Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 2025

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

RE: CCN: 245581
Cycle Start Date: February 12, 2025

Dear Administrator:

On March 6, 2025, we informed you of imposed enforcement remedies.

On March 7, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 12, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 12, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 12, 2025.

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.

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

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.

If you have not achieved substantial compliance by May 12, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Fair Oaks Nursing & Rehab Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 12, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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 - Health Regulation Division 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 August 12, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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March 19, 2025

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

Re: State Nursing Home Licensing Orders
Event ID: GRVC11

Dear Administrator:

The above facility was surveyed on March 6, 2025 through March 7, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING ______ B. WING ______	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS NURSING & REHAB LLC	201 SHADY LANE DRIVE WADENA, MN 56482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/6/25 through 3/7/25, 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, H55818981C (MN00111116) and H55818922C (MN00111115) with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement	F 689	1. R1 and R2 were immediately returned to the facility upon discovery with no	3/21/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/26/2025

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

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F 689	Continued From page 1 interventions to provide adequate monitoring and supervision for 2 of 3 residents (R1, R2) who reside on a memory care unit. R1 and R2 identified with wandering, elopement behaviors, and left the facility without staff being aware of where they were. Findings included: R1's elopement risk assessment completed on 1/5/25, identified he was ambulatory, had a history of wandering/elopement/exit seeking, dementia, wandered within the home without leaving grounds, and experienced sundowners (increased confusion, difficulty sleeping, anxiety, agitation, hallucinations, pacing and disorientation people living with dementia may experience from dusk throughout the night). He scored 10 on the assessment (0-8 low risk, 9-10 at risk to wander, 11-above high risk to wander) and was at risk to wander. R1's care plan dated 1/6/25, identified activity of daily living (ADL) self-care deficit and high risk for falls related to weakness, blind in right eye, hearing difficulty, and impaired cognition. He was independent with straight care (walker per DON) in halls, room, and transfers and required guidance for orientation. He was an elopement risk/wanderer/at risk to leave facility without notice/unauthorized related to dementia. Staff were directed to monitor for exit seeking, wandering, talking about leaving facility, document episodes, and offer activities for distraction, toileting, walking inside/outside, call family, structured activities, food, conversation, television, and books. He lived in the special care/secured unit and staff were directed to monitor for tailgating when visitors were in the	F 689	injuries. R1 and R2 were reassessed for elopement risk. 2. Because this could affect every resident on the Memory Care unit with exit seeking behaviors, magnetic alarms have been placed on the egress doors leading to the outside of building. All residents on the memory care unit have been reassessed for elopement risks. 3. Elopement risk and prevention policy & procedure was reviewed and deemed appropriate; no revisions were made. All staff have been educated regarding no longer using the memory care exit door. Magnetic locks have been placed to alarm if door(s) are opened. 4. Initial audit of all residents on memory care unit has been completed with updates to care plans as needed regarding interventions of residents who are a high risk for exit seeking behaviors. Audits will be completed 5 days/week x 4 weeks during IDT to identify any increase in exit seeking behaviors and that interventions were/are implemented.	

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F 689	Continued From page 2 building and provide a safe and secure environment. R1's Cognitive Performance Test (CPT) (a standardized occupational therapy (OT) assessment initially developed as a research instrument to assess cognition in daily tasks performance and change over time with Alzheimer's disease) dated 1/8/25, identified and an average CPT score of 4/4 out of 5/6 and indicated the need for 24-hour supervision. R1's admission Minimum Data Set (MDS) dated 1/9/25, identified continent of bowel and bladder. His diagnoses included congestive heart failure (CHF), kidney failure, diabetes mellitus (DM), dementia, anxiety, and no falls. Admitted to facility on 1/3/25, from a hospital. He had moderately impaired cognition, no behaviors, and sometimes socially isolated himself. He required set-up/clean up assistance with toileting hygiene, supervision/cues for eating, independent with oral hygiene, dressing himself, sit to stand, all transfers, ambulated up to 150 feet in corridor, walking on uneven surface and steps/curbs not attempted due to medical condition or safety concerns, used a walker for mobility. His medications included antipsychotic, antidepressant, diuretic, opioid antiplatelet, and hypoglycemic (lowers blood sugar). A wander guard or alarm system was not used. R1's OT evaluation dated 2/7/25, identified he had demonstrated a physical decline and OT services would be restarted to improve activities of daily living (ADLs) participation and safety. History included legally blind right side, high risk for falls, moderate/severe cognitive performance, moderately impaired decision making, and	F 689		

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F 689 Continued From page 3 F 689

impaired safety awareness. He moved slowly and demonstrated impaired balance at evaluation. OT was started three times a week with a duration of 30 days.

