DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 16, 2025

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

RE: CCN: 245461
Cycle Start Date: April 30, 2025

Dear Administrator:

On April 30, 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.

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 April 22, 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, Eventide Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 30, 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:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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)

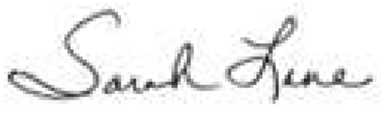
In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why 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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May 16, 2025

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

Re: Event ID: JM5D11

Dear Administrator:

The above facility survey was completed on April 30, 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
	245461	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS On 4/29/25 through 4/30/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H54613249C (MN00112395) with a deficiency issued at F689 PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	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 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 ensure adequate supervision for 1 of 3 residents (R1) reviewed for accidents. This failure resulted in an immediate jeopardy (IJ) when R1 eloped from the facility, and was found 5 hours later, approximately 4 miles from the facility, after dark.	F 689	Past noncompliance: no plan of correction required.	

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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F 689	Continued From page 1 The IJ began on 4/16/25 at 6:27 p.m., when R1 exited an alarmed door at the facility and staff failed to respond timely and complete a full property search for R1. R1 was located by the police approximately four miles from the facility at 12:00 a.m. Director of quality and infection prevention and director of clinical services were notified of the IJ at 5:15 p.m. on 4/30/25. The facility implemented corrective action by 4/22/25, prior to the start of the survey and therefore is issued as past non-compliance. Findings include: R1's annual Minimum Data Set (MDS) dated 4/7/25, identified moderately impaired cognition. He required partial to moderate assistance with shower/bathe, set up/cleanup for eating, oral and personal hygiene, upper/lower body dressing, and independent with toileting hygiene, all transfers, ambulation, and bed mobility. He was frequently incontinent of bladder and continent of bowel. R1's diagnoses included epilepsy, dementia, orthro static hypotension (a drop in blood pressure occurred when a person stood up after sitting or lying down), hemiplegia (weakness on one side of the body), anxiety, chronic obstructive pulmonary disease (COPD), and depression. He was administered antidepressants and diuretics (increased urine output). R1's care plan dated 4/18/25, identified a self-care deficit related to subarachnoid hemorrhage (bleeding occurred in the space between the brain and a protective layer surrounding the brain due to a weak blood vessel), poor safety awareness, anxiety, epilepsy, weakness, rhabdomyolysis (a rare muscle injury	F 689		

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F 689	Continued From page 2 where muscles break down), abnormalities of gait and mobility, major depressive disorder (MDD), and bell's palsy (temporary facial paralysis usually on one side of the face). Staff were instructed to assist as needed to change an incontinent product pull-up. He had potential for falls, ambulated with a front wheeled walker (FWW), and required supervision and assistance as needed (PRN). He had potential for safety concerns due to risk for elopement, wandered on the unit, asked about exits, and attempted to open stairway door. Staff were directed to check placement of WanderGuard on left ankle and workability, engage him in activities as much as able, wore jacket occasionally, if seen with one on, complete education about alerting staff if he wanted to leave facility, discuss resident's gratitude, if comments were made about wanting to leave, initiate frequent checks and update all staff on unit, monitor for getting onto elevator. If he approached the elevator, offer to go on a walk with him. Remind him he cannot leave facility unit without telling staff. He wandered frequently and discussed how he wanted to leave. Staff were directed to monitor mood and behavior, offer emotional support, provide 1:1 visit for conflict resolution/problem solving, redirection as needed, and report changes in mood. He was considered a vulnerable adult due to placement in a skilled nursing facility as well as physical impairments. R1's elopement risk assessment dated 1/31/25, identified he was cognitively impaired with poor decision-making skills, dementia, major depressive disorder, and anxiety. He had verbalized the desire to leave facility, wandered near an exit door, and aimlessly (confused, moves without purpose). Interventions include secured unit, wander guard located on left ankle,	F 689		

