Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2025

Administrator
Central Health Care Center
444 NORTH CORDOVA
LE CENTER, MN 56057

RE: CCN: 245401

Cycle Start Date: August 5, 2025

Dear Administrator:

On August 21, 2025, we notified you a remedy was imposed. On September 3, 2025, the Minnesota Departments of Health 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 08/06/2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective 09/05/2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 21, 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 08/05/2025. 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,

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

September 12, 2025

Administrator
Central Health Care Center
444 NORTH CORDOVA
LE CENTER, MN 56057

Re: Reinspection Results
Event ID: 1D298E-H2

Dear Administrator:

On 09/03/2025 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 08/05/2025. At this time these correction orders were found corrected.

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

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
August 21, 2025

Administrator
Central Health Care Center
444 NORTH CORDOVA
LE CENTER, MN 56057

RE: CCN: 936540100
Cycle Start Date: August 5, 2025

Dear Administrator:

On August 5, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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 August 5, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 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 September 5, 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 September 5, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 5, 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 5, 2025. This prohibition is not subject to appeal. 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.

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, Central Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 5, 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 February 5, 2026 (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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245401**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Health Care Center	**444 NORTH CORDOVA , LE CENTER, Minnesota, 56057**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/31/25, 8/1/25, and 8/5/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54014127C (MN00112800) with a deficiency issued at F689 and F842. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to immediately respond to a wandergard door alarm, which was sounding, allowing 1 of 1 resident (R1) to get half a mile away from the facility before being found. The IJ began on 5/3/25, and the immediacy was removed on 8/5/25. The above findings constituted substandard quality of care, and an extended survey was conducted. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		08/01/2025
F0689 SS = SQC-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	F0689	A formal Elopement Policy and Procedure, including: · Definitions and identification of elopement and wandering behavior · Required interventions for at-risk residents · Staff roles and responsibilities in prevention and response · Detailed response procedure · Monthly audits and staff retraining requirements	08/06/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245401	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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F0689 SS = SQC-J	Continued from page 1 accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review, the facility failed to conduct comprehensive elopement risk assessments for 2 of 3 residents (R1, R3) identified as an elopement risk. Additionally, the facility did not promptly respond to a sounding Wanderguard alarm or ensure proper functioning of alarmed exit doors. This resulted in an immediate jeopardy when R1 left the facility and was found half a mile from the facility. The IJ began on 5/3/25, when it was identified R1 had eloped through the facilities south door, with the alarm sounding and walked 0.5 miles away from the facility. On 8/1/25 at 1:26 p.m., the director of nursing (DON) and business office manager were notified of the IJ. The IJ was removed on 8/5/25 at 12:55 p.m., after it could be verified the facility had implemented an acceptable removal plan. However, non-compliance remained at a D for isolated scope and severity which indicated no actual harm, with potential for more than minimal harm. Findings include: R1's face sheet dated 7/31/25, identified R1 admitted to the facility 4/2025, with diagnoses of dementia (decline in cognitive function), morbid obesity (overweight), aphasia (language disorder that affects communication and comprehension), and signs and symptoms involving cognitive functions and awareness (encompass a range of mental processes including memory, attention, language, and problem-solving abilities). R1’s admission Minimum Data Set (MDS) dated 4/21/25, identified R1 did not talk and was rarely/never understood but sometimes understood others. R1 had severely impaired daily decision-making skills. Wandering occurred 1-3 days but did not trigger a significant risk of getting to a potentially dangerous place or outside of the facility but intruded on privacy/activities of others. R1 was able to walk without assistive devices, dependent on staff for lower body dressing and substantial assistance with upper body dressing. R1’s Brief Interview for Mental Status (BIMS) dated 4/21/25, identified R1 was unable to complete the interview, which indicated staff completed the interview and identified a memory problem with short- and long-term memory, and moderate impairment with	F0689	Continued from page 1 Development and implementation of Elopement Risk Assessment Tool which included: · Tool considers history of wandering, cognitive status, behavioral indicators, and functional mobility · All residents were assessed using this tool by nursing leadership · Results of assessments were reviewed with Interdisciplinary Team (IDT) and incorporated into resident care plans · Elopement risk assessment to be completed upon admission, quarterly, and PRN upon any changes noted. Information obtained to be used in creating an individualized care plan Care plan revisions: · For all residents identified at risk for elopement, individualized care plans were updated to include: clear, tailored interventions (room location, increased checks, redirection strategies); use and maintenance of Wanderguard devices, diversional activities and environmental controls, updated completed and singed by IDT Wanderguard and Door alarm monitoring procedure: · Weekly door and wander guard system inspection protocol has been established and incorporated into the facility maintenance schedule · Maintenance will test each wander guard enabled door weekly and document results in a newly implemented door alarm inspection log · Nursing staff are required to verify wander guard functionality at the beginning of each shift and document it · All staff to be educated on immediate alarm response time to decrease the potential risk to the resident for harm. Staff education and re-training: · All staff educated on: revised elopement policy and procedure, use of the elopement risk assessment tool, wander guard system checks and documentation, emergency response protocols for elopement; training included scenarios and drill; attendance logs and training on file, new hires will receive this training during	

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F0689 SS = SQC-J	Continued from page 2 decisions. R1 did not have a comprehensive elopement risk assessment completed. R1's care plan dated 4/24/25, identified behaviors related to dementia and at risk for wandering. Interventions included: address wandering behavior by walking with or attempt to redirect from inappropriate area, engage in divisional activity (4/16/25); intervene wandering as needed to protect rights and safety of others, approach in a calm manner, divert attention, remove from situation/take to another location (4/16/25); Wanderguard placed on ankle, staff to ensure placement each shift (4/16/25). R1's physician orders dated 4/15/25, identified a Wanderguard was placed on left ankle and make sure Wanderguard was in place and functioning daily. Additional orders dated 4/23/25, identified to document frequency of R1 wandering into other resident's rooms and if R1 was redirectable. R1's progress notes from 4/15/25-5/2/25, identified R1 wandered into other resident rooms and walked a significant amount around the building. R1 was not always redirectable for staff. R1's progress note dated 5/3/25 at 2:49 p.m., identified at approximately 10:46 a.m., R1 eloped from the facility via the south door. The alarm was sounding. NA-A notified by a resident that R1 had walked past her door but did not come back around and pass her door again. NA-A alerted staff of elopement. Staff searched outside, asked community members that were in the area, and were directed on where R1 was seen. R1 was assessed for injuries and offered water upon return to facility, Wanderguard assessed and working properly. South door examined and noted that it would not sound if the door was not fully closed. R1 placed on 15-minute checks. Physician, family member, and DON notified of incident. R1 was found as 0.5 miles from the facility. The Weather Channel identified the temperature on 5/3/25 to be ranged from 60-79 degrees Fahrenheit with stray thunderstorms. R1's Resident Safety Assessment dated 5/3/25, identified 15-minute checks began on 5/3/25 at 11:45 a.m., and ended on 5/13/25 at 10:00 p.m. when the door was fixed. During an observation on 7/31/25, R1's room was located	F0689	Continued from page 2 orientation Monitoring and Quality Assurance: · The Quality Assurance and Performance Improvement (QAPI) committee will: review all elopement related incidents monthly, audit 10 elopement risk assessments and care plans weekly for 8 weeks, then monthly for four months, audit door alarm logs and shift wander guard checks weekly, results will be reviewed during monthly QAPI meetings, corrective actions will be implemented for any identified deficiencies	