R1's physical therapy (PT) evaluation dated 2/7/25, identified he had difficulty this week with sit to standing and order was placed for evaluation to be completed. Medical history identified gait abnormalities, unsteadiness on feet, and dementia with behavior disturbances. PT was started three time a week with a duration of 30 days.

R1's progress notes from 2/26/25 through 2/27/25, identified:

-On 2/26/25 at 9:54 a.m. R1 stated to writer his legs were not working and needed help getting up. He was able to get up out of bed with assist of two. Once he was up out of bed was able to ambulate and used front wheeled walker, gait belt, and standby assist. . . Hard of hearing (HOH) wore hearing aids in both ears and refused to wear ... continued to work the physical/occupational therapy during the week.

-On 2/27/25 at 6:51 p.m. nurse noticed R1's walker at the end of the hallway. This nurse started to look for him and alerted other staff to search for him. When this nurse came up towards the nurse's station the phone rang, answered phone and the caller stated "I believe I have one of your residents here (she was from the apartments next door). This nurse immediately sent a staff member over to the apartments to bring him back to the facility. Once he was back into the facility, this nurse asked him how and where he ended up outside. He stated

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F 689	Continued From page 4	F 689		

he pressed the numbers, and it turned green, so opened the door and went out. This nurse asked him where he was going and he replied I do not know, nowhere. Skin was checked for injuries, none noted. Maintenance still here in the building and changed the code on the door. He was placed on 15-minute checks until further notice. Director of nursing (DON) was updated via phone call. This nurse called guardian (phone message stated she was on vacation). Did attempt to call the stand in guardian, unable to reach her. Will attempt to reach her tomorrow. Physician will be updated via fax.

-On 2/27/25 at 9:32 p.m. R1 had been started on 15-minute checks this earning. He has been wandering the hallways with his walker and sitting in recliner chairs in a variety of areas. When he was seen going down to the east hallway with the walker, staff had asked him to go to the lounge area or his room to get his mind off going towards the door at the end of the hallway. He has been closely monitored by staff of his whereabouts.

R2's PT evaluation dated 7/22/24, identified was discharged from PT a few months ago, placed on walking program with caregivers assist of one and front wheeled walker (FWW), had not been walking anymore and had declined in his mobility. He required supervision or touching assistance with ambulation up to 50 feet and unable to attempt 150 feet due to medical conditions or safety concerns. His gait pattern included a very short and shuffling steps where his feet caught on each other, walked very narrow base of support (BOS), and flexed knees.

R2's OT evaluation dated 12/11/24, identified moderately impaired decision making, impaired

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F 689	Continued From page 5	F 689		

safety awareness, and muscle weakness. He had fallen once in the past year and felt unsteady when he walked.

R2's care plan dated 1/2/25, identified limited physical mobility, unsteady gait, weakness, and other abnormalities of gait and mobility. Staff were instructed to have provide assistance of one with ambulation/locomotion and independent with wheelchair-based pivot transfers in room. R2 had purpose driven wandering and tried to get outside to smoke. Staff were directed to monitor for exit seeking or wandering behaviors, attempting to push on doors, type numbers into mag lock, and threatening to leave. Additionally, staff were directed to redirect, assess for needs, take outside for a walk as able, and offer food/drink. R2 had a history of delusions of needing to go to court and wandering/exit seeking increased when someone visited and then left. R2 lived in the special care unit that was secured and staff were directed to monitor for tailgating when visitors were in the building, identify when pattern of wandering was purposeful, aimless, or escapist and intervene as appropriate. R2 had impaired cognition function related to dementia and short-term memory loss. Staff were directed to cue, reorient, and supervise as needed. R2 benefited/required a secure memory care unit due to impaired cognition, dementia with psychotic disturbances, and behaviors. Staff were directed to monitor for changes in behaviors and provide a safe environment.

