Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2025

Administrator
Bethany On The Lake LLC
1020 Lark Street
Alexandria, MN 56308

RE: CCN: 245434
Cycle Start Date: December 12, 2024

Dear Administrator:

On January 10, 2025, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On January 7, 2025, the situation of immediate jeopardy to potential health and safety cited at **F689 - Free of Accident Hazards/Supervision/Devices** was removed.

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 listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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, Bethany On The Lake LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 10, 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.

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 an "E" tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

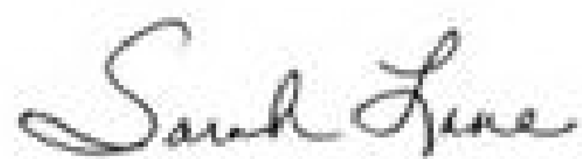
INFORMAL DISPUTE RESOLUTION (IDR)

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

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Sincerely,



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

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January 22, 2025

Administrator
Bethany On The Lake LLC
1020 Lark Street
Alexandria, MN 56308

Re: Event ID: 5PVN11

Dear Administrator:

The above facility survey was completed on January 10, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING ______ B. WING ______	C 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE LLC	1020 LARK STREET ALEXANDRIA, MN 56308

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F 000	INITIAL COMMENTS On 1/8/25 through 1/10/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was NOT in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed: H54344340C (MN00109653) deficiency was issued at F689 at PAST NON-COMPLIANCE. The immediate jeopardy began on 1/6/24, at 6:44 a.m. when R1 set off roam alert, exited the facility through the south door, in the dark in below zero temperature with her walker, and went missing. At 7:10 a.m. approximately two blocks away from the facility R1 was located. The administrator and DON were notified of the immediate jeopardy on 1/10/25 at 1:30 p.m. The facility immediately implemented corrective action and was corrected on 1/7/25, prior to survey and was issued at past noncompliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide adequate supervision to prevent an elopement for 1 of 3 resident (R1) reviewed for supervision. R1 was assessed at risk for elopement and left the facility in the dark, freezing temperatures, and located outside approximately 25 minutes later.

Past noncompliance: no plan of correction required.

The immediate jeopardy began on 1/6/25, at 6:44 a.m. when R1 set off roam alert, exited the facility through the south door, in the dark in below zero temperature with her walker, and went missing. At 7:10 a.m. approximately two blocks away from the facility R1 was located. The administrator and DON were notified of the immediate jeopardy on 1/10/25 at 1:30 p.m. The facility immediately implemented corrective action and was corrected on 1/7/25, prior to survey and was issued at past noncompliance.

Findings include:

According to time and date past weather conditions for Minneapolis weather History for January 6, 2025, the temperature at 5:53 a.m. was three degrees Fahrenheit retrieved from Weather in January 2025 in Minneapolis, Minnesota, USA.

R1's Saint Louis University Mental Status Exam (SLUMS) (an assessment tool for mild cognitive impairment and dementia) dated 11/9/23,

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F 689	Continued From page 2 identified a total score of 9 out of 30 and indicated dementia (27-30 was normal, 21-26 suggested mild neurogenic disorder, and 0-20 suggested major neurocognitive disorder). R1's annual Minimum Data Set (MDS) assessment dated 10/15/24, identified severely impaired cognition, was able to communicate but had difficulty with some words or thoughts without prompting and given time. She felt down, depressed, and hopeless several days (2 to 6 days out of the 7 days during the look back period). She required partial to moderate assistance with personal and toileting hygiene, bath/shower, dressing, and was able to transfer/ambulate up to 150 feet in corridor independently. Her diagnoses included: diabetes mellitus (DM)/insulin dependent, dementia, psychiatric disorder, and required the use of a wander/elopement alarm daily. R1's elopement risk evaluation dated 10/17/24, identified she had a habit/history of wandering or attempts to leave the unit/building, ambulatory, exhibits pacing or agitated behavior, had a cognitive deficit diagnosis, and currently taking opioid or psychotropic medications which may cause confusion. R1's elopement risk score was a 5 (a score of 4 or greater indicates potential for elopement) and care plan goal was identified as resident will not leave the building alone. R1's fall risk assessment date 10/17/24, identified she has had one to two falls in the past six months. Medications used and diagnoses that may have contributed to falls: Hypoglycemic agents (used for low blood sugars), antihypertensives, psychotropics, and peripheral neuropathy (nerves outside the brain and spinal	F 689		