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F0689 SS = SQC-J	Continued from page 3 on the north hall, near the nurses station. At 9:37 a.m., activity staff was observed walking down the hall and met R1, who was walking the north hall independently and began to dance next to him down the hall. At 9:41 a.m., R1 walked to the end of the hall and entered the chapel, with an exit door and keypad next to the door, R1 sat in a recliner. No staff were present in chapel. Another resident was looking out the window, next to the exit door. R1 appeared short of breath and had a white band sticking out of the top of his right sock, consistent with a Wanderguard bracelet. At 9:45 a.m., R1 stood up and went to the exit door and looked out the glass door, turned around and began walking back down the hall. At 9:55 a.m., R1 continued to walk down hallways. During a phone interview on 7/31/25 at 3:26 p.m., housekeeper (HSK)-A stated she witnessed R1 walking around the facility earlier in the morning on 5/3/25. HSK-A heard the noise of the alarm, and saw all the nurses were looking around and checking rooms. HSK-A was alerted a resident was missing. HSK-A left the facility and went toward the park. HSK-A saw people at the park and asked if they had seen a person matching R1's description. HSK-A was directed in the direction R1 was seen. HSK-A caught up to R1 between the library and the post office. HSK-A called the facility informed licensed practical nurse (LPN)- where they were and that she was going to stay with R1. NA-C brought a wheelchair. A nurse and two other nursing assistants also arrived to HSK-A's location. During an interview on 7/31/25 at 10:13 a.m., NA-B stated the Wanderguard helps to tell staff when a resident goes outside because the door alarm will go off. The door would alarm and lock if a resident with a Wanderguard got too close, and a code was needed to open the door and turn off the alarm. The south hall was a high traffic area with an exit door. NA-B stated there was no way the door would open with a Wanderguard. It was possible a person exited from that door and R1 managed to leave. R1's wife would take him outside, but facility staff does not because they did not know if R1 would come back inside willingly. R1 went room to room in the halls and staff just keep an eye on him. On 5/3/25, NA-B did not hear the alarm sounding and stated a person needed to be down the south hall or in the lobby to hear the alarm. NA-B was informed the south alarm was sounding, R1 was missing, and no one saw R1 exit the building. The search began room to room looking for R1. One staff member got in a car and drove to R1's location as reported by someone in the community. NA-B was unsure how long R1 was missing but he was several blocks away and was	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245401	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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Central Health Care Center	**444 NORTH CORDOVA , LE CENTER, Minnesota, 56057**

(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
F0689 SS = SQC-J	Continued from page 4 difficult to get him to come back to the facility. After R1 was back in the facility he was on 15-30 minute checks. NA-B did not receive re-education from the facility after the incident. During phone call on 8/1/25 at 8:27 a.m., NA-A stated R1 would lay on his bed and sometimes walk around the building. On 5/3/25, NA-A went to answer a call light on the south hall, and heard the south door alarm sounding. The south hall door was closed. NA-A looked down the south hall first and then saw RN-C and asked RN-C to walkie talkie for staff to look for R1 down the other halls. NA-A looked down her assigned halls and another NA and RN-C looked down the other hall. Sometimes, R1 would wander through the employee doors so NA-A went down to the laundry room and R1 was not in there. NA-A went outside and looked around the parking lot and did not see R1. Someone outside the facility told HSK-A R1 was down by the post office and HSK-A found R1. NA-A ran down the road and could see HSK-A with R1 slowly walking back to the facility. R1 was on 10-20 minute checks for at least the day or next couple of days. When registered nurse (RN)-B was interviewing staff after the incident, she had the south door slightly open and in the 45 minutes it was open the alarm did not go off and that was how we thought it was the door. Although the facility knew the door alarmed, they had not checked outside of the building but checked inside the facility first. During a phone call on 8/1/25 at 9:54 a.m., NA-C stated staff go in and out of the south door a lot. NA-C was working in the laundry department and was in the backroom on 5/3/25. R1 was an elopement risk because he constantly walks the facility. NA-A came into the laundry room looking for R1. NA-C did not hear the alarm. NA-C immediately went to the main lobby and heard the south alarm going off. NA-C immediately went outside and started looking around the premises. NA-C heard HSK-A had found R1 and went to meet up with them. R1 looked really tired and exhausted so NA-C ran back to the facility and got a wheelchair and wheeled it back to R1 and HSK-A. R1 walked most of the way back, it was probably the last four blocks that R1 decided to sit in the wheelchair and ride back. NA-C was aware R1 had 15-minute checks the rest of the day and the maintenance director (MND)-A was called to check the south door because of the latch and staff were to make sure the door was latched when coming and going. NA-C was unaware of any education provided after the incident. During a phone interview on 8/1/25 at 10:07 a.m., NA-D stated 5/3/25 was her first shift at the facility and	F0689		

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F0689 SS = SQC-J	Continued from page 5 she had not had training on alarms or elopement. NA-D arrived at 5:30 a.m., and R1 was awake and walking the halls. NA-D noticed R1 was walking around the facility and checking the doors and staff told her that R1 had been up doing that all night. NA-D was in a room with a resident on the south hall and stated she kept hearing what sounded like an alarm, "beep, beep, beep." NA-D was unsure what it was. NA-D was told by another NA, a resident got out of the building. Staff went room to room and when they could not find R1, went outside. A community member took a staff person down to R1. NA-D was unsure if the facility had an elopement plan for R1 but knew he should not exit the facility alone because he had the Wanderguard on. During a phone interview on 8/1/25 at 8:53 a.m., LPN-A stated the south door alarm is not as loud as the main entrance alarm but it can be heard at the nurses station and down the halls. There was no specific elopement procedure, usually staff are assigned to halls to search bathrooms, closets, everywhere and alert staff if the resident was found. At the time of the incident on 5/3/25, RN-C and an NA had been in a room with the door closed on the north hall. LPN-A was on the east hall providing a treatment to another resident when RN-C called to her on the walkie-talkie system to come to the front desk right away. LPN-A was unsure of the specific time RN-C called her but thought it was around 10:00 a.m. LPN-A went to the front desk and RN-C stated they were looking for R1. The south door alarm was sounding. LPN-A stated she and RN-C started to think maybe R1 went outside with someone as he had a tendency to go in the activity room, which was located on both sides of the south door and other resident rooms. Dietary, housekeeping, laundry, and nursing departments all looked for R1. LPN-A stayed inside the building by the nurses station and her assigned hall as RN-C went outside the facility. A staff person walkie-talkie they saw R1 and that is how LPN-A knew he was found. R1 was brought back to the facility in a wheelchair, he was exhausted. LPN-A completed a full set of vital signs, gave water, checked R1's feet for blisters, and began 15-minute checks upon return. RN-C notified RN-B of the incident. LPN-A did not notify the police of the incident. During an interview on 7/31/25 at 9:50 a.m., RN-A stated R1 wandered around the facility and into other resident rooms. RN-A recalled R1 was placed on 15-minute checks after he eloped on 5/3/25, as the facility determined the south door he exited from did not latch properly. RN-A thought the 15-minute checks continued until the south door was fixed. RN-A was not aware of precautions put in place for the other	F0689		

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F0689 SS = SQC-J	Continued from page 6 resident (R2) that resided in the facility on 5/3/25 and had a Wanderguard. RN-A was unaware of any education or facility drills completed on elopement after the incident. During a phone interview on 8/1/25 at 10:43 a.m., RN-C stated she was not sure if the facility had an elopement assessment. RN-C had noticed R1 going to doors and pushing on them a couple of times on the morning of 5/3/25. When R1 eloped on 5/3/25, RN-C was assisting with a transfer in another resident's room. When they finished the transfer and left the room, they heard the door alarm sounding. RN-C immediately thought of R1, and her and the aide went to R1's room and he was not in there. RN-C and the aide looked around for R1 and RN-C used the walkie-talkie and notified LPN-A that the door alarm was sounding, and they could not locate R1. Staff were notified via walkie-talkie that R1 was missing. There was not a specific procedure that was followed, everyone just scrambled. LPN-A was more familiar with the facility and directed staff where to look. R1 was found by the post office. A NA met up with the staff that found R1 and once RN-C knew R1 was found and where the location was, RN-C met up with R1 and the staff and walked with them towards the facility. Another staff member brought a wheelchair because R1 appeared very tired and R1 sat in it and was transported back to the facility. R1 had a full body exam for injuries and 15-minute checks were initiated. LPN-A notified the nurse practitioner. RN-C was unaware if the police were notified but knew she had not notified them. A sign was placed on the south door to make sure it shut completely if you go in or out of it until it was fixed. The facility thought the south door was ineffective and that was how R1 was able to get out. During a phone interview on 8/1/25 at 10:24 a.m., RN-B stated the facility does not have a formal assessment for elopement risk. If a resident attempted to leave the facility, that was when a Wanderguard was put on. The door system will lock and an alarm will sound when a resident attempts to open the doors. R1 wandered the facility daily and frequently pushed on exit doors. On 5/3/25, LPN-A called RN-B, who was the designated on-call nurse at the time and notified her R1 had eloped and was already back at the facility. RN-B recalled R1 had walked out the south door, staff heard the alarm and started looking for R1. Staff did not see R1 anywhere nearby or on facility grounds. Some staff saw community members in the nearby park and approached them and asked if they had seen R1, and they had and pointed the direction R1 went. HSK-A was able to see R1 in the distance and communicated to LPN-A that R1 was	F0689		