R2's CPT dated 1/8/25, identified an average CPT score of 4.0/5.6 and indicated moderate cognitive impairment and the need for 24-hour supervision and assistance.

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R2's quarterly MDS dated 1/27/25, identified admitted to facility on 10/4/22. from a hospital. He had severely impaired cognition, sometimes socially isolates self, rejection of care happened 4 to 6 days out of 7 during look back period, and delusions (misconceptions or beliefs that are firmly held, contrary to reality). He had bilateral lower extremity impairment and used a wheelchair for mobility. He required supervision/touching with toileting hygiene, upper, lower body dressing, sit to stand, and all transfers, wheel 150 feet once seated in wheelchair in corridor or similar space, set-up or clean-up for personal hygiene, and walk at least 10 feet once standing was not attempted due to medical condition or safety concerns. He was frequently incontinent of bladder and always continent of bowel. R2's diagnoses included cancer, dementia, and psychotic disorder. Medications included antipsychotic antiplatelet, and no falls. A wander guard or alarm system was not used.

R2's elopement risk assessment completed on 2/12/25, identified he could move without assistance while in wheelchair, had a history of wandering/elopement/exit seeking (past hospitalization or history from resident/family), dementia diagnosis and severely impaired cognition, several times a week making statements of leaving for Billings, Montana wheeling self in wheelchair to the exits. He scored seven on the assessment and identified at low risk to wander.

R2's progress notes from 2/24/25 through 3/4/25, identified:

-On 2/24/25 at 11:13 a.m. activities brought him

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FAIR OAKS NURSING & REHAB LLC	201 SHADY LANE DRIVE WADENA, MN 56482

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up to the main floor for church services in the chapel. He did fine during the service, when it was time to go back downstairs, he had behaviors. He wanted to go down the stairs to go outside and leave. He did not want to go on the elevator, activity director (AD) said Well, we will go up, she pressed the lower floor button, and he noticed that they were going down and not up. He swore at the AD and tried to get out of wheelchair. AD got him off elevator and blocked the elevator until it shut. He wanted to go back up; AD told him that she did not remember the code. He got upset, swore at the staff member again and AD walked away.

-On 2/26/25 at 1:36 p.m. he came up to nurse's station several times this shift wanted to speak with business office and call was made per his request. He stated he needed money to get to Billings, Montana to pick up his car parked in Billings, and he was going to need gas money.

-On 2/27/25 at 5:54 p.m. at approximately 4:57 p.m. AD stated to this nurse R2 was outside. This nurse alerted staff and two staff went to bring him back into the facility. At 5:04 p.m. R2 and staff are back into the facility, and he was asked where and how her got out. He replied he knew the code to the door and opened the door and went out. He stated I was going to the sheriff's office to go report his care missing. This nurse checked skin for injuries, none noted. He was placed on 15-minute checks. Door code was changed by maintenance . . . DON updated via phone.

-On 2/27/25 at 9:14 p.m. he was on 15-minute checks this evening (p.m.) shift. He had been in his room playing cards, watching television (TV) and up to nurse's station for pop several times. . .

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he told the nurse he was on his way to Billings, Montana to go get his car and just stopped here for the night to get some rest, did not think he would be arrested. The nurse stated he was not under arrest this was not a jail, and he was in the nursing home. He stated you could have fooled me this is not a jail; then why could he not have left earlier like he did. Those two girls ran right towards him, and he did not know what he was going on. The nurse stated again he was not in jail or under arrest they brought you back so you could eat supper. He was ok with this explanation and continued his card game.

-On 3/4/25 at 9:18 p.m. He had his all belongings packed in a suitcase in his room. He stated he was going to Billings, MT in the morning. He was going to check out the casinos there and get his car.