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cord are damaged causing weakness, numbness, and pain in the hands or), a diabetes type I, heart disease, and Alzheimer's. Agitation occurred less than daily. Gait analysis: used an assistive device (e.g., cane, walker, etc.) and wore poorly fitting shoes.

R1's care plan date 10/29/24, identified she was at risk for elopement, wandering, had a diagnosis of dementia with psychosis with a goal she will not leave the building alone. Staff were instructed to redirect her during attempts to leave the building using calm language, calling her son, offering a snack and/or wheelchair to bring her back to her room, answer door alarms promptly, and monitor wander guard for proper functioning. She was at risk for alteration in mobility with a history of falls and staff were directed to follow physical therapy (PT) orders, and independently transfer and ambulate in hallway with walker. Additionally she was at risk for falls due to encephalopathy (brain dysfunction and can appear as confusion, memory loss, personality changes and/or coma in the most server form), history of falls, left foot drop (difficulty lifting the front part of the foot to help clear the floor), lumbar stenosis (narrowing of the spinal cannel can cause pressure on the spinal cord or nerves that go from spinal cord to your muscles), and diabetes. Staff were directed to follow PT and occupational therapy (OT) instructions for mobility function. She had an alteration in psychosocial well-being and was to be monitored for safety concerns such as elopement.

R1's progress note dated 11/5/24 at 6:33 a.m. Resident walked the halls before midnight with her coat on. Approached doors and talked about getting a kid on the bus. Redirected back to the

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nurse's station. She eventually fell asleep in the recliner at the nurse's station until 2:00 a.m.

R1's electronic medication administration record dated December 2024, identified the roam alert on her walker was documented as checked every night shift at 11:30 p.m. 12/1/24 through 12/31/24.

R1's PT evaluation dated 12/10/24, identified she had dementia with anxiety, history of falls, generalized muscle weakness, and other abnormalities of gait and mobility. She felt unsteady when walking and worried about falling. Walking 10 feet on uneven surfaces was not attempted due to medical conditions or safety concerns and curb/steps (1 step/curb) not applicable. She had decreased (3 out of 5) musculoskeletal strength identified in left lower extremity (hip, knee, and ankle). Assessment summary identified decreased dynamic balance, motor control deficits, postural alignment/control, and strength impairments.

R1's progress notes from 1/6/24 through 1/7/25 identified:

-On 1/6/25 at 8:22 a.m. Late Entry: at 6:44 a.m. she set off roam alert and exited the building through the south facing door of facility. She left wearing a coat, shoes, and walker with intentions of finding two boys. Writer responded to door alarm, was unable to locate resident immediately after turning off alarm. Other staff were asked for assistance in locating resident in and outside building, and a code white was called. Director of nursing (DON) and all staff assisted at this time. Resident was found by facility staff one block away ambulating with walker, directed to staff vehicle, and brought back to her room at the

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F 689	Continued From page 5 facility without incident. A skin check was immediately performed with nursing and medical doctor (MD). Her skin was intact without injury and was provided a warm blanket that was changed out once it cooled down. Her roam alert was functioning and on her walker. An additional roam alert was added to her ankle. MD updated to incident and delusions reported during incident. Medications reviewed and nursing requested a lab check and urinalysis (UA) for possible infection. Every 15-minute checks were initiated for 24 hours. Staff education provided on elopement policy. If resident wandered to an exit she would be redirected to her room or nurse's station. She will remain in line of sight while in hallways. Her son was notified and updated at 11:10 a.m. today. -On 1/6/25 at 3:02 p.m. orders for urinalysis/urine culture (UA/UC) and basic metabolic panel (BMP) due to increased confusion and possible urinary tract infection (UTI). -On 1/6/25 at 6:34 p.m. orders regarding resident leaving building. Observe face, hands, feet for any cold related injury times 48 hours. Review of facility's Vulnerable Adult Maltreatment Report identified on 1/6/25 at 6:44 a.m. R1 set off the roam alert and exited the building through the south facing door of the facility. She left wearing a winter coat, socks, shoes, pants with her walker and intentions of finding two boys. She was located approximately one block away ambulating with her walker and hood up. She was standing with two other individuals who were neighbors to the facility. She was directed to staff vehicle and brought back to her room without incident. Upon immediate return to the facility MD and staff	F 689		