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F0689 SS = SQC-J	Continued from page 7 found but was a distance ahead of her. HSK-A caught up to R1 and was able to convince him to turn around and began walking back with him. Another staff came with a wheelchair and R1 sat in it and was wheeled back to the facility. LPN-A checked R1's vital signs and gave water to hydrate. No injury was noted to R1's body during physical exam. RN-B investigated the south door Wanderguard function. There were times where the door would not fully latch so RN-B notified MND-A of her findings. RN-B had staff initiate 15-minute checks for R1 while the door was not functioning. RN-B was not concerned about initiating 15-minute checks for R2 as R2 had a motion sensor alarm placed while he was in his room and staff always escorted him to and from the dining room, where he remained supervised. RN-B was not aware if anyone checked the functionality of the door alarms on a regular basis. During an interview on 8/1/25 at 10:59 a.m., maintenance director (MND)-A stated he was unaware when the Wanderguard door system was installed but it was prior to him working at the facility and he had been the maintenance director for at least a year. MND-A thought there were five doors with the Wanderguard system on them. The facility had never had a maintenance plan in place for the doors to be checked as far as MND-A was aware and the doors had never been checked and he did not keep a log. MND-A was made aware of the door not properly latching on 5/3/25. MND-A adjusted the door and hinges and ordered a new hydraulic closer. MND-A was unsure when the door was fixed but thought it was probably within that week. The facility amazon order dated 5/19/25, identified an order for a Dynasty Door Closer, commercial grade size 4 spring, hydraulic automatic series 4000 Door Closer Sprayed Aluminum was ordered on 5/19/25, shipped to the facility on 5/20/25. The facility did not identify when the order arrived at the facility. During an interview on 8/1/25 at 9:33 a.m., DON stated the facility has never done elopement risk assessments. During a subsequent interview at 11:11 a.m., DON stated the facility determined if a resident is at risk for elopement upon admission when they talk with the family, or if they are a known wanderer from information obtained from the hospital or facility resident transferred from. After R1 returned to the facility staff gave him fluids, performed a skin check, completed vital signs, and placed him on 15-minute checks to ensure it would not happen again. To mitigate elopement, interventions in the care plan include distraction, activity, staff interaction, redirection, typical dementia type interventions included to deter	F0689		

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F0689 SS = SQC-J	Continued from page 8 them going in that direction. The Wanderguard company was not notified to assess the system as the facility felt it was the hydraulics leaking and the door was not locking, it was slightly ajar, so R1 was able to get out. If the door had been working properly it would have locked and stayed locked so R1 would not have been able to leave the facility. The facility does not test the doors to make sure the Wanderguard system is working properly. The facility had an elopement policy, staff communicated on walkie-talkies, and each nurse should take their assigned NA's, have them do an all-clear check when an alarm went off. R1 was removed from 15-minute checks on 5/13/25 as maintenance had done repair on the door hinge that allowed the door to shut securely while waiting for the hydraulic part. Since the door was able to close, staff felt R1 was safe, and he was removed from 15-minute checks. The IJ was removed on 8/5/25, when the facility revised and implemented the following that was verified through staff interview on 8/5/25. A formal Elopement Policy and Procedure, including: · Definitions and identification of elopement and wandering behavior · Required interventions for at-risk residents · Staff roles and responsibilities in prevention and response · Detailed response procedure · Monthly audits and staff retraining requirements Development and implementation of Elopement Risk Assessment Tool which included: · Tool considers history of wandering, cognitive status, behavioral indicators, and functional mobility · All residents were assessed using this tool by nursing leadership · Results of assessments were reviewed with Interdisciplinary Team (IDT) and incorporated into resident care plans · Elopement risk assessment to be completed upon admission, quarterly, and PRN upon any changes noted. Information obtained to be used in creating an individualized care plan	F0689		

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F0689 SS = SQC-J	Continued from page 9 Care plan revisions: · For all residents identified at risk for elopement, individualized care plans were updated to include: clear, tailored interventions (room location, increased checks, redirection strategies); use and maintenance of Wanderguard devices, diversional activities and environmental controls, updated completed and singed by IDT Wanderguard and Door alarm monitoring procedure: · Weekly door and wander guard system inspection protocol has been established and incorporated into the facility maintenance schedule · Maintenance will test each wander guard enabled door weekly and document results in a newly implemented door alarm inspection log · Nursing staff are required to verify wander guard functionality at the beginning of each shift and document it · All staff to be educated on immediate alarm response time to decrease the potential risk to the resident for harm. Staff education and re-training: · All staff educated on: revised elopement policy and procedure, use of the elopement risk assessment tool, wander guard system checks and documentation, emergency response protocols for elopement; training included scenarios and drill; attendance logs and training on file, new hires will receive this training during orientation Monitoring and Quality Assurance: · The Quality Assurance and Performance Improvement (QAPI) committee will: review all elopement related incidents monthly, audit 10 elopement risk assessments and care plans weekly for 8 weeks, then monthly for four months, audit door alarm logs and shift wander guard checks weekly, results will be reviewed during monthly QAPI meetings, corrective actions will be implemented for any identified deficiencies R3's face sheet dated 8/1/25, identified R3 admitted 5/2025. Diagnoses included anxiety disorder, and dementia.	F0689		

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F0689 SS = SQC-J	Continued from page 10 R3's optional state assessment MDS dated 6/8/25, identified moderate cognitive impairment. No wandering or behaviors. R3 did not have a comprehensive elopement risk assessment completed. R3's care plan dated 5/21/25, identified self-care deficit with interventions requiring assistance of one staff with dressing. A care plan focus dated 5/22/25, identified R3 had diagnoses of dementia, poor memory recall, and anxiety. R3 was new to the facility and needed explanations, reminders, and assistance to attend activities of her choosing. Interventions included offer to sit outside with R3 when the weather is nice. A second focus on 5/21/25, identified R3 had impaired cognitive function related to dementia. Intervention on 7/25/25, identified R3 had a history of wandering away from the facility, order to have Wanderguard on and checked each shift to ensure placement. R3's progress note dated 5/13/25 at 1:00 p.m., identified a nurse-to-nurse report from the hospital. The hospital stated R3 had dementia with sundowning behaviors and does not always know place and time. At 9:12 p.m., R3 became more upset as the night progressed and had no idea why her family “dumped” her at facility. R3's progress note dated 5/17/25 at 1:26 p.m., identified R3 exhibited poor memory recall by forgetting her recent hospital stay as well as reason for residing at facility. R3's progress note dated 6/5/25 at 2:57 p.m., identified R3 was seen pacing back and forth in the hallway, unable to find her room. Walked with R3 towards her room and she was able to remember where it was. R3's progress note dated 6/17/25 at 9:34 p.m., identified R3 experienced confusion, believed she was at work and that she able to walk herself home. R3's physician dictation note dated 6/30/25, identified R3 had increased confusion, which contributed to her long-term residency at facility. R3 does have sundowning, easily redirected. R3's progress note dated 7/1/25 at 8:18 p.m., identified R3 was found outside on the east side of the building. R3 was confused on what door to enter. R3 is able to go outside unsupervised and is alert and	F0689		