During an interview on 3/6/25, at 12:13 p.m. licensed practical nurse (LPN)-A stated she had worked 2/27/25 day shift, gave report, and left for the day. She returned to facility at approximately 4:45 p.m. and entered the memory care unit through the east hallway door located at the end of the hallway. R1 stood at the end of the hallway with his walker by the exit door when she entered, dressed in a flannel shirt, jeans, shoes, and was legally blind in one eye. He frequently told staff he wanted to go home and tried to exit the facility. R2 was in the hallway by the nurse's station in his wheelchair, was delusional, frequently asked for his car, wanted to leave the facility, and told us he was going to Billings, Montana. No wander guards were used in the memory care unit. Two NAs were at the nurse's station and the evening nurse was in the medication room located across from the nurse's station. She entered the

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medication room, talked with the nurse, and signed some papers for a total of about 15 minutes. She walked down to the exit door located at the end of the east hallway and R1 remained standing with his walker by the exit door. She stood in front of the exit door and located on the wall on the left side of the door was a code pad. R1 stood approximately seven feet behind her. She used her left hand, covered the code pad, punched in the numbers with her right hand, the light on the pad turned green, pushed the door open, entered the stairwell. The door sounded like it latched, kept walking, did not look back to see where R1 was located, opened the outside exit door, and walked out of the building in two seconds, and did not see a resident. She did not look through the window located in the inside door before she left, the door closed and latched, and she thought it was locked. She was unaware the door had taken up to three to five seconds to be locked. The east end hallway exit door was not a designated employee entrance/exit door. She was in a hurry, had parked close to that door, and ran in and out quickly. The exit door was not to be used by staff or visitors after the incident on 2/27/25. She heard R1 had caught the door before it locked, placed his foot, and held it while he flagged down R2. R1 and R2 exited the facility together and when they were found and brought back to the facility and placed on every 15-minute checks for at least five days. She was aware R1 and R2 had talked about leaving and tried to exit the memory care unit. The east hallway and exit door were not visible from the nurse's station. The staff would be expected to monitor and keep the resident within site so that they were kept safe.

During an interview on 3/6/25 at 12:33 p.m.

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F 689	Continued From page 10 nursing assistant (NA)-B stated the memory care unit was a locked unit and when a resident indicated they wanted to leave they would be monitored frequently every 15 to 30 minutes. R1 was admitted to the memory care unit not too long ago, paced the hallways and talked about leaving. Recently R1 talked more about leaving and pushed on exit doors. R2 was admitted quite a while ago and stated frequently, he did not have to be there, was held against his will, and had not signed any papers to be there. R2 talked almost daily about leaving. On 2/27/25 R1 was restless at 2:45 p.m. and provided a snack. Just after 3:45 p.m. R2 requested to go outside to smoke and was informed by LPN-B he no longer smoked. NA-A had asked LPN-B if R 1 was able to go outside. LPN-B stated R1 could not go outside alone. At 4:15 p.m. NA-A went on a short break, and she completed cares with a resident from 4:15 p.m. to 4:30 p.m. NA-A returned to the memory care unit at 4:30 p.m. and along with her walked back to nurse's station. She stated the last time she saw had R2 was between 4:00 p.m. and 4:30 p.m. Between 4:30 p.m. and 4:45 p.m. AD informed us R2 had gotten out of the building. NA-B along with NA-A immediately went outside to get R2. We found R2 in the front of the building by the archway off the side of the road stuck in a mud puddle in his wheelchair. R2 was angry, fought staff, stated he planned on calling the police station to get his keys to his truck, and had taken three staff to get him back to the building. R2 was unable to walk. We arrived back to the building at about 5:00 p.m. LPN-A had received a phone call from the apartments located on campus approximately 200 feet away. NA-A and NA-B stood in the apartment entry way with two female residents without his walker. R1 had poor vision, could only see out of one eye, unsteady	F 689		

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F 689	Continued From page 11 gait, would fallen if he had taken a wrong step, and required the assistance of a walker when ambulating. R1 would not be safe out in the community by himself, had dementia, and a poor memory. The double doors were closed earlier in the shift, tried to redirect him, he had placed hand sanitizer on his hands, and attempted to put a code in to open the exit door. There could have been more supervision of the residents during that time on 2/27/25. The nurse that exited the door at the end of the east hallway should have checked the door prior when she left the building. Staff needed to be more aware of their surroundings to keep the residents safe in the memory care unit. We are not able to see the exit door in the east hallway from the nurse's station. During an interview/observation on 3/6/25 at 1:17 p.m. R2 sat in his wheelchair in his room, well groomed, fully dressed in shoes, and television and radio on. He played cards by himself on a small desk. He stated he had waited for the sheriff to come and visit, trying to get out of here. He stated he stopped in here about one year ago and did not get sent here. He had parked his car here, was stolen, someone rolled it and got wrecked. They changed the combination on the door at the end of the hallway and he was unable to get out of the building. During an interview on 3/6/25 at 3:54 p.m. NA-D stated R1 ambulated independently with a walker and staff were expected to redirect him if he showed signs and/or talked about exit seeking. Today R1 told me he did not want to be here and tried to get out through the locked ½ door located at the entrance of the memory care unit, redirection was provided. Staff were expected to monitor R1 at least every 20 minutes when he	F 689		

