with MDS nurse. This will be ongoing to ensure up-to-date information is available to our team, it is added on our calendars to recur every week. Elopement audits were conducted 3 x week for 1 week, 2 x week for 1 week, 1 x week for 4 weeks. This will be completed by the week of 6/30/25. Measures put into place to ensure that it will not recur: While our current wanderguard system works, it will be expiring due to age of programming. We received an estimate for the cost of a new Wanderguard Blue system to be installed. It is being reviewed by our corporate office. Maintenance is conducting daily tests as per manufacturer guidelines. All new admits/readmits will have elopement assessments completed the day of admission/readmission and then again on their 5-day assessment (occurs on day 8). Will review quarterly after that and as needed. The date all of the measures will be finalized for the deficiency is 06/30/25.	

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F 689	Continued From page 11 R2's progress note dated 4/30/25, identified cognitive impairment of "some forgetfulness." R2's Elopement Risk assessment dated 4/30/25, identified R2 had no history of elopement attempts and was a new resident within the last 90 days. The cognition section identified cognitive deficit of short-term memory loss and a change in cognition in the last 90 days. A pre-populated list of conditions contributing to elopement risk identified R2 had the following: recent infection, dementia, hallucinations, and new medication in the past 30 days. No behaviors, verbalizations, or life experiences that could contribute to elopement were identified and a Wanderguard (wearable bracelets that trigger alarms when a resident approaches a door sensor by an exit or restricted area) was not placed. The analysis noted, "not at risk for elopement at time of assessment." The assessment failed to identify R2's conditions contributing to elopement risk of: altered mental status, amnesia, REM sleep behavior disorder, adjustment to new environment, and visual deficits. The assessment failed to identify R2's needed level of supervision or identify how it was determined that she was not at risk for elopement based on the risk factors identified. R2's care plan for psychotropic medications dated 5/1/25, identified she used psychotropic medications. Interventions included monitor/record occurrence of for target behavior symptoms (SPECIFY: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. The intervention failed to identify R2's specific behaviors which were to be monitored	F 689		

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F 689	Continued From page 12	F 689		

and recorded.

R2's behavior progress note dated 5/2/25, indicated she was heard calling out for help and found crawling out of bed at 12:20 a.m. R2 stated she wanted to get into her wheelchair, was brought to the common area by staff, requested a sandwich then specifically a fish sandwich, and declined other offered snacks. R2 stayed in her wheelchair until she requested to go to bed at 1:30 a.m.

R2's progress note dated 5/2/25, identified she complained of trouble sleeping and requested PRN melatonin.

R2's progress note dated 5/3/25, identified she requested PRN Melatonin due to difficulty falling asleep at night.

R2's progress note dated 5/4/25, indicated R2 complained of trouble sleeping and took PRN Melatonin.

R2's progress note dated 5/5/25 at 2:55 a.m., indicated the facility received a phone call from the police stating R2 called 911. R2 reported to staff that she called because she wanted to talk to her grandson and he was a police officer. R2 was redirected and went back to sleep.

R2's progress note dated 5/5/25, noted R2 had trouble following commands, disorganized thinking, moderate cognitive impairment including memory loss and moderate confusion, and sometimes understood others. Behaviors included "resident is awake at night."

R2's progress note dated 5/5/25, indicated R2

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F 689	Continued From page 13 had signs of short-term memory loss, mild cognitive impairment, and chronic confusion demonstrated by refusal of cares, refusal of redirection, and delusions. Mood and behaviors identified intermittent sleep and wandering at night. R2 was educated on safety concerns of impulsivity, poor safety awareness, and confusion. R2's progress note dated 5/5/25 at 9:06 p.m., indicated R2 came walking out of her room at 9:00 p.m. using her wheelchair as a walker. R2 took Melatonin and was up at the nursing station until more tired. R2's progress note dated 5/5/25 at 11:41 p.m., indicated she came out of her room at 11:00 p.m., stated staff needed to call 911 right now, and called 911 herself but would not say why. R2 took papers from the nursing station and refused to return the facility's phone. An officer arrived and spoke with R2, stated she did not complain of anything and the officer was not sure why they had been called. R2 returned to her room at 11:45 p.m. and refused to get into bed. Although R2's progress notes identified R2 had both wandering at night and increased behaviors there was no indication R2 was re-assessed for elopement risk or needed level of supervision nor were appropriate interventions developed, and implemented to prevent or mitigate the risk of elopement. R2's progress note dated 5/6/25 at 12:37 a.m., indicated a new medication, Trazadone (an anti-depressant also used to treat insomnia), was ordered for administration at bedtime as needed for sleep.	F 689		

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F 689	Continued From page 14 R2's progress note dated 5/6/25, identified R2 came wheeling out of her room at 12:05 a.m. and went down the north hall. R2 then wheeled down to the end of the hall and turned around, backed her wheelchair by another resident room, began waving to something or someone she was seeing, and then entered the other resident's room. R2 then left the other resident room, propelled down the north hall back to the common area, and began saying "good morning" to a stationary chair. She signaled come here with her finger while looking at no one and sat next to the chair having a conversation with it. She then wheeled around in the common area, attempted to go behind the nursing station, and asked why "those kids" were back there. She continued to wheel around into the dining area, came out, was offered and took a PRN Trazadone to help with her insomnia, and wheeled herself back into her room. Progress note dated 5/6/25 at 1:25 a.m., identified R2 "has been awake and roaming since beginning of night shift." R2's physician orders dated 5/6/25, included: - Trazadone hydrochloride (HCl) 50 mg tablet, give 50 mg by mouth one time a day for insomnia, difficulty falling, and/or staying asleep. - Observe for side effects of anti-depressant medication. Side effects listed included trouble sleeping and other unusual changes in mood or behavior. R2's Behavior Assessment dated 5/7/25, identified she had verbal behavioral symptoms directed towards others with examples listed including delusions and calling 911 without	F 689		

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ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 689	Continued From page 15 explanation. The assessment identified her behaviors did not put her at significant risk for physical illness or injury but did interfere with her care and significantly disrupt the care environment. Root cause of behaviors was identified as being newly admitted and diagnoses of Parkinson's disease, dementia, and seizure history. The assessment identified R2 had not exhibited wandering behaviors, despite progress notes indicating she repeatedly left her room at night and wandered around the facility. R2's progress note dated 5/10/25, identified R2 had some forgetfulness, slept intermittently, wandered at night, and wandering had decreased since starting a new sleep medication. R2's progress note dated 5/11/25, indicated she came walking out of her room with a walker at 9:00 p.m. and sat down in a chair. Staff explained she should not walk by herself and to request assistance when ready to return to her room. 15 minutes later R2 was found to have walked herself back to her room and stated she didn't need help and could walk just fine by herself. R2's behavior progress note dated 5/12/25 at 5:56 a.m., indicated R2 was not in her room on last rounds. R2 was found in a room at the end of a different hall, had her brief off, and was "ducking down to hide" when a nursing assistant opened the door. R2 was naked from the waist down and would not tell staff why she was in the room or what she was looking for. R2 was assisted back to her room and dressed. R2's progress note dated 5/14/25, indicated she wandered at night.	F 689		

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F 689	Continued From page 16 R2's record between 5/6/25 and 5/15/25 identified despite R2 demonstrated several episodes of wandering, had confusion, forgetfulness, and had unpredictable ability to ambulate independently. There was no indication a comprehensive assessment was completed that would identify R2's risk for elopement and/or level of supervision nor evidence the care plan was revised. R2's incident report dated 5/16/25 at 8:00 p.m., identified registered nurse (RN)-B assisted R2 with a phone call and R2 then conversed with another resident at the nursing station. RN-B then left to take the other resident to their room and when RN-B came out of the room R2 wasn't at the nursing station. Staff began searching the facility immediately. RN-B went outside to search, and police had arrived and stated R2 had called 911. R2's spouse also arrived. R2 was found outside across the street without a wheelchair talking to her spouse using the neighbor's phone. Police and staff brought R2 back to the facility, she was assessed with no injuries noted and refused vital signs. R2's spouse sat with her until she fell asleep and a Wanderguard was placed on her left wrist. R2's physician orders dated 5/16/25, included: - Check Wanderguard functioning at bedtime. - Check placement of Wanderguard every shift for elopement risk. - Change Wanderguard one time a day every month on the 23rd day. R2's care plan for elopement dated 5/16/25, identified she was unable to leave the facility independently with history of elopement. Interventions included Wanderguard placed on	F 689		

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F 689	Continued From page 17 left wrist, staff or family to supervise all outdoor activities, and family to sign R2 out in facility book before leaving. The care plan did not identify interventions that included needed level of supervision, identification and monitoring of behaviors/triggers/risk factors for elopement, or related management. R2's record lacked evidence she was comprehensively assessed for elopement risk prior to or on 5/16/25 despite her successful elopement from the facility that day. R2's record did not identify her needed level of supervision or appropriate interventions apart from placement of a Wanderguard. R2's record did not indicate how documented confusion, delusions, hallucinations, restlessness, agitation, visual and communication deficits, impulsivity, seeking behaviors and verbalizations, and desire to go home were comprehensively assessed, monitored, or mitigated to decrease related risk of elopement. R2's Elopement Risk assessment completed three days after R2 eloped dated 5/19/25, included R2 had made one previous attempt to elope on 5/16/25 when she ambulated unassisted to a neighbor's house across the street. The assessment identified she had a Wanderguard on her left wrist and she was a risk for elopement related to recent elopement. The assessment did not include or identify R2's documented cognitive deficit of intermittent confusion and conditions contributing to elopement risk of delusions, agitation, new medications within past 30 days, visual deficits, communication deficits, and REM sleep behavior disorder. The assessment did not identify R2's documented behaviors of impulsivity, agitation, restlessness, seeking behaviors, and verbalizations of looking for someone and	F 689		