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F0689 SS = SQC-J	Continued from page 11 orientated times three and understood that she got turned around. DON and on-call doctor notified and a verbal order was obtained to put a Wanderguard on R3. At 8:24 p.m., a dietary note identified R3 was seen walking on the grass by the dietary office window towards the east end of the building. The dietary director went outside and met R3 who stated she must have gotten lost and was trying to find her way back into the building. Dietary director walked with R3 to the main entrance, sat outside for about 10 minutes, and returned inside the building. R3's progress note dated 7/4/25 at 8:58 p.m., identified R3 was agitated after supper because she could not go outside by herself due to the Wanderguard. Attempted to go outside twice and set the alarm off each time. R3's progress note dated 7/6/25 at 9:47 a.m., identified R3 was upset she could not go outside due to the Wanderguard and would not leave the front door so other residents and visitors could get in or out. At 10:47 a.m., R3 was placed on 15-minute checks due to refusing to put the Wanderguard back on. R3 continued to sit on the bench outside the front door. R3's Resident Safety Assessment for 15 minute checks began on 7/6/25 at 6:00 a.m., two pages that included 15-minute increments of time were provided. The second page, undated had "done" written across it beginning at 10:30 a.m. A handwritten note on the first page dated 7/6/25, identified R3 did not attempt to leave facility when outside. There was no indication R3 had a Wanderguard on at this time. R3's progress note dated 7/7/25 at 12:10 p.m., identified a wanderguard was placed on R3's left ankle. At 3:00 p.m., R3 was upset that the wanderguard was on and just wanted to sit outside. Activity staff sat outside with R3. R3's progress note dated 7/13/25 at 2:43 p.m., identified R3's family member requested the activity department put a schedule together as to when R3 could go outside with them. R3's physician dictation note dated 7/14/25, identified on 7/1/25, R3 was found outside the facility, and it was unclear how long she was outside, though it was believed to be under half an hour. R3 initially went outside to sit and then waked to the other side of the building, attempted to enter through a locked door, which led to some confusion. As a result a Wanderguard was applied. R3 stated when she gets near the door the	F0689		

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F0689 SS = SQC-J	Continued from page 12 alarm goes off and that is scary for her. R3's family member would like her to have a second chance at not wearing the Wanderguard. Plan included to continue wearing the Wanderguard and look into an assisted living facility that allows safe wandering outside, until that changes R3 will continue to need to wear the Wanderguard. BIMS 9, continues sundowning with wandering behavior, raising safety concerns. An order for dementia-ok for Wanderguard to ensure increased safety. R3's order communication form beginning date of 7/8/25, identified on 7/1/25: see progress note, R3 found on east side of building not able to find entrance door back into facility. Wanderguard placed due to noted incident. Since Wanderguard placed resident cut off once and becomes upset related to having to wear it. R3 had zero knowledge of incident. Please advise if to continue Wanderguard. BIMS on 6/6/25 moderate impairment with a score of 9. Nurse Practitioner signed the order on 7/14/25. R3's Treatment Administration record dated 7/2025, identified to begin on 7/8/25, identified check to ensure Wanderguard is in place on left ankle and not expired every shift and test Wanderguard weekly to ensure working, test with tester. During an observation and interview on 7/31/25 at 9:50 a.m., RN-A stated last time she heard the door alarm go off was when R3 was trying to get out the door. R3 was observed at the main entrance door. A staff member was inside the nurses station pushed and held a button that appeared like a doorbell. R3 and an activity staff went outside and sat down. R3 just likes to sit outside on the bench. During an interview on 7/31/25 at 10:13 a.m., NA-B stated R3 feels like she does not need to be at the facility, she wants to be at home. We do not have 15-minute checks on R3 because she knows and follows directions. During a phone interview on 8/1/25 at 8:27 a.m., NA-A stated since R1 had eloped, NA-A liked to make sure where the residents with Wanderguards are at times and tried to keep them in the lobby so when she completed tasks she can quickly look to make sure the residents were still there. During an interview on 8/1/25 at 11:11 a.m., DON stated she has heard the alarm sounding on the doors when R3 attempts to exit. The facility did not do an elopement risk assessment on R3 because the facility does not	F0689		

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F0689 SS = SQC-J	Continued from page 13 have elopement risk assessments. The facility policy and procedure for missing resident reviewed 6/8/22, identified: · Notify current staff of resident missing · All staff to search all rooms, closets, etc. · If unable to locate resident notify DON and social services · Notify local police department-give police a copy of face sheet and picture of resident. Description of what resident is wearing. Additional information that would be helpful · Notify family and/or legal guardian · Social service and/or DON to follow up with vulnerable adult policy and procedure The facility Missing Resident undated, identified Initial Actions printed at the top of the paper. The paper was divided in half with the first side blank and the side next to it identifying actions to be completed: · Record the time that the resident was discovered missing and when and where he/she was last seen · Verify the resident has not signed out or been discharged · Perform census verification and resident roll call to determine if there are any other missing residents · Activate facility's EOP (emergency operation plan) and appoint a facility Incident Commander if warranted · Search the facility's grounds for the resident. If necessary, distribute copies of the residents photograph to staff searching the grounds. Keep a record of the areas searched. Be sure to check: closets, walk-in refrigerators/freezers, storage units, under beds and behind furniture · If the missing resident is not found following an expedient search, call 9-1-1 and provide: name and description of missing resident, description of clothing, ambulation method, cognitive status, photo if available · Notify responsible party/next of kin that resident is	F0689		

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(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
F0689 SS = SQC-J	Continued from page 14 missing and search is underway · Notify MN Department of Health to report an unusual occurrence and activation of facility's EOP · Coordinate with public safety agencies in searching for the missing resident · Once the resident is found, notify the responsible party/next of kin, facility staff, and public safety agency representative The facility Wander Management Transmitters User Guide dated 11/2018, identified it is the responsibility of the facility to establish and facilitate a regular inspection schedule for your system. It is recommended that a yearly inspection of the system by a qualified representative be completed for safety and performance. Failure to provide regular inspection of these products may result in equipment and/or system failure. System maintenance and testing it the responsibility of the facility to establish and facilitate a regular maintenance schedule for the system. This includes regular inspection, testing and cleaning. It is recommended to do monthly maintenance of the system and the facility keep records of maintenance and test completions. Failure to provide regular inspection of these products may result in equipment and/or system failure. Each transmitter is stamped with a warranty expiration date. Using a transmitter beyond the printed expiration date can result in system failure and/or elopement. When the CodeWatch is placed on a residents ankle, be sure to adjust the antennas at each door to a 4-5 foot range to the ankle. Failure to do so may allow a resident to elope because they will be closer to the door when the door detects their transmitter. All transmitters must be tested prior to use to verify proper operation, this includes every time the band is replaced.	F0689		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F0842	Corrective action taken: Records identified as incomplete or missing information were immediately reviewed and updated. Affected residents' records were corrected to ensure they were accurate, complete and properly filed.	08/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245401	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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Central Health Care Center	**444 NORTH CORDOVA , LE CENTER, Minnesota, 56057**

(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
F0842 SS = D	Continued from page 15 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for-	F0842	Continued from page 15 A full audit of all active and recently discharged resident records was conducted to identify any similar deficiencies. Any incomplete or inaccurate records found were corrected promptly. Measures put into place: The facility implemented a resident record audit tool to verify completion of admission, transfer, discharge, vital signs and progress notes were transferred. Staff received education on regulatory requirements for timely, complete and accurate documentation in resident records. The medical records coordinator (or designee) will monitor all records to ensure proper organization and accessibility. Updated policy and procedure on resident record maintenance was reviewed with all staff. Monitoring to ensure ongoing compliance: The medical records coordinator (or designee) will audit a sample of resident records weekly for 4 weeks, then monthly for 3 months. Audit findings will be reported to QAPI Committe for review and corrective action as needed. Ongoing compliance will be incorporated into the facility's annual QAPI review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245401**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/05/2025**

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F0842 SS = D	Continued from page 16 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to maintain a complete and accurate medical record for 1 of 1 residents (R1) reviewed for complete and accurate medical record. Findings include: R1's face sheet dated 7/31/25, identified R1 admitted to the facility 4/2025. R1's vital sign record dated 5/2025, did not identify recorded vital signs after he returned from elopement. A facility paper dated 5/3/25, listed a nurse and three nursing assistants (NA)'s names and a list of resident names with boxes to write in. R1's name was handwritten with a first name only and had vital signs listed, without a time, as temperature 97.2, pulse 73, respirations 18, blood pressure 130/68, oxygen 96%, and no pain. During an interview on 8/1/25 at 12:41 p.m., Director of Nursing (DON) stated she was not able to locate the vital signs in R1's electronic medical record. DON	F0842		