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walked the hallways and/or sat down by the exit door to keep him safe. R1 was at risk for elopement, falls, frequently confused, and would have not been safe outside, in a parking lot or ambulating on uneven ground by himself. R2 frequently talked about wanting to leave the building. We were expected to redirect him with snacks and acknowledge his whereabouts, both usually worked. She checked on him at least every hour and he often visited the nurse's station. She had seen him frequently down at the end of the east hallway by the exit door. R2 attempted self-transfers, unable to walk independently, used a wheelchair for mobility, refused assistance with cares, and required help with hygiene.

During an interview on 3/7/25 at 9:15 a.m. activity director (AD) stated she clocked out for the day between 4:50 p.m. and 5:00 p.m. She left the facility building, got into her car, drove north to leave the parking lot, and when she went around the corner saw R2. He was located between the front and the east parking lot on the side of the road in his wheelchair approximately 100 feet from the building. He had pushed himself backwards with his feet going north. R2 wore a coat, tennis shoes, pants, and a shirt. She did not talk to him, re-entered the facility building and once she reached the memory care unit she saw LPN-B, NA-A and NA-B located in the nurse's station. She informed the staff R2 was outside, and they stated were surprised and unaware he had been missing. NA-A and NA-B ran down to the end of the east hallway and out the exit door. R2 had pushed himself 100 more feet down the road when she arrived back outside. R2 resisted and refused to come back inside the building, locked his feet down on the ground, one shoe

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F 689	Continued From page 13 came off, and staff pushed him back to the facility. Earlier in the week he had talked about going to Billings, Montana to get his car, was frequently confused, and at risk for elopement. Once they returned to the memory care unit, LPN-B stated she had received a phone call from the apartments located approximately 300 feet away, R1 had left the memory care unit also and walked over there. Along with NA-A and NA-B, she walked over to the apartments and assisted the staff. The NA's stood on each side of R1, placed their arm underneath his arm pits and walked him back to the facility. During an interview on 3/7/25 at 9:49 a.m. administrator stated she was notified on 2/27/25 at 4:50 p.m. by DON R2 was located outside of the building. She received another phone call shortly after that and R1 was located at the apartment building next door. R1 and R2 were appropriately dressed, outside temperature was around 45 degrees and both were outside for approximately 12 minutes. She had reviewed the video recording of the incident and LPN-A exited the east hallway door, R1 stood close by, door looked closed but slightly gaped/open. R1 reached for the door may have caught it before it latched (took three seconds to lock). R1 was a pacer and walked the hallways frequently but she was unaware he had exiting seeing behaviors prior to this incident. Three staff had worked the shift on the memory care unit, NA was on a short break, nurse and NA were on the floor. Staff were unaware R1 and R2 were missing or when they were seen last. Staff provided sufficient supervision on 2/27/25 and continued to. She was unsure whether staff were able to see residents from the nurse's station in the east hallway. Her focus was on how the residents got out of the	F 689		

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facility. Staff would be expected to monitor residents with an elopement risk located by an exit door with staff entered and exited the door. There should have been increased supervision prior to this incident when R1 was located by the east hallway exit door. R1 would have not been safe outside by himself, walking on uneven ground, and was at risk for falls.