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assessed her for injury. No injuries or sin alterations were observed. She denied injury, maltreatment, or falling while out of the facility.

R1's electronic medication administration record dated December 2024, identified the roam alert on her walker was documented as checked every night shift at 11:30 p.m. 1/1/25 through 1/6/25.

Facility Device Activity Report dated 1/6/25, identified:

-1/6/25 at 6:44 a.m. alarm on south entrance door two.
-1/6/25 at 6:48 a.m. (4 minutes 14 seconds) user cleared alarm on south entrance door two.

R1's medical doctor (MD)-B assessment dated 1/6/25, identified she was seen today at the request of the nursing supervisor to evaluate for possible injury related to elopement. She had a history of dementia and elopement. With an alert device in place, exited the building through the south facing door having navigated steps to get there. She reported left the facility with the intention of finding two boys. She wore a coat, shoes, no mittens/gloves, and used her walker. She the facility for approximately 30 minutes [sic]. There was reference to her seeing wheels on the walls of her room. She returned to the facility at the time of my visit and stated, well that was stupid, regarding her leaving the building. Her main complaint was cold hands and denied fall, injury, or maltreatment. Her temperature was 97.3 degrees Fahrenheit and physical exam identified she was alert, cheerful, hands cool to the touch with no evidence of frost nip or frostbite with adequate capillary refill, and normal sensation. She did not appear to have suffered

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any ill effects from her elopement. Nursing staff will closely monitor her for skin changes.

R1's progress noted dated 1/7/25 at 9:39 a.m. Follow up note from elopement episode on 1/6/24. Resident skin is intact, denies pain., and made no mention of elopement except that it was cold yesterday. Conversation was nonsensical per baseline. No exit seeking noted. Resident has a wander guard on right ankle and walker. Will continue to monitor for changes.

Memo dated 1/7/25, written by DON provided to staff identified: The wanderguard or Roam Alert system requires and emergency response when it is alarming. The alarm cannot be disarmed unless you visualize and account for all residents with a wander guard or roam alert. Remember a thorough search is indicated by searching inside and out the facility. We have created a new "elopement binders" for each station. They have face sheets for those residents that have a wander guard or roam alert currently in house. Please use these binders as reference to who you should account for when a roam alert is sounding.

R1's MD-A 60-day medical review visit 1/8/25 at 8:00 a.m. unfortunately two days ago she had an elopement episode. She was confused and did not really have any intentions of eloping. She went outside looking for someone. She has had hourly checks since that day and expressed no further desire to exit seek.

During an interview on 1/9/25 at 11:30 a.m. PT stated she had arrived at work on 1/6/25 at 7:05 a.m., parked her car on the street (11th street) by the facility south exit/entrance door. PT stated

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she was approached by a registered nurse (RN)-A, informed R1 was missing, and was asked for help to locate her. She stated it was dark outside and cold with the temperature somewhere around zero. She got back in her car and drove west down 11th street, past the side street located at the west side of the facility building where the side walk ended with an egress ramp for easy exit onto the street, down a hill past four houses past another side street to the right and where the fifth house was located on the right side of the road. PT stated at approximately 7:10 a.m. she observed R1 as she stood with her walker on the side of the road with a neighbor (approximately two blocks away from facility). R1 was fully dressed in pants, shirt, shoes, socks, and a black coat with the hood placed over her head, and nothing on her hands. She approached R1, she knew who she was, but seemed confused/forgetful, unsure as to why she was outside, and said her hands were cold. She walked R1 around to the passenger side of the car, assisted her inside, and placed the walker in the car. She drove her to the front of the facility building and assisted her inside, and back to her room. She stated R1 was able to walk on flat surfaces with her walker, had foot drop, and made an extra effort to pick that foot when walking so that she did not trip. PT stated the ground outside was uneven and placed her at a higher risk for a fall. She was unsure as to how R1 managed to go outside and down two steps with her walker from the facility south exit door to get to the sidewalk.