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F0842 SS = D	Continued from page 17 looked through old nurse assignment sheets and found the one dated 5/3/25 and will enter them in the electronic health record. The facility Medical Records Policy undated, identified all paper records will be stored securely in a locked medical records room or filing cabinets within the facility.	F0842		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 21, 2025

Administrator
Central Health Care Center
444 NORTH CORDOVA
LE CENTER, MN 56057

Re: State Nursing Home Licensing Orders

Event ID: 1D298E-H1

Dear Administrator:

The above facility survey was completed on August 5, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/31/25, 8/1/25, and 8/5/25, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		08/05/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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20000	Continued from page 1 The following complaints were reviewed: H54014127C (MN00112800) with a licensing order issued at: 0830, 695. 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 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.	20000		
20695	Retention, Storage, and Retrieval; Retention CFR(s): MN Rule 4658.0470 Subp. 1 Subpart 1. Retention. A resident's records must be preserved for a period of at least five years following discharge or death. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to maintain a complete and accurate medical	20695	Facility Response Corrective action taken: Records identified as incomplete or missing information were immediately reviewed and updated. Affected residents' records were corrected to ensure they were accurate, complete and properly filed.	08/06/2025

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20695	Continued from page 2 record for 1 of 1 residents (R1) reviewed for complete and accurate medical record. Findings include: R1's face sheet dated 7/31/25, identified R1 admitted to the facility 4/2025. R1's vital sign record dated 5/2025, did not identify recorded vital signs after he returned from elopement. A facility paper dated 5/3/25, listed a nurse and three nursing assistants (NA)'s names and a list of resident names with boxes to write in. R1's name was handwritten with a first name only and had vital signs listed, without a time, as temperature 97.2, pulse 73, respirations 18, blood pressure 130/68, oxygen 96%, and no pain. During an interview on 8/1/25 at 12:41 p.m., Director of Nursing (DON) stated she was not able to locate the vital signs in R1's electronic medical record. DON looked through old nurse assignment sheets and found the one dated 5/3/25 and will enter them in the electronic health record. The facility Medical Records Policy undated, identified all paper records will be stored securely in a locked medical records room or filing cabinets within the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee should review policies and procedures, train staff, and implement measures to ensure facility medical records are complete and accurate. The DON or designee should conduct audits of the facility's medical records to ensure they are complete and accurate. The results of those audits should be taken to Quality Assurance Performance Improvement (QAPI) to determine compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: thirty (30) days.	20695	Continued from page 2 A full audit of all active and recently discharged resident records was conducted to identify any similar deficiencies. Any incomplete or inaccurate records found were corrected promptly. Measures put into place: The facility implemented a resident record audit tool to verify completion of admission, transfer, discharge, vital signs and progress notes were transferred. Staff received education on regulatory requirements for timely, complete and accurate documentation in resident records. The medical records coordinator (or designee) will monitor all records to ensure proper organization and accessibility. Updated policy and procedure on resident record maintenance was reviewed with all staff. Monitoring to ensure ongoing compliance: The medical records coordinator (or designee) will audit a sample of resident records weekly for 4 weeks, then monthly for 3 months. Audit findings will be reported to QAPI Committe for review and corrective action as needed. Ongoing compliance will be incorporated into the facility's annual QAPI review.	
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must	20830	A formal Elopement Policy and Procedure, including: · Definitions and identification of elopement and wandering behavior · Required interventions for at-risk residents · Staff roles and responsibilities in prevention and response	08/06/2025

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20830	Continued from page 3 be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review, the facility failed to conduct comprehensive elopement risk assessments for 2 of 3 residents (R1, R3) identified as an elopement risk. Additionally, the facility did not promptly respond to a sounding Wanderguard alarm or ensure proper functioning of alarmed exit doors. This resulted in an immediate jeopardy when R1 left the facility and was found half a mile from the facility. The IJ began on 5/3/25, when it was identified R1 had eloped through the facilities south door, with the alarm sounding and walked 0.5 miles away from the facility. On 8/1/25 at 1:26 p.m., the director of nursing (DON) and business office manager were notified of the IJ. The IJ was removed on 8/5/25 at 12:55 p.m., after it could be verified the facility had implemented an acceptable removal plan. However, non-compliance remained at a D for isolated scope and severity which indicated no actual harm, with potential for more than minimal harm. Findings include: R1's face sheet dated 7/31/25, identified R1 admitted to the facility 4/2025, with diagnoses of dementia (decline in cognitive function), morbid obesity (overweight), aphasia (language disorder that affects communication and comprehension), and signs and symptoms involving cognitive functions and awareness (encompass a range of mental processes including memory, attention, language, and problem-solving abilities). R1's admission Minimum Data Set (MDS) dated 4/21/25, identified R1 did not talk and was rarely/never understood but sometimes understood others. R1 had severely impaired daily decision-making skills. Wandering occurred 1-3 days but did not trigger a significant risk of getting to a potentially dangerous place or outside of the facility but intruded on privacy/activities of others. R1 was able to walk without assistive devices, dependent on staff for lower body dressing and substantial assistance with upper body dressing. R1's Brief Interview for Mental Status (BIMS) dated 4/21/25, identified R1 was unable to complete the	20830	Continued from page 3 · Detailed response procedure · Monthly audits and staff retraining requirements Development and implementation of Elopement Risk Assessment Tool which included: · Tool considers history of wandering, cognitive status, behavioral indicators, and functional mobility · All residents were assessed using this tool by nursing leadership · Results of assessments were reviewed with Interdisciplinary Team (IDT) and incorporated into resident care plans · Elopement risk assessment to be completed upon admission, quarterly, and PRN upon any changes noted. Information obtained to be used in creating an individualized care plan Care plan revisions: · For all residents identified at risk for elopement, individualized care plans were updated to include: clear, tailored interventions (room location, increased checks, redirection strategies); use and maintenance of Wanderguard devices, diversional activities and environmental controls, updated completed and singed by IDT Wanderguard and Door alarm monitoring procedure: · Weekly door and wander guard system inspection protocol has been established and incorporated into the facility maintenance schedule · Maintenance will test each wander guard enabled door weekly and document results in a newly implemented door alarm inspection log · Nursing staff are required to verify wander guard functionality at the beginning of each shift and document it · All staff to be educated on immediate alarm response time to decrease the potential risk to the resident for harm. Staff education and re-training: · All staff educated on: revised elopement policy and procedure, use of the elopement risk assessment tool,	

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20830	Continued from page 4 interview, which indicated staff completed the interview and identified a memory problem with short- and long-term memory, and moderate impairment with decisions. R1 did not have a comprehensive elopement risk assessment completed. R1’s care plan dated 4/24/25, identified behaviors related to dementia and at risk for wandering. Interventions included: address wandering behavior by walking with or attempt to redirect from inappropriate area, engage in divisional activity (4/16/25); intervene wandering as needed to protect rights and safety of others, approach in a calm manner, divert attention, remove from situation/take to another location (4/16/25); Wanderguard placed on ankle, staff to ensure placement each shift (4/16/25). R1’s physician orders dated 4/15/25, identified a Wanderguard was placed on left ankle and make sure Wanderguard was in place and functioning daily. Additional orders dated 4/23/25, identified to document frequency of R1 wandering into other resident’s rooms and if R1 was redirectable. R1’s progress notes from 4/15/25-5/2/25, identified R1 wandered into other resident rooms and walked a significant amount around the building. R1 was not always redirectable for staff. R1’s progress note dated 5/3/25 at 2:49 p.m., identified at approximately 10:46 a.m., R1 eloped from the facility via the south door. The alarm was sounding. NA-A notified by a resident that R1 had walked past her door but did not come back around and pass her door again. NA-A alerted staff of elopement. Staff searched outside, asked community members that were in the area, and were directed on where R1 was seen. R1 was assessed for injuries and offered water upon return to facility, Wanderguard assessed and working properly. South door examined and noted that it would not sound if the door was not fully closed. R1 placed on 15-minute checks. Physician, family member, and DON notified of incident. R1 was found as 0.5 miles from the facility. The Weather Channel identified the temperature on 5/3/25 to be ranged from 60-79 degrees Fahrenheit with stray thunderstorms. R1’s Resident Safety Assessment dated 5/3/25, identified 15-minute checks began on 5/3/25 at 11:45 a.m., and ended on 5/13/25 at 10:00 p.m. when the door	20830	Continued from page 4 wander guard system checks and documentation, emergency response protocols for elopement; training included scenarios and drill; attendance logs and training on file, new hires will receive this training during orientation Monitoring and Quality Assurance: · The Quality Assurance and Performance Improvement (QAPI) committee will: review all elopement related incidents monthly, audit 10 elopement risk assessments and care plans weekly for 8 weeks, then monthly for four months, audit door alarm logs and shift wander guard checks weekly, results will be reviewed during monthly QAPI meetings, corrective actions will be implemented for any identified deficiencies	