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F 689	Continued From page 18 seeking people. Further, the assessment failed to identify R2's needed level of supervision or interventions to mitigate identified risk of elopement apart from placement of a Wanderguard. During an interview on 5/19/25 at 1:30 p.m., R2 stated she had a Wanderguard on her wrist and R2's family member (FM)-A, noted it was placed the day before yesterday (5/17/25). FM-A stated this was placed because she had left the facility, and staff didn't know where she was for a few minutes. R2 stated she had been dreaming that she had to get away and ran out the door a block away barefooted even though she had been unable to walk on her own with therapy. FM-A stated this was confusing because most of the time she couldn't walk without her walker. R2 stated there was a man sitting outside at a house across the street and she used his phone to call 911, but did not remember why she called. FM-A indicated he was present when she returned to the facility, staff assessed her, and he stayed with her until she fell asleep. R2 stated they put the Wanderguard on her after that and she hadn't tried going outside since then (since 5/16/25). FM-A stated R2 had good days and bad days with memory due to her dementia and Parkinson's. Sometimes her moods were like a light switch and she would suddenly get quiet with a drained look and not say anything. R2's progress note dated 5/17/25 at 3:08 a.m., indicated R2 wheeled herself out of her room and around the common area. R2's behavior progress note dated 5/17/25 at 9:02 p.m., indicated she was seen by staff twice walking down the hall with her walker unassisted	F 689		

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F 689	Continued From page 19 on the evening shift. R2's progress note dated 5/18/25, identified her thinking was disorganized. During an interview on 5/19/25 at 3:28 p.m., nursing assistant (NA)-E stated she knew if someone was an elopement risk because they would usually have a Wanderguard on and be on a list posted at the nursing station of residents who could not be left outside unattended. NA-E stated R2 was very confused all the time and always thinks she's going to go home. NA-E saw R2 yesterday (5/18/25) with all of her in clothes in her hands and the hangers taken off. R2 was confused since she admitted to the facility and was always trying to get out, wheeling herself around, didn't sleep, and couldn't sit still. R2 once thought it was time to go to bed at 2:00 p.m. R2 would wheel around and say she was going to go home mostly during the night, beginning around 6:00 p.m. when she would start to get anxious and confused. NA-E noted R2 was "like fogged out" and you could talk to her and she wouldn't respond at times. Staff knew Wanderguards worked when residents got close to the door, though there had been trouble recently where sometimes doors would alarm when a resident with a Wanderguard touched it and sometimes they would not. R2's progress note dated 5/19/25, indicated she had forgetfulness, signs of short-term memory loss, and disorganized thinking. R2's progress note dated 5/19/25, identified it was follow-up on the elopement note. A Wanderguard had been placed on her left wrist with orders to monitor placement and functioning	F 689		

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F 689	Continued From page 20 and replace routinely, which was also added to her care plan. Diagnoses that could have contributed were identified as altered mental status, Parkinson's disease, dementia, and amnesia. A new elopement assessment had been completed. During an interview on 5/19/25 at 3:12 p.m., NA-D was not aware if R2 was an elopement risk and did not know R2 had a Wanderguard. NA-D knew if a resident had a Wanderguard because it would be on the resident, reported to staff, and on the care plan. NA-D knew who was at risk of elopement because it was reported to staff and the facility had a Wanderguard system that would detect when an at-risk resident was close to a door so staff could intervene and redirect. During an interview on 5/19/25 at 3:47 p.m., licensed practical nurse (LPN)-A stated residents at risk of elopement had Wanderguards and this was care planned and on the treatment administration record (TAR). LPN-A stated R2 was absolutely an elopement risk and had eloped on 5/16/25. LPN-A noted R2 would walk by herself outside of her room without a walker or footwear, stroll around in her wheelchair, and get antsy. LPN-A noted R2 had more behaviors at night. R2's elopement progress note dated 5/20/25, indicated R2 was sitting calmly in her wheelchair by the nursing station after receiving her pills at 9:10 p.m. RN-A went to the kitchen to put a meal tray away at approximately 9:30 p.m. at which time R2 remained in her wheelchair in the common area watching the birds. At approximately 9:40 p.m., RN-A returned to the nursing station and R2's wheelchair was still there	F 689		

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F 689	Continued From page 21 but R2 was gone. RN-A began searching for R2 and alerted all staff, the DON, 911, and family. At approximately 10:20 p.m. the facility received a call from the police stating R2 had been found seven or eight blocks away, had fallen, did not appear injured, and would be transported to the emergency department for follow up. R2's emergency department hospital After Visit Summary dated 5/21/25, indicated she was discharged from the hospital and back to the facility. Imaging, labs, and tests looked "good." Referrals were placed for memory care and in the meantime, it was okay for R2 to return to the facility. There were no new orders and no noted injuries. The facility's Nursing Home Incident Report #360607 dated 5/20/25, was submitted to the state agency (SA) and identified R2 had eloped that evening. The incident description included "Resident was discovered to not be in room, and subsequent search did not immediately show that she was in facility. Staff say they heard no alarms from the doors, which were armed at the time." During an interview on 5/23/25 at 10:30 a.m., RN-A stated she was working on 5/20/25 when R2 eloped. RN-A noted R2 was sitting and watching the birds when RN-A left the nursing station to go to the kitchen. RN-A stated upon her return approximately 10 minutes later, R2's wheelchair was still there but R2 was gone. RN-A stated the Wanderguard door alarms had not gone off, she was not aware R2 was missing until she returned and saw R2 missing. RN-A called 911, staff began to search, and police called the facility informing RN-A that R2 was found seven to eight blocks away, had stated she fell down,	F 689		

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F 689	Continued From page 22 and would be transported to the emergency department. R2's Elopement Risk assessment dated 5/20/25, included R2 had made previous successful elopement attempts with frequency of one time event and note that R2 eloped five days ago and did elope again that evening, leaving the facility and ambulating seven or eight blocks away without walker or wheelchair. The assessment noted R2 had a Wanderguard on her left wrist "due to elopement." The analysis section noted the circumstances of the elopement documented in progress note dated 5/20/25 and noted "No pain or discomfort reported before the elopement. wander guard was [on, sic] her left wrist and works properly." The assessment failed to comprehensively or accurately identify all of R2's cognitive deficits, conditions and diagnoses contributing to elopement risk, and behaviors and verbalizations. Further, the assessment failed to identify R2's needed level of supervision or interventions to mitigate identified risk of elopement apart from placement of a Wanderguard. R2's elopement care plan was revised with new interventions on 5/20/25 that included: check placement of Wanderguard every shift, check function of Wanderguard daily, check expiration date of device; notify team (nursing, activities, housekeeping, dietary, social services) if I am observed to be wandering, purposeful wandering, or stating things such as "I'm leaving," "I need to find **," "I am calling 911." R2's cognition care plan dated 5/20/25, identified R2 had impaired cognitive function/dementia or impaired thought processes. Interventions	F 689		

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F 689	Continued From page 23 directed staff to cue, reorient, and supervise as needed (was not defined) and monitor/document/report as needed any changes in cognitive function. Additional intervention dated 5/20/25, for focus of psychotropic medication directed staff to identify target behaviors for monitoring/recording including wandering. R2's elopement care plan failed to identify her needed level of supervision or interventions to mitigate the identified risk of elopement apart from presence of a Wanderguard. The care plan identified the need to notify various individuals if wandering behaviors or verbalizations were noted, but did not identify how to manage/respond to these behaviors or mitigate the associated risk of elopement. During an interview on 5/20/25, the facility's nurse manager, RN-C, stated residents were assessed for elopement risk on admission, with significant changes, annually, and as needed. A resident would be re-assessed if there was new or increased wandering, exit-seeking, or talk about leaving and should be done as soon as staff were aware of the behavior. Nurse managers completed the elopement risk assessments, but any nurse could do it. The assessment would be filled out and the nurse would "make a decision" about whether or not a person should have a Wanderguard on. RN-C stated she utilized the elopement risk assessment to determine if a resident needed a Wanderguard. There was no threshold on the assessment for when to place a Wanderguard or when someone was identified as an elopement risk, it was not an "objective scale." RN-C stated she completed R2's initial elopement assessment dated 4/30/25. RN-C stated the assessment should have identified R2's	F 689		

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F 689	Continued From page 24 communication deficit, adjustment to a new environment, altered mental status, amnesia, and REM sleep behavior disorder because they contribute to elopement risk. If she had identified the aforementioned items on assessment, she "would have identified her [R2] as an elopement risk" and would have care planned this, though may not have applied a Wanderguard at that time. RN-C stated she had viewed the assessment as "does she need a Wanderguard ... not so much risk" and would be looking at it differently in the future. RN-C confirmed the assessment was not accurate. She reviewed R2's progress notes, stated R2 was completely disoriented at night and exit-seeking, and R2 should have been re-assessed for elopement risk on 5/5/25 when she called 911 looking for her grandson because this was verbalizing looking for/seeking someone. RN-C noted ongoing progress notes prior to 5/16/25 identifying wandering behaviors and R2 should have been reassessed when she started having behaviors. RN-C stated a Wanderguard should have been applied when R2 started wandering at night and this would have helped to mitigate her risk of elopement. RN-C stated it wasn't applied until after her elopement on 5/16/25 and confirmed no other interventions to mitigate risk of elopement were implemented. RN-C confirmed she did not see any comprehensive assessment to determine R2's needed level of supervision and "we did not assess for her level of supervision or put any interventions in place." RN-C noted if the Wanderguard system was not functioning properly, then the facility had no interventions in place. She was unaware the Wanderguard system was not functioning properly and did not think R2's current level of supervision was adequate, especially at night. Further noted R2	F 689		

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F 689	Continued From page 25 eloped on 5/16/25 and should have been re-assessed for elopement risk that evening once she was back in the building, but confirmed an assessment was not completed until 5/19/25. During observation and interview on 5/20/25 at 8:44 a.m., Environmental Services Director (ESD) stated the five doors with Wanderguard systems were tested daily using an extra Wanderguard device signaling bracelet to ensure the system was working properly. The ESD noted the tests were recorded in a logbook but, upon review of the logs, stated they had not been completed consistently. The ESD and surveyor proceeded to test the five doors with an extra Wanderguard bracelet and found the following: four of the five doors did not alarm when the Wanderguard bracelet was in proximity of the door alarm, and one of the five doors did not alarm when passed through with the bracelet with the doors already opened by the automatic door button. During a follow up interview at 3:15 p.m., ESD stated he was not aware of any current issues with the Wanderguard system prior to this testing including both alarms not sounding due to Wanderguard bracelet proximity and the ability to exit a door without an alarm sounding. The ESD was not aware of how long these issues had been going on, no concerns had been reported by staff completing routine daily door testing. In a subsequent interview on 5/23/25 at 12:14 p.m., ESD stated the Wanderguard system had been inspected by a technician on 5/21/25 and a "dead spot" of about one foot on two of the five doors was identified. ESD stated if a resident with a Wanderguard bracelet exited through these doors the alarm would not sound because of the area of not reading the bracelet. New antennas and control box were installed to remove the area	F 689		