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F 689	Continued From page 3 utilization of check in /check out log, recreational activities. R1 had two wander/elopement alarms (an electronic device that monitors a resident's movement and alerted staff when movement was detected). R1's Progress Notes on 4/17/25 indicated: -at 12:10 a.m. late entry: left voicemail for his brothers to alert of elopement. Spoke with one brother at 7:00 p.m. Stayed in communication with his brothers through the night. Updated brother upon resident's safe return to facility. -at 12:29 a.m. late entry: returned to facility just before 12:00 a.m. Cognition was at baseline, alert, followed commands, and able to answer questions. He was aware he had been out of the facility for an extended amount of time he described that he walked to get things figured out for him to return to his home and live with his daughter. Did not know specifically where he was going, but reported he was familiar with the area. R1 denied being in any danger or talking to anyone during his walk. A full health status assessment was completed upon return to facility. R's shoes were dry and no evidence of walking through mud or water noted. He stated his leg were tired and was noted to be incontinent of bowel and bladder. Mood upon arrival was stable; stated he was glad to be home and sorry for scaring anyone. Note indicated frequent checks were initiated on resident for the night. -at 3:06 p.m. provider was updated with concerns. The Supplementary Police Report dated 4/17/25, identified a missing person: elderly man with brain injury walked away from the medical	F 689		

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F 689	Continued From page 4 retirement home. Numerous efforts were made to locate him but were unsuccessful until an alert was issued to the public. Shortly after the alert was made a citizen indicated they had seen him and he was in Fargo. Details: Dispatch stated the missing person had left approximately 40 minutes prior to being dispatched and was walking with a walker. Upon arrival to the facility, he was informed the missing person suffered from a traumatic brain injury, had symptoms like dementia, memory severely impacted, and unable to care for himself. He was provided a name, description, and photo, and searched the area but was unable to locate him. Facility was requested to review their premises cameras. The last time the missing male was seen on their camera system he was located on 7th street and 14th avenue south and walked east towards 8th street south when he went off camera. Time stamp of when he walked out of facility building was 6:27 p.m. His family was contacted and were concerned about his welfare and unsure if he had his cell phone with him. A ping was conducted, may have possibly been his phone number and showed it was in rural Clay County, and unsuccessful in locating it. During the investigation the concern for his welfare was growing. Based on information from family and facility staff it was believed he would not be able to care for himself or able to find his way back. As the time of him being gone and the falling temperature it was believed if he was not located soon, it could have become lift threatening. A press release was sent out at approximately to the Cass/Clay County areas at approximately 11:29 p.m. Once the alert was released numerous calls came in indicating they believed they had seen him and one person indicated he was seen around Big Top Bingo near 25th street	F 689		

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F 689	Continued From page 5 and 6th avenue two hours prior. Fargo officer responded to that area and located the resident at approximately 12:00 a.m. on 4/17/25, and within a half hour of the alert being broadcaster. He was cold and had soiled himself in the squad car. He was transported back to the facility without issues. During the investigation facility staff canvassing the area and the community by walking around. A drone was requested and used to actively fly around the local college and along the Red River when he was located. R1's records revealed facility implemented 30-minute checks upon R1's return to the facility on 4/17/25. Records reflect checks starting at 12:30 a.m. through 5:00 p.m. 0 4/18/25. The facility 5-day incident report summary dated 4/17/25 at 2:14 p.m., identified R1 was assessed to be a high risk for elopement, had a WanderGuard to his ankle, and alerted staff when he was close to an exit door. At 6:23 p.m. his wander guard triggered a warning at an exit. The receptionist received the warning and immediately called the charge nurse on the unit he resided on and informed the nurse where the alarm was warning. Charge nurse reported she had seen R1 about 10 minutes prior to when the phone call was received. She immediately went to the area and looked for him. At 6:27 p.m. his wander guard was detected at a different exit, which triggered a warning, and his wander guard triggered an alarm. The receptionist called the charge nurse again and told her where his wander guard had alerted. The alarm was triggered on the opposite side of the building. He was active, mobile, walked quickly and was steady on his feet. The staff nurse and another staff member went to that area and began search	F 689		