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20830	Continued from page 5 was fixed. During an observation on 7/31/25, R1's room was located on the north hall, near the nurses station. At 9:37 a.m., activity staff was observed walking down the hall and met R1, who was walking the north hall independently and began to dance next to him down the hall. At 9:41 a.m., R1 walked to the end of the hall and entered the chapel, with an exit door and keypad next to the door, R1 sat in a recliner. No staff were present in chapel. Another resident was looking out the window, next to the exit door. R1 appeared short of breath and had a white band sticking out of the top of his right sock, consistent with a Wanderguard bracelet. At 9:45 a.m., R1 stood up and went to the exit door and looked out the glass door, turned around and began walking back down the hall. At 9:55 a.m., R1 continued to walk down hallways. During a phone interview on 7/31/25 at 3:26 p.m., housekeeper (HSK)-A stated she witnessed R1 walking around the facility earlier in the morning on 5/3/25. HSK-A heard the noise of the alarm, and saw all the nurses were looking around and checking rooms. HSK-A was alerted a resident was missing. HSK-A left the facility and went toward the park. HSK-A saw people at the park and asked if they had seen a person matching R1's description. HSK-A was directed in the direction R1 was seen. HSK-A caught up to R1 between the library and the post office. HSK-A called the facility informed licensed practical nurse (LPN)- where they were and that she was going to stay with R1. NA-C brought a wheelchair. A nurse and two other nursing assistants also arrived to HSK-A's location. During an interview on 7/31/25 at 10:13 a.m., NA-B stated the Wanderguard helps to tell staff when a resident goes outside because the door alarm will go off. The door would alarm and lock if a resident with a Wanderguard got too close, and a code was needed to open the door and turn off the alarm. The south hall was a high traffic area with an exit door. NA-B stated there was no way the door would open with a Wanderguard. It was possible a person exited from that door and R1 managed to leave. R1's wife would take him outside, but facility staff does not because they did not know if R1 would come back inside willingly. R1 went room to room in the halls and staff just keep an eye on him. On 5/3/25, NA-B did not hear the alarm sounding and stated a person needed to be down the south hall or in the lobby to hear the alarm. NA-B was informed the south alarm was sounding, R1 was missing, and no one saw R1 exit the building. The search began room to room looking for R1. One staff member got in a	20830		

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20830	Continued from page 6 car and drove to R1's location as reported by someone in the community. NA-B was unsure how long R1 was missing but he was several blocks away and was difficult to get him to come back to the facility. After R1 was back in the facility he was on 15-30 minute checks. NA-B did not receive re-education from the facility after the incident. During phone call on 8/1/25 at 8:27 a.m., NA-A stated R1 would lay on his bed and sometimes walk around the building. On 5/3/25, NA-A went to answer a call light on the south hall, and heard the south door alarm sounding. The south hall door was closed. NA-A looked down the south hall first and then saw RN-C and asked RN-C to walkie talkie for staff to look for R1 down the other halls. NA-A looked down her assigned halls and another NA and RN-C looked down the other hall. Sometimes, R1 would wander through the employee doors so NA-A went down to the laundry room and R1 was not in there. NA-A went outside and looked around the parking lot and did not see R1. Someone outside the facility told HSK-A R1 was down by the post office and HSK-A found R1. NA-A ran down the road and could see HSK-A with R1 slowly walking back to the facility. R1 was on 10-20 minute checks for at least the day or next couple of days. When registered nurse (RN)-B was interviewing staff after the incident, she had the south door slightly open and in the 45 minutes it was open the alarm did not go off and that was how we thought it was the door. Although the facility knew the door alarmed, they had not checked outside of the building but checked inside the facility first. During a phone call on 8/1/25 at 9:54 a.m., NA-C stated staff go in and out of the south door a lot. NA-C was working in the laundry department and was in the backroom on 5/3/25. R1 was an elopement risk because he constantly walks the facility. NA-A came into the laundry room looking for R1. NA-C did not hear the alarm. NA-C immediately went to the main lobby and heard the south alarm going off. NA-C immediately went outside and started looking around the premises. NA-C heard HSK-A had found R1 and went to meet up with them. R1 looked really tired and exhausted so NA-C ran back to the facility and got a wheelchair and wheeled it back to R1 and HSK-A. R1 walked most of the way back, it was probably the last four blocks that R1 decided to sit in the wheelchair and ride back. NA-C was aware R1 had 15-minute checks the rest of the day and the maintenance director (MND)-A was called to check the south door because of the latch and staff were to make sure the door was latched when coming and going. NA-C was unaware of any education provided after the incident.	20830		

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During a phone interview on 8/1/25 at 10:07 a.m., NA-D stated 5/3/25 was her first shift at the facility and she had not had training on alarms or elopement. NA-D arrived at 5:30 a.m., and R1 was awake and walking the halls. NA-D noticed R1 was walking around the facility and checking the doors and staff told her that R1 had been up doing that all night. NA-D was in a room with a resident on the south hall and stated she kept hearing what sounded like an alarm, "beep, beep, beep." NA-D was unsure what it was. NA-D was told by another NA, a resident got out of the building. Staff went room to room and when they could not find R1, went outside. A community member took a staff person down to R1. NA-D was unsure if the facility had an elopement plan for R1 but knew he should not exit the facility alone because he had the Wanderguard on.

During a phone interview on 8/1/25 at 8:53 a.m., LPN-A stated the south door alarm is not as loud as the main entrance alarm but it can be heard at the nurses station and down the halls. There was no specific elopement procedure, usually staff are assigned to halls to search bathrooms, closets, everywhere and alert staff if the resident was found. At the time of the incident on 5/3/25, RN-C and an NA had been in a room with the door closed on the north hall. LPN-A was on the east hall providing a treatment to another resident when RN-C called to her on the walkie-talkie system to come to the front desk right away. LPN-A was unsure of the specific time RN-C called her but thought it was around 10:00 a.m. LPN-A went to the front desk and RN-C stated they were looking for R1. The south door alarm was sounding. LPN-A stated she and RN-C started to think maybe R1 went outside with someone as he had a tendency to go in the activity room, which was located on both sides of the south door and other resident rooms. Dietary, housekeeping, laundry, and nursing departments all looked for R1. LPN-A stayed inside the building by the nurses station and her assigned hall as RN-C went outside the facility. A staff person walkie-talkie they saw R1 and that is how LPN-A knew he was found. R1 was brought back to the facility in a wheelchair, he was exhausted. LPN-A completed a full set of vital signs, gave water, checked R1's feet for blisters, and began 15-minute checks upon return. RN-C notified RN-B of the incident. LPN-A did not notify the police of the incident.

During an interview on 7/31/25 at 9:50 a.m., RN-A stated R1 wandered around the facility and into other resident rooms. RN-A recalled R1 was placed on 15-minute checks after he eloped on 5/3/25, as the facility determined the south door he exited from did

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not latch properly. RN-A thought the 15-minute checks continued until the south door was fixed. RN-A was not aware of precautions put in place for the other resident (R2) that resided in the facility on 5/3/25 and had a Wanderguard. RN-A was unaware of any education or facility drills completed on elopement after the incident.