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F 689	Continued From page 26 where the bracelets were not detected. During an interview on 5/20/25 at 10:35 a.m., the administrator stated staff relied on the Wanderguard system to know if a resident at risk of elopement had left the building. Staff would know because of the beeping at the doors from the Wanderguard alarms. Administrator acknowledged the system had failed. She noted the doors were tested daily by maintenance and she would expect the system to be tested in accordance with manufacturer recommendations. She would expect the Wanderguard system to be functional 24 hours per day seven days per week and a resident with a Wanderguard should not be able to get through the door without the alarm sounding. She noted the doors should be set up to alarm when a resident's Wanderguard device was in proximity, not only upon the door being opened. Administrator was not aware that it was currently possible, as established by the surveyor and maintenance testing the doors, to get a Wanderguard bracelet through a door without it alarming or to approach a door without it alarming. This was "horrifying" and possibly how R1 was able to elope from the facility. If the door did not alarm, staff wouldn't be aware that a resident had eloped until they were noted to be missing. "We obviously need to fix our system". In the absence of a functioning system, staff would check on residents who were elopement risks but that was probably not realistic because the facility was a "big place." Staff would not be able to adequately supervise residents with Wanderguards the way they needed to or keep the residents safe without the Wanderguard system functioning correctly. During an interview on 5/23/25 at 3:50 p.m., the	F 689		

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F 689	Continued From page 27 director of nursing (DON) stated when R2 was first admitted to the facility she was not an elopement risk. The DON noted when R2 began wandering and had an increase in behaviors, she should have been re-assessed with her risk for elopement identified, increased supervision implemented, and care plan updated. The DON stated R2's elopement risk assessments were not completed accurately because they failed to identify predisposing and contributing factors and therefore were not comprehensive. During an interview on 5/20/25 at 10:35 a.m., the administrator stated she would expect residents to be comprehensively assessed for elopement risk and believed this was done by reviewing notes from a new resident's referral papers for exit seeking behaviors and completion of a Brief Interview for Mental Status (BIMS) assessment by social work or therapy. She would expect re-assessment if a resident had a significant change and quarterly. A significant change would be a behavioral change such as wandering towards the doors or trying to open them, or a significant change in behavioral or medical condition. The administrator could not articulate how residents were comprehensively assessed for elopement risk and supervision needs. The immediate jeopardy that began on 5/8/25, was removed on 5/23/25, and was verified through observation, interview, and document review when the facility implemented the following interventions: - Reviewed policies and procedures related to elopement, elopement assessments, and Wanderguard system. - Identified residents at risk of elopement by completing comprehensive elopement risk	F 689		

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F 689	Continued From page 28 assessments with development, implementation, and care planning of appropriate interventions aside from Wanderguard devices. - Educated all licensed staff on elopement risk assessments and development/implementation of appropriate immediate interventions. - Educated all facility staff on residents at risk for elopement. - Ensured Wanderguard system was functioning for all exits and repaired doors identified as not functioning as intended. - Educated ESD and designee on testing of Wanderguard system per manufacturer recommendations. - Elopement training was completed for all staff including: identifying residents at risk and appropriate notification, procedures to follow for residents have Wanderguards including testing, and procedures in the event of an elopement. Facility policy titled Elopement dated 8/1/22, identified the facility would "assess each resident and if identified at risk for wandering or elopement, will implement measures to properly and safely address their care needs to prevent elopement." Procedure included, "A.) All residents will be assessed on admission for risk of wandering or elopement. B.) At any time a resident is identified at risk for elopement, an elopement assessment will be completed and a plan put into place, which will include the resident's: a. Cognitive status b. Ambulation and mobility status (if independent in ambulation or wheelchair mobility, and/or able to open the door independently, may be at higher risk) c. History of wandering and/or attempts to leave the building d. Wandering patterns (how often/where/time of day/duration) e. Supervision required to leave the building. Interventions to prevent elopement may	F 689		

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F 689	Continued From page 29 include any of the following: Room located close to the Nurse' station or further from the exit door, ii. More frequent checks or at specific times of the day iii. Assessed by RT and in activity programs during high wander times iv. Wanderguard bracelet on the resident's person or equipment, such as walker or wheelchair, to alert staff if the resident is attempting to leave the building. g. The nurse will enter this plan into the resident's care plan in the electronic medical record (EMR) ... Suspected elopement: ... B.) When the resident who eloped is located: a. Complete a medical evaluation to identify potential injuries. b. Notify family and persons previously contacted. c. Notify the physician. d. Conduct an investigation to determine how the elopement occurred in order to correct any underlying contributing factors. e. Complete an "Incident Report" and document incident in the medical record. f. Report the 'elopement' incident to the state agency (MDH) as 'potential Neglect'. C.) In the event of an elopement, a care center wide audit will be completed including: a. Ensuring all resident's wanderguards are functioning properly b. Checking all doors with wanderguard alerts to ensure functioning properly c. Checking that all residents have daily wanderguard checks completed in the eMAR d. If needed., update any resident's elopement/safety care plans e. If needed, provide education to care center staff to ensure resident safety."	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		6/16/25

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F 732	Continued From page 30 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to post accurate data reflecting the total number and actual hours worked per shift by nursing staff directly responsible for resident care on a daily basis. This had the potential to affect all	F 732	How corrective action will be accomplished for those residents fund to have been affected by the deficient practice. Requirements were reviewed with the	

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F 732	Continued From page 31 34 residents residing in the facility and their visitors who may wish to review the information. Findings include: The facility's nurse staff posting form with date revised 4/17/25, included two pages for each calendar day. The first, titled [Facility] Nursing Schedule, included the following information: Nursing staff roles/titles (nurse, charge nurse, trained medication aide (TMA), nursing assistant (NA), and nurse on-call); names of staff filling the specific role for a given shift; scheduled hours of the shift with start time and end time. The second, titled Report of Nursing Staff Directly Responsible for Resident Care, included the date and daily census as well as a list identifying position (registered nurse (RN), licensed practical nurse (LPN), TMA, and NA), shift worked, hours (number of staff who worked the specified shift in the specified role), and total hours covered. The facility's Nursing Schedule dated 5/17/25, included an NA, NA-F, identified as working from 10:00 p.m. to 6:30 a.m. with letters "AL" written in and circled next to the name. There were no modifications made to the listed shift hours of 10:00 p.m. to 6:30 a.m. The Report of Nursing Staff Directly Responsible for Resident Care dated 5/17/25, included an entry for position of NA, shift worked from 10:00 p.m. to 6:30 a.m., hours times one, and total hours worked of eight. In an email dated 5/19/25 at 5:50 p.m., the administrator noted the facility's overnight staff covered the assisted living center in addition to the facility and did not believe those hours were being tracked. In a subsequent email at 6:02 p.m., the administrator indicated there was a	F 732	scheduler, DON, and Human Resources on the total number and actual hours worked per shift by nursing staff. Human Resources and the HUC will ensure the NAR or license staff time provided at the assisted living will not be included in the nursing home hours worked. How the facility will identify other residents having the potential to be affected by the same deficient practice. The schedule is posted for all residents to review. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The nursing staff has been trained to update the schedule in real time for any changes. The HUC verifies the accuracy of the updated schedule and modifies the posting if inaccurate. HR will ensure the hours are tracked accordingly within payroll to ensure PBJ compliance. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. A weekly audit will be initiated to ensure the schedule is reflecting real time changes. These audits will be completed twice per week for two weeks, once per week for two weeks. Then monthly for three months to ensure compliance. Audits will be reviewed at QAPI to determine ongoing need. This deficiency was corrected 6/16/25.	

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F 732	Continued From page 32 tracking log and provided an hours log of nursing home staff covering at the assisted living (AL) titled AL Filling In Time Book. Facility document titled AL Filling in Time Book was a log book with dated entries from 3/9/25 through 5/19/25. The log directed staff: "Please write down times for the following: counting meds, rounds, any call lights/calls you get, falls, potential emergencies. Any time you go over there please document it!" signed by the director of nursing (DON). Additional hand-written note directed "Please fill out when you get calls/go to the ALF [assisted living facility]. Thanks, [DON]. Please write down rounds too! & how long those take." The log book sheets with entries from month of May 2025 included columns for room number, time of call, total time spent, what they needed, and any other information. The room number column was used by staff to document the date and other information column used by staff to sign their initials. AL Filling in Time Book entries corresponding with NA-F's shift from 5/17/25 at 10:00 p.m. through 5/18/25 at 6:30 a.m. included the following: - 5/17/25 at 10:00 p.m., 10 minutes total time spent for key handoff, with NA-F's initials. - 5/18/25 at 1:00 a.m., 20 minutes total time spent for rounds, with NA-F's initials. - 5/18/25 at 3:15 a.m., 20 minutes total time spent for rounds, with NA-F's initials. - 5/18/25 at 6:00 a.m., 10 minutes total time spent for key handoff, with NA-F's initials. The total documented time NA-F spent working at the assisted living and not in the nursing home during the shift from 10:00 p.m. to 6:30 a.m. was one hour.	F 732		

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F 732	Continued From page 33 The facility's nurse staff posting dated 5/17/25, failed to reflect the time NA-F spent working at the assisted living and not the nursing home. Neither the actual hours worked (listed as 10:00 p.m. to 6:30 a.m.) nor the total hours worked (listed as eight) accurately reflected NA-F's time spent providing resident care in the facility. Based on documentation provided and reviewed above, accurate documentation would have included actual hours worked of 10:10 p.m. to 1:00 a.m., 1:20 a.m. to 3:15 a.m., 3:35 a.m. to 6:00 a.m., and 6:10 a.m. to 6:30 a.m. as well as total hours worked of seven. During an interview on 5/19/25 at 3:28 p.m., nursing assistant NA-E stated nursing staff were responsible for the residents at the connected assisted living at night and had to take care of the residents in both facilities simultaneously. NA-E indicated staff from the nursing home would go over to the assisted living facility to provide cares and assistance. During an interview on 5/23/25 at 11:45 a.m., the staffing coordinator (SC) stated the nurse staff postings for the facility did not reflect the hours staff worked in the assisted living and therefore were not accurate. The SC further stated the hours should be adjusted in "real time" such as if someone called off for their shift, but this was not completed until the next day when she came in to work. During an interview on 5/20/25 at 10:35 a.m., the administrator stated the facility was typically staffed with one nurse and two NA's at night. The administrator confirmed these staff assisted with providing cares at the assisted living during their	F 732		