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F 689	Continued From page 6 for him. The receptionist did not see him exit the doors on the camera at that time. It was unknown if he had exited the building. Staff looked inside the building and through the windows and unable to see him in the immediate areas close to the windows or in the parking lot. Charge nurses on the units were contacted and delegated staff to search on each unit. Unit commons, room to room, and outside searches were conducted and he was not found. Charge nurse called DON, she assisted with the search for approximately 10 minutes and camera footage was viewed and R1 was identified exiting the building at 6:26 p.m. based on camera time. He was wearing a red winter jacket, black shirt, long black pants, white tennis shoes with socks and a ball cap. The camera showed R1 exit the building, walked on the sidewalk near the entrance of the assisted living side of the facility. Once he left the facility property the camera did not capture a specific route or direction he went after that. Police, family and executive director were notified and the search parameters widened as time went on. The police officer sent an alert out to the community and he was located by the police offer at 11:57 p.m. approximately 4 miles away from the facility and escorted back. The temperature outside was 62 degrees when he left the building and around 53 degrees when he returned. Upon arrival to facility R1 was immediately assessed from head to toe. No medical treatment was needed and he was unharmed. He stated he planned to go home and wanted to live with his daughter, denied telling anyone about his plan and did not sign out prior to leaving. He stated he was familiar with the area and never felt lost but at some point, was turned around. Frequent checks were completed throughout the night and he slept all night. He was unsure why he took the path he did last	F 689		

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F 689	Continued From page 7 night. He was educated about safety, alerting staff if he wanted to leave the unit or go outside, verbalized understanding of this, but education provided to him will be ongoing. His primary care provider was updated and rounded on him this morning. She completed a verbal contract for safety with him stating he will not elope. Staff that had worked at the time of the incident were educated verbally about the incident and steps to prevent a reoccurrence, frequent checks, safety, and his plan of care. The receptionist received immediate verbal education about the importance of a quick response to the alert, stay in the area with the resident. The wander guard system worked as intended, no concerns with the system itself. The staff member had unintended lapsed in response time when the alarm went off. Education on elopement was being discussed at shift changes and a mandatory meeting for all staff has been set up for tomorrow along with additional times to attend next week. All education will be completed by 4/24/25. Resident's care plan will be reviewed and updated to prevent reoccurrence. Resident interviews will be completed and all residents will be assessed for elopement per facility policy. The investigation was ongoing. During an interview/observation on 4/29/25 at 12:44 a.m., R1 laid on bed covered up with a blanket fully dressed in jogging pants and a cap, T-shirt with slip on shoes/slippers without socks with a white wander guard bracelet located on his left ankle. He stated he does not sleep well and walked the floors especially at night. Walker was placed next to bed. They did not like when he went outside and placed a wander guard on his ankle. He did not know it picked him up wherever he went. He had left the facility in the evening and	F 689		

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F 689	Continued From page 8 did not tell anyone he planned on going out. He was told when he decided to leave the facility he should have told someone and didn't. He left with his walker and found it difficult to walk on the sidewalks and streets. He had been a rebel all his life and was doing something he was not supposed to do. It was dark out when he left the facility and had not paid much attention to where he was walking. He crossed intersections and state troopers and cops were out looking for him and he was gone over a couple of hours. All he knew was he wanted to get out of here, tired of being told what to do and staying on this floor. He found it hard to live like that, wanted a break, they were not giving him one, so took it on his own. He really did not know where he was headed. There was a female cop that came down to the river and informed him there was a lot of people looking for him and very happy she found him. He was happy to have been found also, he was freezing. During an interview on 4/30/25 at 9:17 a.m. receptionist (R)-A stated she was the main person who set up the WanderGuard system for resident determined to be at risk and checked the door sensors with a WanderGuard tag weekly. There were five wall sensors to detect a WanderGuard. The wall sensor would detect a resident with a WanderGuard when the resident approached the door, gave a warning beep out loud and then once the resident moved closer and/or opened the exit door the beep changed to a different tone and louder. Her computer would notify her and provided resident tag/wander guard information, their location. There was a map located on the computer that showed where the resident was in the building only on 1st floor after the sensor was set off by a WanderGuard. She had visual access to real time and the ability to	F 689		