During an observation on 1/9/25 at 12:20 p.m. located on the inside of the south exit door at eye level was a printed sign: CAUTION this door leads to stairs without an egress ramp. For safe

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transition to the outside, please use either the east or west doors located approximately 50' away to the left and right. Additionally located off to the right of that sign was a red stop sign at waist level, underneath the sign was a horizontal metal bar used to push door open and below the bar was another red stop sign posted. Off to the right side of the door at eye level located on the wall was wall pad with numbered buttons on it used to unlock the door with an entered code. PT entered the code and opened the inside exit door and observation showed an entry way that had an outside glass door with long vertical glass windows on each side of the door where outside could be seen. She pushed open the outside door and there was a cement platform that led to two long horizontal step that spanned the length of the south entry/exit door with a black railing located on each side and one in the middle between the steps. There was a sidewalk from the steps that extended out to the main public sidewalk which was horizontal from the facility building running both east and west the sidewalk going west ended prior to reaching the side road on the west side of the building with an egress ramp. The road continued down the street without a sidewalk.

During an interview on 1/9/25 at 12:40 p.m. RN-A stated R1 walked independently with her walker, was confused and forgetful, unable to make any of her own decisions, and would have not been safe out in the community by herself. She had seen a decline in R1's dementia and confusion were severe. R1 frequently mixed up her days with her nights, did not sleep well and up a lot during the night. She stated R1 for the most part was usually up by 6:15 a.m., fully dressed herself in shirt, pants and shoes but also wore gripper

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE LLC	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 socks and sometimes her jacket. R1 made her appearance in hallways with her walker about every 30 minutes unless she was sleeping, came to dining room for meals but if not there 15 minutes prior to the meal staff would go get her. R1's ambulation had worsened since admission, did not understand the concept of her foot drop and front end of foot drug on the floor, which made her a high risk for falls. She stated a roam alert was attached to R1's walker and had not tried to open an exit door prior to 1/6/25, of which she was aware. She arrived at work on 1/6/25 at 6:15 a.m., report started at 6:30 a.m. at the medication cart located by the nurse's station. She had seen R1 last during the middle of the report when R1 came out of her room and turned to the left, headed south down the hallway (away from where report was) with her walker, fully dressed in shoes and jacket on. She stated she did not attempt to redirect R1, continued with report until right before 6:45 a.m., walked through the dining room, grabbed water for medication pass, unlocked medication room, grabbed apple sauce and nebulizer treatments out of the refrigerator then heard the exit door alarm go off. She left her walkie on the medication cart, walked down to the south end of the hallway where one exit door was located, looked outside through the window, then realized it was the south door alarm down the south hallway to the left that had alarmed. She approached the south end door, unable to hear anything, so turned off the door alarm. RN-A stated staff were expected to respond the door alarm immediately and should have been left on until R1 was found. She opened the inside exit door and walked into the entry way, looked out the widows and thought how could R1, an elderly woman, maneuver herself down those steps with a walker without falling and was no	F 689		

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evidence she exited that door. She opened the outside door, was dark outside and looked around. RN-A stated she did not step outside, it was cold, near zero temperature, no coat or phone, and had not processed yet if R1 was inside or outside the building. She walked from the entry and back into the facility building, combed through sitting areas inside the building, went down to east/west hallway and asked NA-C for assistance to help locate R1, then called director of nursing (DON) and a Code White (missing resident). She went outside through the west door for about two to three minutes, walked down the sidewalk, between vehicles in the parking lot, was still dark out and relied on the street for light. RN-A stated staff would have been expected to go outside and check the surrounding areas right away, but her point of view was she had no sight of her, there was only one streetlamp, and did not see anyone. PT found R1 outside by the side of the road with her walker approximately 20 minutes after she exited the facility. Once R1 was brought back to the tacitly she completed an assessment along with the provider on site, no injuries were noted. She initiated every 15-minute checks for 24 hours, applied another roam alert to R1's ankle and education was provided to all staff that same day.