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F 732	Continued From page 34 shifts at the facility. During an interview on 5/20/25 at 4:55 p.m., the DON stated facility staff had been providing services at the assisted living since before she started working there in October of 2023. She was not sure exactly when this practice began. In a subsequent interview on 5/23/25 at 11:54 a.m., the DON stated the posted nurse staffing hours included identification of certain staff assigned each day to cover helping in the assisted living (staff with "AL" written next to their names), however the postings did not reflect the specific time or amount of time that was spent working outside of the nursing home. Facility policy on staffing was requested but not received.	F 732		
F 836 SS=F	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet	F 836		5/29/25

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F 836	Continued From page 35 the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to be in compliance with the supplemental nursing service agency (SNSA) requirements when the facility obtained nursing services from Swenswen Staffing, LLC (an SNSA) which was not registered with the commissioner as required. This had the potential to affect all 34 residents of the facility who received services from the supplemental staff. Findings include: Review of the SNSA website on 5/27/25, did not identify Swensen Staffing, LLC as being registered with the commissioner as required. Email communication sent on 5/27/25 at 3:09 p.m., the staffing coordinator (SC) verified that Swenswen Staffing had provided staff in the facility in the past month. Review of the staffing schedules from 5/12/25	F 836	How corrective action will be accomplished for those residents found to have been affected by deficient practice. Our facility is no longer using agency staff due to non registry with the commissioner. Notification was provided to agency staff and our scheduler that we would no longer be utilizing the agency staff services. Going forward, all agency staff contracts will require registration with the commission. If the agency is not in compliance, they will not be authorized to work in our facility. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Administrator will be responsible for verifying the SNSA status of any staffing agency prior to their use. All current staffing agency contracts were reviewed and verified commission compliance.	

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F 836	Continued From page 36 through 5/23/25, verified that Swenswen Staffing, LLC provided supplemental nursing staffing to the facility on the following days: -5/13/25 nursing assistant 6:00 p.m. to 6:30 a.m. -5/13/25 trained medication aide 1:00 p.m. to 2:00 p.m. -5/17/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/18/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/21/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/22/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/24/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/24/25 nursing assistant from 6:00 p.m. to 6:30 a.m. Review of the Minnesota Department of Health approved SNSA's current as of 5/27/25 did not include Swenson Staffing, LLC. Review of an email dated 5/27/25 at 6:50 p.m., Swenswen Staffing, LLC forward a certificate for registration as a SNSA, however it had expired on 1/25/24. During an interview on 5/27/25 at 4:09 p.m., the Administrator stated she was not aware that Swenswen Staffing, LLC was not registered as required and was not aware of the facility's responsibility to verify that the SNSA was registered prior to obtaining staff from the agency. A policy on supplemental staffing was requested but was not provided.	F 836	What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur. The Administrator will ensure compliance with staffing agencies upon contract signing and anytime staffing agencies must be reintroduced due to staffing need. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Administrator will review all current agency staffing contracts at QAPI to ensure compliance. Agency usage will be reviewed each pay period to ensure commission compliance. Results will be brought back to QAPI for review and further ongoing need.	
F 838 SS=F	Facility Assessment	F 838		6/16/25

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F 838	Continued From page 37 CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that	F 838		

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F 838	Continued From page 38 may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the	F 838		

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F 838	Continued From page 39 governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident	F 838		

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	245376	A. BUILDING _____ B. WING _____	C 05/27/2025

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F 838	Continued From page 40 care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review and update the facility assessment to identify the facility's staffing plan for number of staff needed to ensure sufficient qualified staff were available to meet residents' needs. Findings include: In an email dated 5/19/25 at 5:50 p.m., the administrator noted overnight staff at the facility also worked at the assisted living facility. She noted this was "an oversight if that isn't listed in the facility assessment" and she would work on getting it corrected as soon as possible. In a subsequent email at 6:02 p.m., the administrator indicated there was a tracking log and provided an hours log of nursing home staff covering at the assisted living (AL) titled AL Filling In Time Book. Facility document titled AL Filling in Time Book was a log book with dated entries from 3/9/25 through 5/19/25. The log directed staff: "Please write down times for the following: counting meds, rounds, any call lights/calls you get, falls, potential emergencies. Any time you go over there please document it!" signed by the director of nursing (DON). Additional hand-written note directed "Please fill out when you get calls/go to the ALF [assisted living facility]. Thanks, [DON]. Please write down rounds too! & how long those take." The log book sheet entries identified that overnight staff spent time working in the assisted living nearly every single day, multiple times per shift.	F 838	How corrective action will be accomplished for thoese residents found to have been affected by the deficient practice. The facility assessment has been updated to read on the staffing plan that 'the nurse or NAR does round at the assisted living for approximately 30 minutes per evening/NOC shift.' The time in the nurses time log is compared to their actual punched hours to ensure accuracy to be disclosed on the PBJ reports. How the facility will identify other residents having the potential to be affected by the same deficient practice. The nurse or NAR is equipped with a cell phone and walkie talkie for immediate communication should he/she be needed at the nursing home which is a short attached hallway away. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. We will be disclosing the facility assessment staffing plan on the resident board. The facility assessment should match the posted schedule. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The facility assessment staffing plan vs the scheduled hours will be audited by the	

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F 838	Continued From page 41 The facility assessment dated 4/8/25, noted it was coordinated by the current administrator and last reviewed and approved at Quality Assessment and Assurance/Quality Assurance and Performance Improvement (QAA/QAPI) on 2/7/25. The assessment included a staffing plan with assessment date 4/8/25. The staffing plan identified staff positions and total number needed or average or range for each position with note to "indicate any shared positions." The staffing plan identified licensed nurses providing direct care included two on day shifts, two on evening shifts, and one on overnight shifts for both weekdays and weekends. Nursing assistants (NA's) and trained medication aides (TMA's) included three to four NA's/TMA's on days shifts, three NA's/TMA's on evening shifts, and two NA's/TMA's on overnight shifts for both weekdays and weekends. The staffing plan did not identify any of the licensed nurse, NA, or TMA positions or shifts as being shared with the assisted living or reflect the needed number of staff or hours worked in the facility for each role adjusted for time spent working in the assisted living. The facility assessment failed to accurately identify the number of staff needed to meet resident needs and was not updated to identify that nursing staff were shared with the assisted living. During an interview on 5/20/25 at 4:55 p.m., the DON stated facility staff had been providing services at the assisted living since before she started working there in October of 2023. She was not sure exactly when this practice began. During an interview on 5/20/25 at 10:35 a.m., the administrator stated the facility was typically staffed with one nurse and two NA's at night. The administrator confirmed these staff assisted with	F 838	HUC once per week for 4 weeks, then once every two weeks, then once per month for three months. If at any time the schedule and posted assessment aren't in agreement, time analysis will take place and the facility assessment will be updated and reported after monthly QAPI personnel have approved. The facility assessment is reviewed annually at QAPI, unless being update sooner as noted.	

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F 838	Continued From page 42 providing cares at the assisted living during their shifts at the facility. In a subsequent interview on 5/23/25 at 3:43 p.m., the administrator stated the facility assessment was completed prior to her employment at the facility which began two months ago. She believed it was last updated in 2024. This was not consistent with documentation in the facility assessment. In a subsequent interview on 5/27/25 at 4:59 p.m., the Administrator stated the facility assessment was not reflective of the actual hours worked in the nursing home because the staff hours worked in the assisted living had been counted towards the facility's identified staffing hours determined by the assessment. The administrator further noted the current facility assessment was therefore not correct. Facility assessment policy requested but not received.	F 838		
F 851 SS=C	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and	F 851		6/20/25

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F 851	Continued From page 43 services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.	F 851		

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F 851	Continued From page 44 §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to submit accurate and/or complete data for staffing information based on payroll and other verifiable and auditable data during 1 of 1 quarter (Quarter 2) reviewed, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 34 residents of the facility who received services from the supplemental staff. Findings include: CMS CASPER Report 1702S titled Staffing Summary Report for dates 1/1/25 through 3/31/25, was a Payroll Based Journal (PBJ) report and included a summary of staffing hours listed by job title. The reported identified the following total nursing staff hours for Quarter 2: - Certified nurse aide (nursing assistant, NA), 5,491.52 hours - Registered nurse (RN), 2,393,98 hours - Licensed practical/vocational nurse (LPN), 2,018.75 - RN director of nursing (DON), 488.00 - Medication aide/technician (trained medication aide, TMA), 131.00 In an email dated 5/19/25 at 5:50 p.m., the administrator noted the facility's overnight staff covered the assisted living center in addition to the facility. In a follow-up email at 6:02 p.m., the administrator indicated there was a tracking log	F 851	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. We have updated our Assisted Living logbook to better reflect time staff is spending rounding at the assisted living. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents could be affected at any one time. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Using those written times, the HR Director is then tracking the time allocated toward meeting the Facility Assessment. The employee punching in and out allows a record of actual time in the facility. This is reported directly into UKG (timekeeping software), and used to report for PBJ (Payroll Based Journal). How the facility will monitor its corrective actions to ensure that the deficient practice is veing corrected and will not recur. HR will check the UKG timecards from the previous day, verifying hours match	

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F 851	Continued From page 45 and provided an hours log of nursing home staff covering at the assisted living (AL) titled AL Filling In Time Book. Facility document titled AL Filling in Time Book was a log book with dated entries from 3/9/25 through 5/19/25. The log directed staff: "Please write down times for the following: counting meds, rounds, any call lights/calls you get, falls, potential emergencies. Any time you go over there please document it!" signed by the director of nursing (DON). Additional hand-written note directed "Please fill out when you get calls/go to the ALF [assisted living facility]. Thanks, [DON]. Please write down rounds too! & how long those take." The log book sheets with entries from month of May 2025 included columns for room number, time of call, total time spent, what they needed, and any other information. The room number column was used by staff to document the date and other information column used by staff to sign their initials. AL Filling in Time Book included entries from various staff members during Quarter 2 dated 3/9/25 through 3/31/25, documenting time spent working at the assisted living and not the facility. The total documented time spent by facility staff working at the assisted living from 3/9/25 through 3/31/25, was greater than 50 hours. Some entries were illegible or identified time was spent at the assisted living but did not identify the total amount of time spent. During an interview on 5/20/25 at 4:55 p.m., the DON stated facility staff had been providing services at the assisted living since before she started working there in October of 2023. She was not sure exactly when this practice began.	F 851	scheduled hours and time punches in and out have been performed each night. HR will need to verify the employees who worked according to the current schedule after the HUC audits who actually worked according to any changes made to the schedule by the charge nurse. HR will track the time spent rounding to be able to accurately update the Facility Assessment. Reported PBJ hours should match scheduled and tracked hours. This will be verified at monthly QAPI. HR will ensure accurate and or complete data for staffing information is submited to CMS. This deficiency was corrected on June 19, 2025.	