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F 689	Continued From page 9 see the resident at the door and if within the camera view. She looked to see if the resident was alone or with staff/family and directed her as to if it was an emergency or not. She viewed the monitor and kept an eye on them if was a resident regularly seen. When located by themselves she would go to the door sensor that alarmed and redirect them. Staff are contacted via phone or walkie when assistance was needed due to behaviors and not re-directable. She would stay with the resident until staff arrived. If a resident was seen leaving the building alone, staff would be notified as soon as possible and she would run to the door, stop them from going any further, and stay with them until staff arrived to assist. When she was unable to find the resident after a sensor went off, she would search the area of the sensor, in the hallway, and then go outside to search. Usually takes about 6 minutes of the inside building search by the sensor area. If it was determined an emergency all staff would be alerted, instructed to turn their walkies to channel 10 so that we can all be on the same page and updated. The receptionists were responsible to check the WanderGuards with a tester and confirm a signal was seen and working properly. Review of the testing log identified R1's WanderGuard was tested on 4/10/25 at 7:48 a.m., and on 4/17/25 at 8:36 a.m. and was identified as working properly. R-A indicated she was not working when R1 exited out of the south entrance doors located over by the assisted living. During an interview on 4/30/25 at 11:40 a.m. R-C stated on 4/16/25 at 6:27 p.m., a sensor alarm went off at the service door located on 2nd floor and notified her it was R1. She called and talked with LPN-A and asked if she had eyes on him.	F 689		

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	245461	A. BUILDING _____ B. WING _____	C 04/30/2025

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F 689	Continued From page 10 She was on the telephone with another resident's family and when LPN-A called her back, she indicated no. The service elevators sensors were located on all three floors and alarmed when a resident would enter with a WanderGuard on. There was a pin number that had to be entered into the keypad to get onto service elevator. She had gone over to the service elevator on the 1st floor and checked but R1 was not located. LPN-A came down to 1st floor with two NA's and searched the bathrooms next to the chapel area (R1 commonly used those bathrooms) and the link area (hallway entrance that connected the long-term care to the hallway that led to the south entrance door). After she returned to her receptionist desk, she had noticed the wellness exit door alarm had went off and missed it when she was away from her desk looking for R1 by the service area elevators. She was unsure of what time that had occurred due a new sensor alarmed located at the link (front door area) had gone off when she was located at the desk by the computer. LPN-A and her were located at the main reception desk talked briefly and she may have missed seeing R1 exit the building on the camera. LPN-A and NA's walked up the to the south front door entrance/link area and searched for R1 and she stayed at reception desk to monitor the cameras. She stated after LPN-A indicated she was unable to find R1 on 2nd floor she should have been more proactive, went around her desk, checked the hallways better and further down by the wellness center rather than only by the service door. Three separate sensor alarms were activated and identified it was R1 while he moved about on 1st floor and she could have probably prevented him from getting out of the facility or away from the building outside. She was expected to check outside as soon as the	F 689		