During an interview on 1/9/25 at 2:40 p.m. maintenance director (MD) stated once a resident with a roam alert approached and exit door a warning beep would sound. When the exit door was breached (opened) the alarm beeped faster, and alerted staff on their walkie's. He stated the staff were expected to respond to the alarm immediately and go to exit door, and complete outside and inside building.
following the policy guidelines. There were only

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two residents in the facility that had roam alerts on. The door alarm log indicated the south entrance/exit door alarm on 1/6/25 went off at 6:44 a.m. and was cleared at 6:48 a.m. (4 minutes). He was unsure of the temperature that morning, the snow had pretty much melted, and the road was clean.

During an interview on 1/9/25 at 3:39 p.m. nursing assistant (NA)-B stated she had worked the night shift on 1/5/25 through 1/6/25 morning. R1 would walk around the facility with her walker fully clothed with either gripper socks or tennis shoes on. Occasionally, R1 would walk in hallway with her coat which occurred about every two months. She last saw R1 at 6:25 a.m. laid in bed, sleeping, fully clothed with gripper socks on, no agitation noted during the shift, and when shift ended at 6:30 a.m. went home. NA-B stated R1's cognition was very forgetful, confusion went in spirits but was never totally clear, refused cares at times, would not have been safe outside in the community by herself. NA-B stated R1 was unable to find her way back to the facility.

During an interview on 1/9/25 at 4:24 p.m. floor manager RN-C stated R1's had progressive Alzheimer's, significant cognition impairment, and would have not been safe out in the community by herself. R1 had limited mobility, transferred, and ambulated independently but at risk for a fall. RN-C stated R1 refused cares, had psychosis, delusional thinking patterns, hallucinations, and could be verbally and physically aggressive at times. She said R1 had vascular dementia, made for a behavioral pattern, and was at risk for elopement. R1 walked the hallways with her walker with roam alert attached to it, fully dressed and not uncommon for her to wear her coat. She

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stated RN-A was giving shift to shift report, saw R1 in hallway with her coat on, ambulating with her walker and had not verbally expressed she wanted to leave. She expected staff to respond to an exit door alarm immediately, it was an emergency, and the alarm should have been left on until resident was found and all clear was sounded. She also expected staff to go outside immediately and searched right away for the resident. RN-C stated when the exit door alarm was triggered on 1/6/25 it was dark and cold out and would have been important to see the physical environment and at least walked out to the sidewalk and important to find the resident as soon as possible. She stated R1 was outside approximately 20 minutes before she was found. There was a lack of supervision for R1, staff should have initiated an outside search sooner and staff failed to follow the care plan, R1 should have not been outside alone.

During an interview on 1/10/25 at 11:05 a.m. occupational health and learning RN-B stated once the exit door alarm went off staff were expected to go to the door that alarmed, and the alarm should have remained on until resident was found. Staff were expected to go outside and look for the resident immediately because it was cold outside, could have gotten hurt, and needed to get R1 back into the building. RN-B stated that information was provided in the facility policy and wanted to prevent residents from leaving the facility unassisted such as elopement. She stated all staff education was provided on 1/6/25, and a facility drill was completed on 1/7/25 at two separate times after the elopement so that staff could take part in it and re-educated. R1 had told staff she was looking for the boys and had a purpose to go outside. Previous to the elopement