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F 851	Continued From page 46 During an interview on 5/20/25 at 10:35 a.m., the administrator stated the facility was typically staffed with one nurse and two NA's at night and confirmed these staff members assisted with providing cares at the assisted living during their shifts at the facility. During an interview on 5/23/25 at 12:03 p.m., the director of human resources (DHR) stated he assisted with staff timecards (clock in/out time punches) and used the timecard data for the facility's PBJ reporting of staffing hours. However, the DHR stated he had not been subtracting the time staff spent in the assisted living to reflect the actual time spent working in the facility for the PBJ reporting. The DHR noted they would subtract the hours moving forward now that the facility realized they should have done this. The DHR stated he started working at the facility a few months ago and, since then, the PBJ hours submitted would have been incorrect. Facility PBJ policy requested but not received.	F 851		

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2 000	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 5/19/25, 5/20/25, 5/23/25, & 5/27/25, 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, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H53764567C (MN112953), H53765068C (MN113161), and H53765469C (MN113272 & MN113279) with licensing orders issued at 0010, 0550, & 0830. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 010	MN Rule 4658.0020 Subp 1 LICENSING IN GENERAL; Required Subpart 1. Required. For the purpose of this chapter, a state license is required for a facility where nursing home care is provided for five or more aged or infirm persons who are not acutely ill. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to be in compliance with the supplemental nursing service agency (SNSA) requirements when the facility obtained nursing services from Swenswen Staffing, LLC (an SNSA) which was not registered with the commissioner as required. This had the potential to affect all 34 residents of the facility who received services from the supplemental staff. Findings include: Review of the SNSA website on 5/27/25, did not	2 010	Our facility is no longer using agency staff due to non registry with the commissioner, notification was provided to agency staff and our scheduler that we would no longer be utilizing the agency staff services. Going forward, all agency staff contracts will require registration with the commission. If the agency is not in compliance they will not be authorized to work in our facility. The administrator will be responsible for verifying the SNSA status of any staffing	5/27/25

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2 010	Continued From page 3 identify Swensen Staffing, LLC as being registered with the commissioner as required. Email communication sent on 5/27/25 at 3:09 p.m., the staffing coordinator (SC) verified that Swenswen Staffing had provided staff in the facility in the past month. Review of the staffing schedules from 5/12/25 through 5/23/25, verified that Swenswen Staffing, LLC provided supplemental nursing staffing to the facility on the following days: -5/13/25 nursing assistant 6:00 p.m. to 6:30 a.m. -5/13/25 trained medication aide 1:00 p.m. to 2:00 p.m. -5/17/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/18/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/21/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/22/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/24/25 trained medication aide from 6:00 a.m. to 6:00 p.m. -5/24/25 nursing assistant from 6:00 p.m. to 6:30 a.m. Review of the Minnesota Department of Health approved SNSA's current as of 5/27/25 did not include Swenson Staffing, LLC. Review of an email dated 5/27/25 at 6:50 p.m., Swenswen Staffing, LLC forward a certificate for registration as a SNSA, however it had expired on 1/25/24. During an interview on 5/27/25 at 4:09 p.m., the Administrator stated she was not aware that Swenswen Staffing, LLC was not registered as	2 010	agency prior to their use. All current staffing agency contracts were reviewed and verified to be commission compliant. The administrator will ensure compliance with staffing agencies upon contract signing and anytime staffing agencies must be reintroduced due ot staffing need. The administrator will review all current agency staffing contracts at QAPI to ensure compliance. Agency usage will be reviewed each pay period to ensure commission compliance. Results will be brought back to QAPI for review and further ongoing need. This deficiency was corrected by 05/27/2025	

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2 010	Continued From page 4 required and was not aware of the facility's responsibility to verify that the SNSA was registered prior to obtaining staff from the agency. A policy on supplemental staffing was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could establish policies and procedures to ensure supplemental nursing service agencies (SNSA's) used at the facility are registered with the commissioner as required prior to utilizing any staff from the agency and on an ongoing basis. The administrator or designee could educate appropriate staff on these policies and procedures. The administrator or designee could audit to ensure SNSA's used are on the registry and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 010		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect	2 550	The resident's MDS was reviewed and modified to ensure accurate coding of the wanderguard by the MDS nurse.	6/20/25

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2 550	Continued From page 5 wander/elopement alarm use for 1 of 2 residents (R1) reviewed for MDS accuracy. Findings include: R1's quarterly MDS assessment dated 2/6/25, included section "P0200: Alarms" with alarm type "wander/elopement alarm." The wander/elopement alarm was coded "0" indicating it was not used during the look-back period. R1's Elopement Risk assessment dated 2/6/25, indicated R1 had a Wanderguard placed on her right wrist. The analysis section noted for the assessment reference date (ARD) of 1/31/25 through 2/6/25, information was collected per review of documentation, observation, and interviews with direct care staff and resident. The analysis further noted, "is at risk to wander or elope from facility. Wanderguard in place right wrist. Placement and proper function checked daily." R1's elopement care plan dated 8/28/24, identified she was an elopement risk. Intervention dated 8/28/24, noted R1 had a Wanderguard on her left wrist. On 5/19/25 at 4:01 p.m., the facility's nurse manager, registered nurse (RN)-C, confirmed R1 was one of the residents with a Wanderguard device. At 4:16 p.m., RN-C tested R1's Wanderguard device which was observed to be in place on her left wrist. During an interview on 5/23/25 at 2:05 p.m., the MDS Coordinator (MDS-C) stated R1's quarterly MDS dated 2/6/25 should have identified R1 had a Wanderguard in place and was not accurate.	2 550	An MDS audit of the residents who wear wanderguards was completed by the MDS nurse going back three months on 05/30/25. No other issues with the coding of wanderguards was found. Our MDS nurse was educated on where to find the electronic list of residents who have wanderguards. She was also re-educated on where the information is located within the EHR. Prior to MDS submissions, the MDS nurse will review the electronic list and EHR to ensure accurate coding of the wanderguard on the MDS. Monthly MDS audits of a resident on a wanderguard will be completed by MDS quality to ensure coding for wanderguards is accurate.	

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2 550	Continued From page 6 MDS-C noted she must have missed adding this to the MDS and she would be doing a modification to R1's MDS to correct it. Facility MDS assessment policy requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures on Minimum Data Set (MDS) assessments and the collection of required data/information. The administrator, DON, or designee could educate appropriate staff on these policies and procedures. The administrator, DON, or designee could perform audits to ensure all resident MDS assessments are completed accurately and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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.	2 830		6/30/25

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2 830	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a functioning Wanderguard system and failed to comprehensively assess risk for elopement and appropriate interventions, resulting in elopement for 2 of 7 residents (R1, R2). R1's elopement occurred due to the failure of the Wanderguard system, which did not sound an alarm when R1 exited the building. R2's elopements occurred due to R2's risk of elopement was not accurately comprehensively assessed leading to insufficient supervision and lack of intervention, followed by a failure of the Wanderguard system. The facility's failures resulted in an immediate jeopardy (IJ). The immediate jeopardy began on 5/8/25, when R1 successfully eloped from the building without the alarm sounding and was found by staff outside, unharmed, approximately 15 minutes later, the facility failed to identify malfunctioning alarm system which resulted in subsequent elopements by R2. The administrator, Director of Nursing (DON), nurse manager, and social services director were notified of the immediate jeopardy on 5/20/25 at 3:50 p.m. The immediate jeopardy was removed on 5/23/25, but noncompliance remained at the lower scope and severity level of D, indicating no actual harm but the potential for more than minimal harm, which is not immediate jeopardy Findings include: R1 R1's facesheet dated 5/28/25, identified diagnoses of dementia, delirium, and history of falling.	2 830	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: A resident care conference was held with family, ombudsman and facility to establish a safe plan of care. R2's primary physician reviewed medications and provided suggestions on managing behaviors. Resident careplan was reassessed for their risk of elopement and interventions. Door associated with the elopement are tested daily for compliance. Door where elopement occurred was reset to increase the sensitivity area to alarm. Wanderguard Alarm company was contacted to come onsite and review equipment. Once onsite, parts of the system were updated. The sensitivity was also adjusted. The wanderguard alarm technician met with the Administrator and Environmental Services Director to review manual and best practices. Residents wanderguard bracelets were assessed for proper function and re-located to resident's wrist instad of wheelchair. Elopement assessments will be completed upon admission, quarterly and PRN. Daily within IDT, any residents who have pertinent behaviors which could lead to a potential elopement will be reviewed. Examples of behaviors that we will discuss include residents having paranoid thoughts/actions, hallucinations, increase wandering, confusion, bein found in other rooms hiding, psychotropic medication use (start, end, dose changes).	