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F 689	Continued From page 11 alarm went off and unable to locate the resident at the sensor site. She had received education elopement policy and what could have been done differently. Sensor alarms triggered on 4/16/25 1st floor was verified on the receptionist computer during interview with R-C: 1st alarm elevator went off at service door area - 6:23 p.m. 2nd alarm wellness lobby at 6:26 p.m. 3rd alarm on the link area between care center and hallway to front door at 6:27 p.m. During an interview on 4/30/25 at 11:57 a.m. family member (FM)-A stated he was notified of R1's elopement on the evening of 4/16/25, and prior to that he had not left the facility on his own. He stated R1 stated recently had a hard time dealing with the situation, had a stroke three years ago and short-term memory loss. R1 had told him he did not know what was going on unable to remember, agitated, not one to be tired down/kept inside and was restless. He was good at making up stories so believable he believed what he told people to be the truth and used as a coping mechanism. R1 would have not been safe out in the community that night or any night. FM-A stated he did not feel that R1 was fully safe at the facility and could have easily eloped again. Once he had gotten out on 4/16/25 unknown if he really knew where he was going. FM-A had inquired about a IPOD clip on that would be used to track him outside the building, was informed it was against the facility policy for a tracker to be used. R1 was extremely cold when located hours later at almost 12:00 a.m., we were scared for him. The facility was working hard to keep him safe but may need to be moved if his needs are	F 689		

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F 689	Continued From page 12 unable to be met During an interview on 4/30/25 at 12:21 p.m. NA-C stated R1 had dementia and an impaired memory. Staff were expected to have completed safety round every two hours. NA-C worked on 4/16/25 and checked on R1 at 2:30 p.m. and 3:00 p.m. and was laying down on his bed, conversed with him. No mention about leaving the facility that day. At approximately just after 4:00 p.m. he was in the TV room and walked back to his room. We conversed again, asked him if he needed anything, talked about the weather, had a hard time staying in once place for sure. Did not exhibit exit seeking behaviors. NA-C got busy, helped another resident get up for supper and fed a resident. Another NA informed me she was heading to R1's room to get his roommate for supper, since he had forgotten. R1 was still in his room unsure of time. R1 was known to walk the hallways frequently especially at night. R1 had not attempted to leave the floor while he worked. Last time he saw R1 was at 4:00 p.m. After NA-C had finished feeding the resident in the dining room, he was asked by the staff nurse when R1 was seen last time. R1's room, hallway was searched and was told to stop what we were doing and headed downstairs in a panic (was assigned to him) and looked, unable to locate him. NA-C had checked inside the building on 1st floor then went outside for a brief second from the main entrance into the parking lot and searched for him and then was informed to go back upstairs and helped other residents. R1 wound not have been safe out in the community by himself due to his impaired cognition and lack of memory. During an interview on 4/30/25 at 12:49 p.m. licensed practical nurse (LPN)-A stated R1's	F 689		

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F 689	Continued From page 13	F 689		

cognition varies and he was forgetful. He walked the hallways frequently with the walker. Staff were expected to check on him at least every two hours. Last time she saw R1 on 4/16/25 was approximately 15 to 20 minutes prior to when he left the facility walking in the hallway in the west wing . He wore a coat and occasionally wore that because he got cold, fully clothed, not sure about what was on his feet (usually wore slip on loafers with a hard sole) and a baseball cap. At 6:27 p.m. she received a call from R-C and was informed a sensor alarm had gone off by the north corridor elevator. She went over to the north hallway on 2nd floor and to his room and unable to locate him. Approximately 3 minutes had gone by and she received another call from R-C indicating another door sensor alarm had gone off by the link hallway (hallway that links the care center (LTC)) that led to the south entrance door. She went down to the 1st floor immediately and searched in that area, and he was not located She visually looked out from the font door window and windows in the entry way, but did not go outside at this point. She notified all staff in the building and then called the DON at approximately 6:35 p.m. and then assisted with the search outside of the building, in the parking lot and around the front of the building for a couple of minutes. The DON viewed the camera footage and verified he had exited the south front doors. She remained on 1st floor over by the assisted living. A receptionist from the assisted living apartments alerted us that she had seen R1 walking on the sidewalk outside the apartments located on the south end of the building. He passed by the pillar and they lost view of him. Staff continued to check inside and outside the building. At 7:15 p.m. the police department was notified by R-C. She stated the receptionist at the