During a phone interview on 8/1/25 at 10:43 a.m., RN-C stated she was not sure if the facility had an elopement assessment. RN-C had noticed R1 going to doors and pushing on them a couple of times on the morning of 5/3/25. When R1 eloped on 5/3/25, RN-C was assisting with a transfer in another resident's room. When they finished the transfer and left the room, they heard the door alarm sounding. RN-C immediately thought of R1, and her and the aide went to R1's room and he was not in there. RN-C and the aide looked around for R1 and RN-C used the walkie-talkie and notified LPN-A that the door alarm was sounding, and they could not locate R1. Staff were notified via walkie-talkie that R1 was missing. There was not a specific procedure that was followed, everyone just scrambled. LPN-A was more familiar with the facility and directed staff where to look. R1 was found by the post office. A NA met up with the staff that found R1 and once RN-C knew R1 was found and where the location was, RN-C met up with R1 and the staff and walked with them towards the facility. Another staff member brought a wheelchair because R1 appeared very tired and R1 sat in it and was transported back to the facility. R1 had a full body exam for injuries and 15-minute checks were initiated. LPN-A notified the nurse practitioner. RN-C was unaware if the police were notified but knew she had not notified them. A sign was placed on the south door to make sure it shut completely if you go in or out of it until it was fixed. The facility thought the south door was ineffective and that was how R1 was able to get out.

During a phone interview on 8/1/25 at 10:24 a.m., RN-B stated the facility does not have a formal assessment for elopement risk. If a resident attempted to leave the facility, that was when a Wanderguard was put on. The door system will lock and an alarm will sound when a resident attempts to open the doors. R1 wandered the facility daily and frequently pushed on exit doors. On 5/3/25, LPN-A called RN-B, who was the designated on-call nurse at the time and notified her R1 had eloped and was already back at the facility. RN-B recalled R1 had walked out the south door, staff heard the alarm and started looking for R1. Staff did not see R1 anywhere nearby or on facility grounds. Some staff saw community members in the nearby park and approached

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20830	Continued from page 9 them and asked if they had seen R1, and they had and pointed the direction R1 went. HSK-A was able to see R1 in the distance and communicated to LPN-A that R1 was found but was a distance ahead of her. HSK-A caught up to R1 and was able to convince him to turn around and began walking back with him. Another staff came with a wheelchair and R1 sat in it and was wheeled back to the facility. LPN-A checked R1's vital signs and gave water to hydrate. No injury was noted to R1's body during physical exam. RN-B investigated the south door Wanderguard function. There were times where the door would not fully latch so RN-B notified MND-A of her findings. RN-B had staff initiate 15-minute checks for R1 while the door was not functioning. RN-B was not concerned about initiating 15-minute checks for R2 as R2 had a motion sensor alarm placed while he was in his room and staff always escorted him to and from the dining room, where he remained supervised. RN-B was not aware if anyone checked the functionality of the door alarms on a regular basis. During an interview on 8/1/25 at 10:59 a.m., maintenance director (MND)-A stated he was unaware when the Wanderguard door system was installed but it was prior to him working at the facility and he had been the maintenance director for at least a year. MND-A thought there were five doors with the Wanderguard system on them. The facility had never had a maintenance plan in place for the doors to be checked as far as MND-A was aware and the doors had never been checked and he did not keep a log. MND-A was made aware of the door not properly latching on 5/3/25. MND-A adjusted the door and hinges and ordered a new hydraulic closer. MND-A was unsure when the door was fixed but thought it was probably within that week. The facility amazon order dated 5/19/25, identified an order for a Dynasty Door Closer, commercial grade size 4 spring, hydraulic automatic series 4000 Door Closer Sprayed Aluminum was ordered on 5/19/25, shipped to the facility on 5/20/25. The facility did not identify when the order arrived at the facility. During an interview on 8/1/25 at 9:33 a.m., DON stated the facility has never done elopement risk assessments. During a subsequent interview at 11:11 a.m., DON stated the facility determined if a resident is at risk for elopement upon admission when they talk with the family, or if they are a known wanderer from information obtained from the hospital or facility resident transferred from. After R1 returned to the facility staff gave him fluids, performed a skin check, completed vital signs, and placed him on 15-minute checks to ensure it would not happen again. To mitigate	20830		

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20830	Continued from page 10 elopement, interventions in the care plan include distraction, activity, staff interaction, redirection, typical dementia type interventions included to deter them going in that direction. The Wanderguard company was not notified to assess the system as the facility felt it was the hydraulics leaking and the door was not locking, it was slightly ajar, so R1 was able to get out. If the door had been working properly it would have locked and stayed locked so R1 would not have been able to leave the facility. The facility does not test the doors to make sure the Wanderguard system is working properly. The facility had an elopement policy, staff communicated on walkie-talkies, and each nurse should take their assigned NA's, have them do an all-clear check when an alarm went off. R1 was removed from 15-minute checks on 5/13/25 as maintenance had done repair on the door hinge that allowed the door to shut securely while waiting for the hydraulic part. Since the door was able to close, staff felt R1 was safe, and he was removed from 15-minute checks. The IJ was removed on 8/5/25, when the facility revised and implemented the following that was verified through staff interview on 8/5/25. A formal Elopement Policy and Procedure, including: · Definitions and identification of elopement and wandering behavior · Required interventions for at-risk residents · Staff roles and responsibilities in prevention and response · Detailed response procedure · Monthly audits and staff retraining requirements Development and implementation of Elopement Risk Assessment Tool which included: · Tool considers history of wandering, cognitive status, behavioral indicators, and functional mobility · All residents were assessed using this tool by nursing leadership · Results of assessments were reviewed with Interdisciplinary Team (IDT) and incorporated into resident care plans · Elopement risk assessment to be completed upon admission, quarterly, and PRN upon any changes noted.	20830		

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20830	Continued from page 11 Information obtained to be used in creating an individualized care plan Care plan revisions: · For all residents identified at risk for elopement, individualized care plans were updated to include: clear, tailored interventions (room location, increased checks, redirection strategies); use and maintenance of Wanderguard devices, diversional activities and environmental controls, updated completed and singed by IDT Wanderguard and Door alarm monitoring procedure: · Weekly door and wander guard system inspection protocol has been established and incorporated into the facility maintenance schedule · Maintenance will test each wander guard enabled door weekly and document results in a newly implemented door alarm inspection log · Nursing staff are required to verify wander guard functionality at the beginning of each shift and document it · All staff to be educated on immediate alarm response time to decrease the potential risk to the resident for harm. Staff education and re-training: · All staff educated on: revised elopement policy and procedure, use of the elopement risk assessment tool, wander guard system checks and documentation, emergency response protocols for elopement; training included scenarios and drill; attendance logs and training on file, new hires will receive this training during orientation Monitoring and Quality Assurance: · The Quality Assurance and Performance Improvement (QAPI) committee will: review all elopement related incidents monthly, audit 10 elopement risk assessments and care plans weekly for 8 weeks, then monthly for four months, audit door alarm logs and shift wander guard checks weekly, results will be reviewed during monthly QAPI meetings, corrective actions will be implemented for any identified deficiencies R3's face sheet dated 8/1/25, identified R3 admitted	20830		

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20830	Continued from page 12 5/2025. Diagnoses included anxiety disorder, and dementia. R3's optional state assessment MDS dated 6/8/25, identified moderate cognitive impairment. No wandering or behaviors. R3 did not have a comprehensive elopement risk assessment completed. R3's care plan dated 5/21/25, identified self-care deficit with interventions requiring assistance of one staff with dressing. A care plan focus dated 5/22/25, identified R3 had diagnoses of dementia, poor memory recall, and anxiety. R3 was new to the facility and needed explanations, reminders, and assistance to attend activities of her choosing. Interventions included offer to sit outside with R3 when the weather is nice. A second focus on 5/21/25, identified R3 had impaired cognitive function related to dementia. Intervention on 7/25/25, identified R3 had a history of wandering away from the facility, order to have Wanderguard on and checked each shift to ensure placement. R3's progress note dated 5/13/25 at 1:00 p.m., identified a nurse-to-nurse report from the hospital. The hospital stated R3 had dementia with sundowning behaviors and does not always know place and time. At 9:12 p.m., R3 became more upset as the night progressed and had no idea why her family "dumped" her at facility. R3's progress note dated 5/17/25 at 1:26 p.m., identified R3 exhibited poor memory recall by forgetting her recent hospital stay as well as reason for residing at facility. R3's progress note dated 6/5/25 at 2:57 p.m., identified R3 was seen pacing back and forth in the hallway, unable to find her room. Walked with R3 towards her room and she was able to remember where it was. R3's progress note dated 6/17/25 at 9:34 p.m., identified R3 experienced confusion, believed she was at work and that she able to walk herself home. R3's physician dictation note dated 6/30/25, identified R3 had increased confusion, which contributed to her long-term residency at facility. R3 does have sundowning, easily redirected. R3's progress note dated 7/1/25 at 8:18 p.m.,	20830		