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2 830	Continued From page 8 R 1's Minimum Data Set (MDS) assessment dated 2/6/25, identified R1 had severe cognitive impairment and required supervision or touches for transfers, used a wheelchair and/or walker for mobility with staff supervision or touching. R1's elopement care plan focus dated 2/6/25, identified R1 was at risk for elopement related to history of attempts to leave the facility unattended. Interventions of Wanderguard on left wrist, and distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. R1's progress note dated 5/8/25 at 7:45p.m., identified R1 was observed wandering outside of the building, Wanderguard on left wrist and worked properly, was alert and had intermittent confusion. R1's incident report dated 5/8/25 at 7:45 p.m., identified R1 was observed wandering outside of the building and was orientated to person and time only. No predisposing environmental factors. Predisposing psychological factors included confusion and impaired memory. Door alarm/Wanderguard did not activate when R1 exited the building. R1's elopement care plan was revised on 5/9/25 to include encourage R1 to attend activities during highest wandering times (late afternoon/evening). During an interview on 5/20/25 at 1:21 p.m., registered nurse (RN)-A stated on 5/8/25 R1 had been observed in the facility about fifteen minutes earlier when around 7:30 p.m., staff observed R1 wandering outside of the facility near the gazebo, and then immediately brought back into the	2 830	Elopement policy was reviewed and updated by out quality team. All staff have been educated on our elopement policy and completed competency tests related to elopement. This education includes reporting timelines for elopements. Nursing staff have been educated on what makes a resident high, medium, or low risk for elopement. The guidance is in the elopement book for reference. All staff have been educated on who to call when a resident elopes and what to do if a failure in the system is identified. We added an elopement education for all new hires to complete. Nursing staff were all educated on how to complete the elopement assessments within the EHR. Maintenance has a revised sheet for logging results while testing the doors. Maintenance is testing all doors as per manufacturer manual. Results of this testing will be reviewed at QAPI". Audits will be initiated that ensure all new admits/readmits will have elopement assessments completed the day of admission/readmission and then again on their 5-day assessment (occurs on day 8). Will review quarterly after that and as needed. These will be conducted 3x/week for 1 week, 2x week for 1 week, 1s week for 4 weeks. This will be completed by the week of 6/30/25.Facility is currently receiving estimates on the implementation of an upgraded Wanderguard Blue system. Facility is also identifying comparable systems to ensure the best model is to be installed.	

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2 830	Continued From page 9 facility. The facility doors did not alarm when R1 left the facility, however, did go off when R1 was brought back into the facility. RN-A believed that the alarm not sounding may have been because the Wanderguard tag was on her left wrist and the door did not catch the signal. RN-A stated R1's Wanderguard was changed to a new one because it was due to expire soon. RN-A stated staff tested the doors and R1's Wanderguard when R1 returned and they both were working properly, however did not notify maintenance that the door failed to alarm when R1 had exited the building. During an interview on 5/20/25 at 1:27 p.m., director of nursing (DON) stated R1 eloped on 5/8/25 and R1 left the building without the Wanderguard system door alarm going off. R1 should have had a repeat elopement assessment completed at that time and all nurses were able to complete the assessment. DON indicated staff did not notify maintenance the alarm had not sounded and stated when R1 eloped staff should have notified maintenance "immediately". In addition, staff should have assessed all resident Wanderguard devices to ensure proper function, check all doors with Wanderguard sensors to ensure proper function, and provide education to all staff in the building at the time about testing the system. DON stated, "None of that was done." DON's expectation was for all doors to be tested for proper functioning if a resident eloped. DON was not aware of the manufacturer's recommendations for testing and did not know how the doors were being tested. R2 R2's facesheet dated 5/28/25, identified R2 had diagnoses including urinary tract infection (can cause confusion in the elderly), Parkinson's	2 830	The date all of the measures will be finalized for the deficiency is 06/30/25.	

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2 830	Continued From page 10 disease (progressive neurological disorder that affects movement), altered mental status, unspecified convulsions (sudden involuntary muscle contractions and spasms), unspecified dementia (condition causing loss in ability to think, remember, learn, make decisions, and problem solve and symptoms including personality changes and emotional problems), abnormalities of gait and mobility, amnesia (memory loss), rapid eye movement (REM) sleep behavior disorder (a disorder where people act out their dreams during REM sleep), macular degeneration (progressive eye disease of damage to the retina causing loss of central vision), dystrophies involving the retinal pigment epithelium (eye disease involving deposits of pigment in the retina that can cause central vision loss), vitreous degeneration (degeneration of the vitreous fluid in the eye leading to floaters and vision changes), hypermetropia (far-sightedness causing blurry close-up vision), and presbyopia (decline in eyes' ability to focus on nearby objects). R2's Minimum Data Set (MDS) assessment dated 5/7/25, identified she admitted to the facility on 4/30/25. R2 had moderate cognitive impairment, delusions and verbal behavioral symptoms directed toward others, and had no wandering behaviors. R2 required substantial staff assistance with toileting hygiene, mobility in bed, and transfers. R2 used a wheelchair and was dependent on staff for wheelchair mobility. R2 was not independent with any self-cares or mobility. R2's physician orders dated 4/30/25, included: - Observe for side effects of antipsychotic medication. Side effects listed included disorientation or confusion, increased agitation,	2 830		

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2 830	Continued From page 11 and restlessness. - Melatonin (supplement to treat sleep problems like insomnia) 5 milligram (mg) tablet, give 10 mg by mouth as needed (PRN) at bedtime for restlessness/insomnia. R2's progress note dated 4/30/25, identified cognitive impairment of "some forgetfulness." R2's Elopement Risk assessment dated 4/30/25, identified R2 had no history of elopement attempts and was a new resident within the last 90 days. The cognition section identified cognitive deficit of short-term memory loss and a change in cognition in the last 90 days. A pre-populated list of conditions contributing to elopement risk identified R2 had the following: recent infection, dementia, hallucinations, and new medication in the past 30 days. No behaviors, verbalizations, or life experiences that could contribute to elopement were identified and a Wanderguard (wearable bracelets that trigger alarms when a resident approaches a door sensor by an exit or restricted area) was not placed. The analysis noted, "not at risk for elopement at time of assessment." The assessment failed to identify R2's conditions contributing to elopement risk of: altered mental status, amnesia, REM sleep behavior disorder, adjustment to new environment, and visual deficits. The assessment failed to identify R2's needed level of supervision or identify how it was determined that she was not at risk for elopement based on the risk factors identified. R2's care plan for psychotropic medications dated 5/1/25, identified she used psychotropic medications. Interventions included monitor/record occurrence of for target behavior symptoms (SPECIFY: pacing, wandering,	2 830		

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2 830	Continued From page 12 disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. The intervention failed to identify R2's specific behaviors which were to be monitored and recorded. R2's behavior progress note dated 5/2/25, indicated she was heard calling out for help and found crawling out of bed at 12:20 a.m. R2 stated she wanted to get into her wheelchair, was brought to the common area by staff, requested a sandwich then specifically a fish sandwich, and declined other offered snacks. R2 stayed in her wheelchair until she requested to go to bed at 1:30 a.m. R2's progress note dated 5/2/25, identified she complained of trouble sleeping and requested PRN melatonin. R2's progress note dated 5/3/25, identified she requested PRN Melatonin due to difficulty falling asleep at night. R2's progress note dated 5/4/25, indicated R2 complained of trouble sleeping and took PRN Melatonin. R2's progress note dated 5/5/25 at 2:55 a.m., indicated the facility received a phone call from the police stating R2 called 911. R2 reported to staff that she called because she wanted to talk to her grandson and he was a police officer. R2 was redirected and went back to sleep. R2's progress note dated 5/5/25, noted R2 had trouble following commands, disorganized thinking, moderate cognitive impairment including memory loss and moderate confusion, and	2 830		

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2 830	Continued From page 13 sometimes understood others. Behaviors included "resident is awake at night." R2's progress note dated 5/5/25, indicated R2 had signs of short-term memory loss, mild cognitive impairment, and chronic confusion demonstrated by refusal of cares, refusal of redirection, and delusions. Mood and behaviors identified intermittent sleep and wandering at night. R2 was educated on safety concerns of impulsivity, poor safety awareness, and confusion. R2's progress note dated 5/5/25 at 9:06 p.m., indicated R2 came walking out of her room at 9:00 p.m. using her wheelchair as a walker. R2 took Melatonin and was up at the nursing station until more tired. R2's progress note dated 5/5/25 at 11:41 p.m., indicated she came out of her room at 11:00 p.m., stated staff needed to call 911 right now, and called 911 herself but would not say why. R2 took papers from the nursing station and refused to return the facility's phone. An officer arrived and spoke with R2, stated she did not complain of anything and the officer was not sure why they had been called. R2 returned to her room at 11:45 p.m. and refused to get into bed. Although R2's progress notes identified R2 had both wandering at night and increased behaviors there was no indication R2 was re-assessed for elopement risk or needed level of supervision nor were appropriate interventions developed, and implemented to prevent or mitigate the risk of elopement. R2's progress note dated 5/6/25 at 12:37 a.m., indicated a new medication, Trazadone (an	2 830		

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2 830	Continued From page 14 anti-depressant also used to treat insomnia), was ordered for administration at bedtime as needed for sleep. R2's progress note dated 5/6/25, identified R2 came wheeling out of her room at 12:05 a.m. and went down the north hall. R2 then wheeled down to the end of the hall and turned around, backed her wheelchair by another resident room, began waving to something or someone she was seeing, and then entered the other resident's room. R2 then left the other resident room, propelled down the north hall back to the common area, and began saying "good morning" to a stationary chair. She signaled come here with her finger while looking at no one and sat next to the chair having a conversation with it. She then wheeled around in the common area, attempted to go behind the nursing station, and asked why "those kids" were back there. She continued to wheel around into the dining area, came out, was offered and took a PRN Trazadone to help with her insomnia, and wheeled herself back into her room. Progress note dated 5/6/25 at 1:25 a.m., identified R2 "has been awake and roaming since beginning of night shift." R2's physician orders dated 5/6/25, included: - Trazadone hydrochloride (HCl) 50 mg tablet, give 50 mg by mouth one time a day for insomnia, difficulty falling, and/or staying asleep. - Observe for side effects of anti-depressant medication. Side effects listed included trouble sleeping and other unusual changes in mood or behavior. R2's Behavior Assessment dated 5/7/25, identified she had verbal behavioral symptoms	2 830		