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F 689	Continued From page 14 main street desk would have been expected to check the alarming door right away and that was not done. She should have gone outside immediately to stop him from getting too far. LPN-A then indicated, R1 would not have been safe out in the community by himself due to his poor memory and there was a potential he could have been harmed. He was gone from the facility from 6:27 p.m. and was not found and brought back until shortly before midnight. During an interview on 4/30/25 at 3:06 p.m. with nurse practitioner (NP) stated R1 required 24/7 supervision and would have not been safe out in the community by himself. The facility can speak the policy he was determined to leave the building, physically active, and cognitively impaired. The facility policy and procedures are aimed at preventing this from happening. During the survey the administrator and director of nursing (DON) were out of the office and unavailable for interviews. Facility policy Elopement Prevention and Missing Residents dated 4/2024, identified the facility will assure the health, safety and welfare of all residents who are placed in our care. If a resident is missing a search will be conducted. Prevention: each resident is assessed for elopement risk upon admission/hospital return and as needed . . . if a wander guard is placed the elopement risk assessment will be completed quarterly, with significant changes and as needed to determine continued appropriateness. . . Missing resident: Immediate response: record time the person is discovered to be missing, when and where they were seen last. Continue to keep a log of events. Verify the resident had been signed out of the	F 689		

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F 689	Continued From page 15 facility or on an outing. Immediately report to the nurse manager/on-call. Notify all staff working: "attention all staff, missing person alert (location). Please report to the nearest nurse's station for further instruction. Make copies of the missing resident's photograph if available. Conduct a thorough search of the facility and grounds. Assign staff members a specific area to be search. Search room-to-room, under beds and furniture, in walk-in refrigerators/freezers, closets, storage rooms, outside facility grounds, and anywhere a frighten person maybe hiding. Instruct staff members to report back after their assigned areas have been checked and continue to check back every 15 minutes for updates. After initial search or as soon as possible: nurse manager/on-call will notify DON, who will notify the executive director (ED), who will notify law enforcement (call 911). Provide description of the resident and a photograph, including the clothing resident was wearing, mobility and cognitive status. The DON or designee will notify the resident's responsible party. Facility searches unsuccessful: ED or designee will collaborate with law enforcement and assign available staff to start neighborhood search and carry a picture of the missing resident. Upon finding the resident: charge nurse will assess the resident for injuries, complete the elopement risk assessment and document findings. Care plan will be reviewed and updated. ED or designee will notify all staff members, residents, and other responders/searchers that the resident had been found. Complete an incident report and DON or designee will file a vulnerable adult report if indicated. Take immediate action to decrease risk of repeated event with resident involved or others. The past noncompliance immediate jeopardy	F 689		

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F 689	Continued From page 16 began on 4/16/25. The immediate jeopardy was removed and the deficient practice corrected by 4/22/25, after the facility implemented a systemic plan that included the following actions: The facility took the following action to correct the immediate jeopardy and is therefore cited at past non-compliance. -facility began immediate investigation. -upon R1's return to facility a complete head to toe assessment was completed and every 30-minute safety checks were implemented due to risk of reoccurrence on 4/17/25 from 12:30 a.m. through 5:00 p.m. -All staff mandatory meetings have been held on 5 different times. Education included: elopement, missing resident, facility policies and procedures, and this specific incident and interventions had been discussed. -Frequent checks will be completed if statements are made about leaving. -Elopement checks will be completed if R1 makes statements about leaving. -Elopement drills will be conducted. -Wander guard system was checked and in working order. -Policies were reviewed, elopement and missing resident. no changes needed. -Other high elopement resident charts and care plans were reviewed, and triggers and interventions were added as needed. -Pictures of high-risk elopement residents had been dispersed to all departments to review routinely. Pictures updated with any changes.	F 689		

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	00072	A. BUILDING: _____ B. WING _____	C 04/30/2025

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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 4/29/25 through 4/30/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed.	2 000		

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2 000	Continued From page 1 H54613249C (MN00112395). 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		