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20830	Continued from page 13 identified R3 was found outside on the east side of the building. R3 was confused on what door to enter. R3 is able to go outside unsupervised and is alert and orientated times three and understood that she got turned around. DON and on-call doctor notified and a verbal order was obtained to put a Wanderguard on R3. At 8:24 p.m., a dietary note identified R3 was seen walking on the grass by the dietary office window towards the east end of the building. The dietary director went outside and met R3 who stated she must have gotten lost and was trying to find her way back into the building. Dietary director walked with R3 to the main entrance, sat outside for about 10 minutes, and returned inside the building. R3's progress note dated 7/4/25 at 8:58 p.m., identified R3 was agitated after supper because she could not go outside by herself due to the Wanderguard. Attempted to go outside twice and set the alarm off each time. R3's progress note dated 7/6/25 at 9:47 a.m., identified R3 was upset she could not go outside due to the Wanderguard and would not leave the front door so other residents and visitors could get in or out. At 10:47 a.m., R3 was placed on 15-minute checks due to refusing to put the Wanderguard back on. R3 continued to sit on the bench outside the front door. R3's Resident Safety Assessment for 15 minute checks began on 7/6/25 at 6:00 a.m., two pages that included 15-minute increments of time were provided. The second page, undated had "done" written across it beginning at 10:30 a.m. A handwritten note on the first page dated 7/6/25, identified R3 did not attempt to leave facility when outside. There was no indication R3 had a Wanderguard on at this time. R3's progress note dated 7/7/25 at 12:10 p.m., identified a wanderguard was placed on R3's left ankle. At 3:00 p.m., R3 was upset that the wanderguard was on and just wanted to sit outside. Activity staff sat outside with R3. R3's progress note dated 7/13/25 at 2:43 p.m., identified R3's family member requested the activity department put a schedule together as to when R3 could go outside with them. R3's physician dictation note dated 7/14/25, identified on 7/1/25, R3 was found outside the facility, and it was unclear how long she was outside, though it was believed to be under half an hour. R3 initially went outside to sit and then waked to the other side of the	20830		

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20830	Continued from page 14 building, attempted to enter through a locked door, which led to some confusion. As a result a Wanderguard was applied. R3 stated when she gets near the door the alarm goes off and that is scary for her. R3's family member would like her to have a second chance at not wearing the Wanderguard. Plan included to continue wearing the Wanderguard and look into an assisted living facility that allows safe wandering outside, until that changes R3 will continue to need to wear the Wanderguard. BIMS 9, continues sundowning with wandering behavior, raising safety concerns. An order for dementia-ok for Wanderguard to ensure increased safety. R3's order communication form beginning date of 7/8/25, identified on 7/1/25: see progress note, R3 found on east side of building not able to find entrance door back into facility. Wanderguard placed due to noted incident. Since Wanderguard placed resident cut off once and becomes upset related to having to wear it. R3 had zero knowledge of incident. Please advise if to continue Wanderguard. BIMS on 6/6/25 moderate impairment with a score of 9. Nurse Practitioner signed the order on 7/14/25. R3's Treatment Administration record dated 7/2025, identified to begin on 7/8/25, identified check to ensure Wanderguard is in place on left ankle and not expired every shift and test Wanderguard weekly to ensure working, test with tester. During an observation and interview on 7/31/25 at 9:50 a.m., RN-A stated last time she heard the door alarm go off was when R3 was trying to get out the door. R3 was observed at the main entrance door. A staff member was inside the nurses station pushed and held a button that appeared like a doorbell. R3 and an activity staff went outside and sat down. R3 just likes to sit outside on the bench. During an interview on 7/31/25 at 10:13 a.m., NA-B stated R3 feels like she does not need to be at the facility, she wants to be at home. We do not have 15-minute checks on R3 because she knows and follows directions. During a phone interview on 8/1/25 at 8:27 a.m., NA-A stated since R1 had eloped, NA-A liked to make sure where the residents with Wanderguards are at times and tried to keep them in the lobby so when she completed tasks she can quickly look to make sure the residents were still there. During an interview on 8/1/25 at 11:11 a.m., DON stated	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20830	Continued from page 15 she has heard the alarm sounding on the doors when R3 attempts to exit. The facility did not do an elopement risk assessment on R3 because the facility does not have elopement risk assessments. The facility policy and procedure for missing resident reviewed 6/8/22, identified: · Notify current staff of resident missing · All staff to search all rooms, closets, etc. · If unable to locate resident notify DON and social services · Notify local police department-give police a copy of face sheet and picture of resident. Description of what resident is wearing. Additional information that would be helpful · Notify family and/or legal guardian · Social service and/or DON to follow up with vulnerable adult policy and procedure The facility Missing Resident undated, identified Initial Actions printed at the top of the paper. The paper was divided in half with the first side blank and the side next to it identifying actions to be completed: · Record the time that the resident was discovered missing and when and where he/she was last seen · Verify the resident has not signed out or been discharged · Perform census verification and resident roll call to determine if there are any other missing residents · Activate facility's EOP (emergency operation plan) and appoint a facility Incident Commander if warranted · Search the facility's grounds for the resident. If necessary, distribute copies of the residents photograph to staff searching the grounds. Keep a record of the areas searched. Be sure to check: closets, walk-in refrigerators/freezers, storage units, under beds and behind furniture · If the missing resident is not found following an expedient search, call 9-1-1 and provide: name and description of missing resident, description of clothing, ambulation method, cognitive status, photo if	20830		

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20830	Continued from page 16 available · Notify responsible party/next of kin that resident is missing and search is underway · Notify MN Department of Health to report an unusual occurrence and activation of facility's EOP · Coordinate with public safety agencies in searching for the missing resident · Once the resident is found, notify the responsible party/next of kin, facility staff, and public safety agency representative The facility Wander Management Transmitters User Guide dated 11/2018, identified it is the responsibility of the facility to establish and facilitate a regular inspection schedule for your system. It is recommended that a yearly inspection of the system by a qualified representative be completed for safety and performance. Failure to provide regular inspection of these products may result in equipment and/or system failure. System maintenance and testing it the responsibility of the facility to establish and facilitate a regular maintenance schedule for the system. This includes regular inspection, testing and cleaning. It is recommended to do monthly maintenance of the system and the facility keep records of maintenance and test completions. Failure to provide regular inspection of these products may result in equipment and/or system failure. Each transmitter is stamped with a warranty expiration date. Using a transmitter beyond the printed expiration date can result in system failure and/or elopement. When the CodeWatch is placed on a residents ankle, be sure to adjust the antennas at each door to a 4-5 foot range to the ankle. Failure to do so may allow a resident to elope because they will be closer to the door when the door detects their transmitter. All transmitters must be tested prior to use to verify proper operation, this includes every time the band is replaced. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop elopement risk assessment tool to be utilized for all residents, develop a wandergard door alarm monitoring system, review and revise elopement policy and procedures,	20830		

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20830	Continued from page 17 review and revise resident care plans as needed, educate staff including drills and/or teach back methods. Audits could be conducted to ensure nursing policies and procedures are followed. Information obtained could be reviewed and revised at the Quality Assurance Performance Improvement (QAPI) meeting. TIME PERIOD FOR CORRECTION: thirty (30) days.	20830		