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2 830	Continued From page 15 directed towards others with examples listed including delusions and calling 911 without explanation. The assessment identified her behaviors did not put her at significant risk for physical illness or injury but did interfere with her care and significantly disrupt the care environment. Root cause of behaviors was identified as being newly admitted and diagnoses of Parkinson's disease, dementia, and seizure history. The assessment identified R2 had not exhibited wandering behaviors, despite progress notes indicating she repeatedly left her room at night and wandered around the facility. R2's progress note dated 5/10/25, identified R2 had some forgetfulness, slept intermittently, wandered at night, and wandering had decreased since starting a new sleep medication. R2's progress note dated 5/11/25, indicated she came walking out of her room with a walker at 9:00 p.m. and sat down in a chair. Staff explained she should not walk by herself and to request assistance when ready to return to her room. 15 minutes later R2 was found to have walked herself back to her room and stated she didn't need help and could walk just fine by herself. R2's behavior progress note dated 5/12/25 at 5:56 a.m., indicated R2 was not in her room on last rounds. R2 was found in a room at the end of a different hall, had her brief off, and was "ducking down to hide" when a nursing assistant opened the door. R2 was naked from the waist down and would not tell staff why she was in the room or what she was looking for. R2 was assisted back to her room and dressed. R2's progress note dated 5/14/25, indicated she wandered at night.	2 830		

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2 830	Continued From page 16 R2's record between 5/6/25 and 5/15/25 identified despite R2 demonstrated several episodes of wandering, had confusion, forgetfulness, and had unpredictable ability to ambulate independently. There was no indication a comprehensive assessment was completed that would identify R2's risk for elopement and/or level of supervision nor evidence the care plan was revised. R2's incident report dated 5/16/25 at 8:00 p.m., identified registered nurse (RN)-B assisted R2 with a phone call and R2 then conversed with another resident at the nursing station. RN-B then left to take the other resident to their room and when RN-B came out of the room R2 wasn't at the nursing station. Staff began searching the facility immediately. RN-B went outside to search, and police had arrived and stated R2 had called 911. R2's spouse also arrived. R2 was found outside across the street without a wheelchair talking to her spouse using the neighbor's phone. Police and staff brought R2 back to the facility, she was assessed with no injuries noted and refused vital signs. R2's spouse sat with her until she fell asleep and a Wanderguard was placed on her left wrist. R2's physician orders dated 5/16/25, included: - Check Wanderguard functioning at bedtime. - Check placement of Wanderguard every shift for elopement risk. - Change Wanderguard one time a day every month on the 23rd day. R2's care plan for elopement dated 5/16/25, identified she was unable to leave the facility independently with history of elopement. Interventions included Wanderguard placed on	2 830		

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2 830	Continued From page 17 left wrist, staff or family to supervise all outdoor activities, and family to sign R2 out in facility book before leaving. The care plan did not identify interventions that included needed level of supervision, identification and monitoring of behaviors/triggers/risk factors for elopement, or related management. R2's record lacked evidence she was comprehensively assessed for elopement risk prior to or on 5/16/25 despite her successful elopement from the facility that day. R2's record did not identify her needed level of supervision or appropriate interventions apart from placement of a Wanderguard. R2's record did not indicate how documented confusion, delusions, hallucinations, restlessness, agitation, visual and communication deficits, impulsivity, seeking behaviors and verbalizations, and desire to go home were comprehensively assessed, monitored, or mitigated to decrease related risk of elopement. R2's Elopement Risk assessment completed three days after R2 eloped dated 5/19/25, included R2 had made one previous attempt to elope on 5/16/25 when she ambulated unassisted to a neighbor's house across the street. The assessment identified she had a Wanderguard on her left wrist and she was a risk for elopement related to recent elopement. The assessment did not include or identify R2's documented cognitive deficit of intermittent confusion and conditions contributing to elopement risk of delusions, agitation, new medications within past 30 days, visual deficits, communication deficits, and REM sleep behavior disorder. The assessment did not identify R2's documented behaviors of impulsivity, agitation, restlessness, seeking behaviors, and verbalizations of looking for someone and seeking people. Further, the assessment failed to	2 830		

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2 830	Continued From page 18 identify R2's needed level of supervision or interventions to mitigate identified risk of elopement apart from placement of a Wanderguard. During an interview on 5/19/25 at 1:30 p.m., R2 stated she had a Wanderguard on her wrist and R2's family member (FM)-A, noted it was placed the day before yesterday (5/17/25). FM-A stated this was placed because she had left the facility, and staff didn't know where she was for a few minutes. R2 stated she had been dreaming that she had to get away and ran out the door a block away barefooted even though she had been unable to walk on her own with therapy. FM-A stated this was confusing because most of the time she couldn't walk without her walker. R2 stated there was a man sitting outside at a house across the street and she used his phone to call 911, but did not remember why she called. FM-A indicated he was present when she returned to the facility, staff assessed her, and he stayed with her until she fell asleep. R2 stated they put the Wanderguard on her after that and she hadn't tried going outside since then (since 5/16/25). FM-A stated R2 had good days and bad days with memory due to her dementia and Parkinson's. Sometimes her moods were like a light switch and she would suddenly get quiet with a drained look and not say anything. R2's progress note dated 5/17/25 at 3:08 a.m., indicated R2 wheeled herself out of her room and around the common area. R2's behavior progress note dated 5/17/25 at 9:02 p.m., indicated she was seen by staff twice walking down the hall with her walker unassisted on the evening shift.	2 830		

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2 830	Continued From page 19 R2's progress note dated 5/18/25, identified her thinking was disorganized. During an interview on 5/19/25 at 3:28 p.m., nursing assistant (NA)-E stated she knew if someone was an elopement risk because they would usually have a Wanderguard on and be on a list posted at the nursing station of residents who could not be left outside unattended. NA-E stated R2 was very confused all the time and always thinks she's going to go home. NA-E saw R2 yesterday (5/18/25) with all of her in clothes in her hands and the hangers taken off. R2 was confused since she admitted to the facility and was always trying to get out, wheeling herself around, didn't sleep, and couldn't sit still. R2 once thought it was time to go to bed at 2:00 p.m. R2 would wheel around and say she was going to go home mostly during the night, beginning around 6:00 p.m. when she would start to get anxious and confused. NA-E noted R2 was "like fogged out" and you could talk to her and she wouldn't respond at times. Staff knew Wanderguards worked when residents got close to the door, though there had been trouble recently where sometimes doors would alarm when a resident with a Wanderguard touched it and sometimes they would not. R2's progress note dated 5/19/25, indicated she had forgetfulness, signs of short-term memory loss, and disorganized thinking. R2's progress note dated 5/19/25, identified it was follow-up on the elopement note. A Wanderguard had been placed on her left wrist with orders to monitor placement and functioning and replace routinely, which was also added to her care plan. Diagnoses that could have contributed were identified as altered mental	2 830		

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2 830	Continued From page 20 status, Parkinson's disease, dementia, and amnesia. A new elopement assessment had been completed. During an interview on 5/19/25 at 3:12 p.m., NA-D was not aware if R2 was an elopement risk and did not know R2 had a Wanderguard. NA-D knew if a resident had a Wanderguard because it would be on the resident, reported to staff, and on the care plan. NA-D knew who was at risk of elopement because it was reported to staff and the facility had a Wanderguard system that would detect when an at-risk resident was close to a door so staff could intervene and redirect. During an interview on 5/19/25 at 3:47 p.m., licensed practical nurse (LPN)-A stated residents at risk of elopement had Wanderguards and this was care planned and on the treatment administration record (TAR). LPN-A stated R2 was absolutely an elopement risk and had eloped on 5/16/25. LPN-A noted R2 would walk by herself outside of her room without a walker or footwear, stroll around in her wheelchair, and get antsy. LPN-A noted R2 had more behaviors at night. R2's elopement progress note dated 5/20/25, indicated R2 was sitting calmly in her wheelchair by the nursing station after receiving her pills at 9:10 p.m. RN-A went to the kitchen to put a meal tray away at approximately 9:30 p.m. at which time R2 remained in her wheelchair in the common area watching the birds. At approximately 9:40 p.m., RN-A returned to the nursing station and R2's wheelchair was still there but R2 was gone. RN-A began searching for R2 and alerted all staff, the DON, 911, and family. At approximately 10:20 p.m. the facility received a call from the police stating R2 had been found	2 830		

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2 830	Continued From page 21 seven or eight blocks away, had fallen, did not appear injured, and would be transported to the emergency department for follow up. R2's emergency department hospital After Visit Summary dated 5/21/25, indicated she was discharged from the hospital and back to the facility. Imaging, labs, and tests looked "good." Referrals were placed for memory care and in the meantime, it was okay for R2 to return to the facility. There were no new orders and no noted injuries. The facility's Nursing Home Incident Report #360607 dated 5/20/25, was submitted to the state agency (SA) and identified R2 had eloped that evening. The incident description included "Resident was discovered to not be in room, and subsequent search did not immediately show that she was in facility. Staff say they heard no alarms from the doors, which were armed at the time." During an interview on 5/23/25 at 10:30 a.m., RN-A stated she was working on 5/20/25 when R2 eloped. RN-A noted R2 was sitting and watching the birds when RN-A left the nursing station to go to the kitchen. RN-A stated upon her return approximately 10 minutes later, R2's wheelchair was still there but R2 was gone. RN-A stated the Wanderguard door alarms had not gone off, she was not aware R2 was missing until she returned and saw R2 missing. RN-A called 911, staff began to search, and police called the facility informing RN-A that R2 was found seven to eight blocks away, had stated she fell down, and would be transported to the emergency department. R2's Elopement Risk assessment dated 5/20/25, included R2 had made previous successful	2 830		