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F 689	Continued From page 14 on 1/6/25 R1 had not verbalized she wanted to leave the facility nor pushed open an exit door. During an interview on 1/10/25 at 11:16 a.m. family member (FM) stated R1 had a history of falls at home prior to her admission and one at the nursing home. He had talked to the staff, and they had asked R1 why she went out of the building, she told them she saw a little boy out there. He said she most likely thought it was her grandson and wanted to go out there after him. FM stated R1 wore a black Vikings jacket with a hood, refused to wear a cap/hat, and had no gloves or mittens. He had not noticed any change in behaviors recently except when R1's blood sugars dropped too low in the morning, she became moody. FM stated on the morning she left the building it was very cold and right around zero outside, and she was not safe to be outside alone with her dementia. During an interview on 1/10/25 at 12:08 p.m. DON stated R1 required cues, did not make safe choices and was not safe out in the community by herself. She had not seen R1 in the hallways ambulating with her jacket on, the night shift indicated they had seen her at times in the hallway with her jacket on. She identified R1's elopement risk had slowly increased, in November 2024, R1 had talked about looking for some children with her coat on, care plan interventions were updated in July 2024, staff were expected to redirect R1 from exits due to her risk for elopement. She was notified on 1/6/25 at 7:02 a.m. by RN-A via phone R1 was missing and had not been found yet. She asked RN-A if she had checked outside and was told yes, then RN-A informed her she felt that R1 could have not made it down the steps and did not think she was	F 689		

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F 689	Continued From page 15 outside. She instructed RN-A to call a Code White and focus search efforts outside immediately due to the possibly of her being out there was pretty good since it was an exit door that alarmed. DON stated the facility policy was not followed, the exit door alarm should have been left on until the R1 was found and most likely why other staff did not respond to assist with the search. Additionally, when staff look through the glass door/windows it would have been super reflective in the dark and if she would have physically immediately gone outside and taken five steps R1 would have been right there. she was on her way into work from home when the call came through and showed a temperature between zero to one above. She estimated the time R1 was outside was 20 to 25 minutes, walked down the south west sidewalk, crossed a street intersection at the end of the side walk then walked down the road past four houses, crossed another street intersection, and found in front of the fifth house off the side of the road with two neighbors located nearby. Every 15-minute checks were initiated times 24 hours and supervision required when out in hallways ambulating. She expected staff to have intervened and redirected R1 when they saw her with her jacket on in the hallway early that morning. She completed staff interviews, and some felt that if they saw R1 with her coat on in hallway would have intervened and other staff indicated it was normal for her. Most of the staff were educated on 1/6/25. During a follow up interview on 1/10/25 at 12:15 p.m. PT stated the wording on the PT evaluation form dated 12/10/24, curb/steps (1 step/curb) not applicable, was the language used to complete	F 689		

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an evaluation. She stated R1 was not tested for the steps, not something she did in her routine but by reviewing her evaluation that day the results confirmed if she had tested her, she would have been dependent and not able to do it safely on her own.

During an interview on 1/10/25 at 12:45 p.m. NA-B stated she worked the morning shift 1/6/25 and had not seen R1, assisted another resident at 6:30 a.m. She stated her walkie alerted her an exit door alarm had been set off after 6:30 a.m., unsure exactly what time it was at. NA-B stated she finished up transferring another resident then spoke to RN-A and was asked if she had seen R1. She started looking inside the facility then went outside without a coat on along with another staff to search the facility grounds, it was dark and cold out. She went back inside the facility, unsure of time, was notified R1 had been found. She kept a close eye of R1 especially when in the hallway ambulating the rest of her shift. NA-B stated R1 had a history of forgetfulness, easily distracted, and turned around, and confused. We were expected to respond to those alarms immediately and the alarm was to be left on until the resident was found.

During an observation on 1/10/25 at 1:10 p.m. R1 ambulated in hallway, pushed her four wheeled walker from the north end of the hallway towards the south end where her room was located. In the middle of the hallway, R1 stopped and let go of her walker, grabbed her waist band on her pants and with both hands and pulled them up which revealed a roam alert located on her right ankle. An additional roam alert was located on the left upper side of her walker. R1 was fully dressed in shirt, pants, socks, shoes and did not have her

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F 689	Continued From page 17 jacket on. R1 ambulated by raising her left thigh up high in order to lift her left foot off the ground so that her left foot toes hung down, and barely cleared the floor with each step. R1 ambulated past her room doorway and was almost at the end of the hallway when an unidentified staff intervened and redirected her. R1 was cooperative. During an interview on 1/10/25 at 1:16 p.m. MD-A stated R1 had a history of wandering would have not been safe outside by herself in the community and expected staff to monitor her to keep her safe. During an interview on 1/13/25 at 3:02 p.m. licensed practical nurse (LPN)-A stated she was in a resident's room, came out of the room, heard the exit door alarm, walked towards the south end of the building and alarm had been shut off when she was only ½ way down the hallway. She was approached by RN-A between 6:45 a.m. and 7:15 a.m. and was told RN-A had lost R1. She asked RN-A if she had looked outside and was told yes. RN-A walked away and then came back and stated to her, really, I cannot find R1 while she talked on the phone. She called a Code White and we started to search all over the facility inside and outside. She crossed the street by her car and looked through the school parking lot around six cars, southwest corner, down the block to the north and the southwest corner and was unable to locate R1. LPN-A stated staff were expected to respond to an exit door alarm right away, checked to see if there was a resident by the door, and go outside to the end of the block and if how far they may have gotten. She stated it was dark and cold out, unsure of the temperature, and no snow on the ground. She was unsure as to	F 689		

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F 689	Continued From page 18 how R1 had been able to go down two steps with a walker. Facility Elopement policy date 6/2023, identified a safe environment will be provided for all residents. Assure that each resident is properly assessed on an ongoing basis and has appropriate safety precautions in place. Only the administrator or designee may authorize the disabling of the alarm system and is responsible for monitoring for resident safety and resetting the alarm. Documentation should include Entries that are time specific to reflect the responsiveness and "timeliness" of actions taken to locate and assess the resident. Facility policy Wander Guard/Roam Alert dated 11/2023, identified the roam alert system was designed to secure perimeter that helps detect residents from leaving the protected areas of the facility. All staff is required to respond to the roam alert and ensure the safety of our residents. When responding to the alert always open the door at the exit site and look for any resident that may have left the building. Walk around the building to see if resident was on the sidewalk, property, or surrounding area. Once you have checked outside and the resident located and returned inside the facility you can clear the alarm. It should not be cleared prior to locating the resident. Staff need to continue responding to the alert and assist with the search. Facility policy Code White - Missing Residents dated 1/2025, identified all personnel must investigate and report all cases of missing residents. If a resident's whereabouts are not discovered the nurse caring for the resident will page overhead by pressing the page button on	F 689		

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F 689	Continued From page 19 the phone: "Code White (name of resident) please return to your room". Staff, please turn walkies to channel one. Repeat this three times. All staff will begin a thorough search for resident. Searching outside maybe an option as the search area is expanded. Staff can utilize their vehicles to search the perimeter of the building, searching outside maybe needed earlier in the search, depending on the situation. An outside search should take no longer than 15 minutes. When resident is located page overhead "Code White Canceled" repeat this three times. The past noncompliance immediate jeopardy began on 1/6/25. The immediate jeopardy was removed and the deficient practice corrected by 1/7/25, after the facility implemented a systemic plan that included the following actions: began immediate investigation, reviewed policy and procedures, placed a roam alert on R1's right ankle, initiated all staff education the DON provided a memo to staff identifying the wanderguard or Roam Alert system requires and emergency response when it is alarming, conducted audits and drills with staff, tested all current roam alerts for functional use, updated R1's plan of care, provided corrective action and education regarding missing resident and elopement to RN, created a missing resident check list and elopement binder that identified residents in the facility at risk for elopement with roam alerts, and ongoing staff education and audits will be provided.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/8/25 through 1/10/25 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaint was reviewed.	2 000		

Minnesota Department of Health

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

Electronically Signed

Minnesota Department of Health

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2 000	Continued From page 1 H54344340C (MN00109653) No licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		