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2 830	Continued From page 22 elopement attempts with frequency of one time event and note that R2 eloped five days ago and did elope again that evening, leaving the facility and ambulating seven or eight blocks away without walker or wheelchair. The assessment noted R2 had a Wanderguard on her left wrist "due to elopement." The analysis section noted the circumstances of the elopement documented in progress note dated 5/20/25 and noted "No pain or discomfort reported before the elopement. wander guard was [on, sic] her left wrist and works properly." The assessment failed to comprehensively or accurately identify all of R2's cognitive deficits, conditions and diagnoses contributing to elopement risk, and behaviors and verbalizations. Further, the assessment failed to identify R2's needed level of supervision or interventions to mitigate identified risk of elopement apart from placement of a Wanderguard. R2's elopement care plan was revised with new interventions on 5/20/25 that included: check placement of Wanderguard every shift, check function of Wanderguard daily, check expiration date of device; notify team (nursing, activities, housekeeping, dietary, social services) if I am observed to be wandering, purposeful wandering, or stating things such as "I'm leaving," "I need to find **," "I am calling 911." R2's cognition care plan dated 5/20/25, identified R2 had impaired cognitive function/dementia or impaired thought processes. Interventions directed staff to cue, reorient, and supervise as needed (was not defined) and monitor/document/report as needed any changes in cognitive function. Additional intervention dated 5/20/25, for focus of psychotropic medication directed staff to identify target behaviors for	2 830		

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2 830	Continued From page 23 monitoring/recording including wandering. R2's elopement care plan failed to identify her needed level of supervision or interventions to mitigate the identified risk of elopement apart from presence of a Wanderguard. The care plan identified the need to notify various individuals if wandering behaviors or verbalizations were noted, but did not identify how to manage/respond to these behaviors or mitigate the associated risk of elopement. During an interview on 5/20/25, the facility's nurse manager, RN-C, stated residents were assessed for elopement risk on admission, with significant changes, annually, and as needed. A resident would be re-assessed if there was new or increased wandering, exit-seeking, or talk about leaving and should be done as soon as staff were aware of the behavior. Nurse managers completed the elopement risk assessments, but any nurse could do it. The assessment would be filled out and the nurse would "make a decision" about whether or not a person should have a Wanderguard on. RN-C stated she utilized the elopement risk assessment to determine if a resident needed a Wanderguard. There was no threshold on the assessment for when to place a Wanderguard or when someone was identified as an elopement risk, it was not an "objective scale." RN-C stated she completed R2's initial elopement assessment dated 4/30/25. RN-C stated the assessment should have identified R2's communication deficit, adjustment to a new environment, altered mental status, amnesia, and REM sleep behavior disorder because they contribute to elopement risk. If she had identified the aforementioned items on assessment, she "would have identified her [R2] as an elopement risk" and would have care planned this, though	2 830		

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2 830	Continued From page 24 may not have applied a Wanderguard at that time. RN-C stated she had viewed the assessment as "does she need a Wanderguard ... not so much risk" and would be looking at it differently in the future. RN-C confirmed the assessment was not accurate. She reviewed R2's progress notes, stated R2 was completely disoriented at night and exit-seeking, and R2 should have been re-assessed for elopement risk on 5/5/25 when she called 911 looking for her grandson because this was verbalizing looking for/seeking someone. RN-C noted ongoing progress notes prior to 5/16/25 identifying wandering behaviors and R2 should have been reassessed when she started having behaviors. RN-C stated a Wanderguard should have been applied when R2 started wandering at night and this would have helped to mitigate her risk of elopement. RN-C stated it wasn't applied until after her elopement on 5/16/25 and confirmed no other interventions to mitigate risk of elopement were implemented. RN-C confirmed she did not see any comprehensive assessment to determine R2's needed level of supervision and "we did not assess for her level of supervision or put any interventions in place." RN-C noted if the Wanderguard system was not functioning properly, then the facility had no interventions in place. She was unaware the Wanderguard system was not functioning properly and did not think R2's current level of supervision was adequate, especially at night. Further noted R2 eloped on 5/16/25 and should have been re-assessed for elopement risk that evening once she was back in the building, but confirmed an assessment was not completed until 5/19/25. During observation and interview on 5/20/25 at 8:44 a.m., Environmental Services Director (ESD) stated the five doors with Wanderguard systems	2 830		

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2 830	Continued From page 25 were tested daily using an extra Wanderguard device signaling bracelet to ensure the system was working properly. The ESD noted the tests were recorded in a logbook but, upon review of the logs, stated they had not been completed consistently. The ESD and surveyor proceeded to test the five doors with an extra Wanderguard bracelet and found the following: four of the five doors did not alarm when the Wanderguard bracelet was in proximity of the door alarm, and one of the five doors did not alarm when passed through with the bracelet with the doors already opened by the automatic door button. During a follow up interview at 3:15 p.m., ESD stated he was not aware of any current issues with the Wanderguard system prior to this testing including both alarms not sounding due to Wanderguard bracelet proximity and the ability to exit a door without an alarm sounding. The ESD was not aware of how long these issues had been going on, no concerns had been reported by staff completing routine daily door testing. In a subsequent interview on 5/23/25 at 12:14 p.m., ESD stated the Wanderguard system had been inspected by a technician on 5/21/25 and a "dead spot" of about one foot on two of the five doors was identified. ESD stated if a resident with a Wanderguard bracelet exited through these doors the alarm would not sound because of the area of not reading the bracelet. New antennas and control box were installed to remove the area where the bracelets were not detected. During an interview on 5/20/25 at 10:35 a.m., the administrator stated staff relied on the Wanderguard system to know if a resident at risk of elopement had left the building. Staff would know because of the beeping at the doors from the Wanderguard alarms. Administrator acknowledged the system had failed. She noted	2 830		

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2 830	Continued From page 26 the doors were tested daily by maintenance and she would expect the system to be tested in accordance with manufacturer recommendations. She would expect the Wanderguard system to be functional 24 hours per day seven days per week and a resident with a Wanderguard should not be able to get through the door without the alarm sounding. She noted the doors should be set up to alarm when a resident's Wanderguard device was in proximity, not only upon the door being opened. Administrator was not aware that it was currently possible, as established by the surveyor and maintenance testing the doors, to get a Wanderguard bracelet through a door without it alarming or to approach a door without it alarming. This was "horrifying" and possibly how R1 was able to elope from the facility. If the door did not alarm, staff wouldn't be aware that a resident had eloped until they were noted to be missing. "We obviously need to fix our system". In the absence of a functioning system, staff would check on residents who were elopement risks but that was probably not realistic because the facility was a "big place." Staff would not be able to adequately supervise residents with Wanderguards the way they needed to or keep the residents safe without the Wanderguard system functioning correctly. During an interview on 5/23/25 at 3:50 p.m., the director of nursing (DON) stated when R2 was first admitted to the facility she was not an elopement risk. The DON noted when R2 began wandering and had an increase in behaviors, she should have been re-assessed with her risk for elopement identified, increased supervision implemented, and care plan updated. The DON stated R2's elopement risk assessments were not completed accurately because they failed to identify predisposing and contributing factors and	2 830		

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2 830	Continued From page 27 therefore were not comprehensive. During an interview on 5/20/25 at 10:35 a.m., the administrator stated she would expect residents to be comprehensively assessed for elopement risk and believed this was done by reviewing notes from a new resident's referral papers for exit seeking behaviors and completion of a Brief Interview for Mental Status (BIMS) assessment by social work or therapy. She would expect re-assessment if a resident had a significant change and quarterly. A significant change would be a behavioral change such as wandering towards the doors or trying to open them, or a significant change in behavioral or medical condition. The administrator could not articulate how residents were comprehensively assessed for elopement risk and supervision needs. The immediate jeopardy that began on 5/8/25, was removed on 5/23/25, and was verified through observation, interview, and document review when the facility implemented the following interventions: - Reviewed policies and procedures related to elopement, elopement assessments, and Wanderguard system. - Identified residents at risk of elopement by completing comprehensive elopement risk assessments with development, implementation, and care planning of appropriate interventions aside from Wanderguard devices. - Educated all licensed staff on elopement risk assessments and development/implementation of appropriate immediate interventions. - Educated all facility staff on residents at risk for elopement. - Ensured Wanderguard system was functioning for all exits and repaired doors identified as not functioning as intended.	2 830		

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2 830	Continued From page 28 - Educated ESD and designee on testing of Wanderguard system per manufacturer recommendations. - Elopement training was completed for all staff including: identifying residents at risk and appropriate notification, procedures to follow for residents have Wanderguards including testing, and procedures in the event of an elopement. Facility policy titled Elopement dated 8/1/22, identified the facility would "assess each resident and if identified at risk for wandering or elopement, will implement measures to properly and safely address their care needs to prevent elopement." Procedure included, "A.) All residents will be assessed on admission for risk of wandering or elopement. B.) At any time a resident is identified at risk for elopement, an elopement assessment will be completed and a plan put into place, which will include the resident's: a. Cognitive status b. Ambulation and mobility status (if independent in ambulation or wheelchair mobility, and/or able to open the door independently, may be at higher risk) c. History of wandering and/or attempts to leave the building d. Wandering patterns (how often/where/time of day/duration) e. Supervision required to leave the building. Interventions to prevent elopement may include any of the following: Room located close to the Nurse' station or further from the exit door, ii. More frequent checks or at specific times of the day iii. Assessed by RT and in activity programs during high wander times iv. Wanderguard bracelet on the resident's person or equipment, such as walker or wheelchair, to alert staff if the resident is attempting to leave the building. g. The nurse will enter this plan into the resident's care plan in the electronic medical record (EMR) ... Suspected elopement: ... B.) When the resident who eloped is located: a. Complete a medical	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00917	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 29 evaluation to identify potential injuries. b. Notify family and persons previously contacted. c. Notify the physician. d. Conduct an investigation to determine how the elopement occurred in order to correct any underlying contributing factors. e. Complete an "Incident Report" and document incident in the medical record. f. Report the 'elopement' incident to the state agency (MDH) as 'potential Neglect'. C.) In the event of an elopement, a care center wide audit will be completed including: a. Ensuring all resident's wanderguards are functioning properly b. Checking all doors with wanderguard alerts to ensure functioning properly c. Checking that all residents have daily wanderguard checks completed in the eMAR d. If needed., update any resident's elopement/safety care plans e. If needed, provide education to care center staff to ensure resident safety." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review/revise policies and procedures on elopement and the Wanderguard system. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could audit to ensure all residents are comprehensively assessed for elopement risk with development and implementation of appropriate interventions. The administrator, DON, or designee could also audit to ensure the Wanderguard system is tested, maintained, and functions in accordance with manufacturer recommendations. The results of these audits could be reported to their QAPI committee to ensure compliance and determine the need for continued process and systems monitoring. TIME PERIOD FOR CORRECTION:	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 30 Twenty-one (21) days.	2 830		