Review of a camera recording on 3/7/25 at 10:39 a.m. with human resource director (HRD) of the facility memory care unit recorded on 2/27/25, from 4:33 p.m. to 5:03 p.m. identified:

-At 4:33 p.m. LPN-A and LPN-B were in the medication room across from the nurse's station and both exited the room.
-At 4:34 p.m. R1 was seen ambulating independently with a walker down the east hallway towards the exit door and no staff were seen in this hallway until he reached the end of the hallway. LPN-A walked down to the end of the east hallway where there was an exit door located on the left side. R1 was standing with his walker approximately four feet away from the exit door fully dressed in a cap, striped shirt, pants, and shoes on. LPN-A positioned herself in front of the exit door, did not cover up the pad while she punched in the code on the pad located off to the right of the exit door on the wall. HRD verified LPN-A did not cover up the code pad while R1 stood close by looking over her shoulder. The code pad light turned green, and LPN-A glanced to her right briefly, pushed the inside door open, and two seconds later could be seen exiting the building from the outside exit door. There was a window located on the inside exit door approximately 12 inches long by 6 inches wide. LPN-A did not look back or check to see if the

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F 689	Continued From page 15 resident was tail gating. R1 let go of his walker and grabbed the inside exit door handle and pushed it open. R1 stood in the doorway, held door open, his lips moved, and appeared he talked to someone. LPN-B and NA-B were at the nurse's station. -At 4:35 p.m. R2 pushed himself in the wheelchair out of his room located in the same hallway and down to the end of the hallway to the exit door. No staff was seen in the hallway at this time. R2 wore a black jacket, gray t-shirt, jeans, and shoes. R2's approached R1, and his lips were moving and appeared he talked to R1. NA-A and NA-B were at nurse's station. -At 4:36 p.m. R1 held open the inside exit door while R2 pushed himself in his wheelchair out into the stairwell entry. R2 opened the exit door and pushed himself with his feet on the ground outside of facility building. R1 looked toward his unreachable walker located inside the building at the end of that hallway in front of a couch below the large window, then paused for a few seconds. -At 4:37 p.m. R2 was located outside, pushed himself in the wheelchair with his feet over to the white railing on his left side, grabbed a hold of and tried to control how fast he went down the sloped sidewalk. Once he reached the end of the railing released his grip, turned to the left, and tooled down the road. Snow was observed on the ground. R1 closed the inside door, opened the outside exit door, and stood in the doorway. R2 turned wheelchair around and pushed with his feet backwards down the parking lot road. -At 4:38 p.m. R1 let go of the outside exit door and slowly walked away to from the building without his walker to the right. The outside exit door closed and R1 was no longer viewable on the camera. R2 continued to push himself away from the building while he sat in the wheelchair	F 689		

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with his feet, turned himself around, went forward then turned himself backwards again. HR stated he moved faster going backwards. R2 followed the parking lot road that ran alongside the facility building.
-At 4:39 p.m. R2 pushed himself in the wheelchair down the center of the parking lot. There was parked vehicle located on both sides of him: white truck and a black car parked on the left side and an SUV, white van, and a car parked on the right side. R2 went off camera at 4:40 p.m.
-At 4:40 p.m. LPN-B pushed a cart out of the nurse's station and entered the medication room and exited the medication room at 4:41 p.m.
-At 4:41 p.m. NA-A walked off the elevator located next to the exit door at the end of the east hallway, turned right, and walked towards the nurse's station. NA-B walked from the nurse's station area down the east hallway approximately two doors down and entered a resident's room. LPN-B sat at nurse's station.
-At 4:42 p.m. activity director (AD) walked outside to her van located in the parking lot. NA-A and NA-B entered nurse's station together. LPN-B sat in a chair by a computer. NA-A sat in a chair and NA-B prepared ice and water for residents, both located in the nurse's station. HRD stated staff are unable to see residents in the east hallway while the staff where in the nurse's station.
-At 4:45 p.m. LPN-B, NA-A and NA-B were in the nurse's station and AD approached them (per HRD was when AD informed staff she had found R2 located outside in his wheelchair). NA-A and NA-B ran down the east hallway and left the building through the exit door. LPN-A walked out of the nurse's station, down the east hallway, looked in R2's room, and to the exit door at the end of the hallway. LPN-A lifted a walker (R1's, confirmed by HRD) located by the exit door,

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F 689	Continued From page 17 moved it aside then sat down on the couch located below the large window, and looked outside. -At 4:48 p.m. LPN-B stood up from the couch, walked quickly down the hallway towards the nurse's station. -At 4:50 p.m. LPN-B turned around in hallway, walked back down to the end of the east hallway and looked in the last room located on the right side of the hallway across from the exit door. She walked back down the east hallway to the other end, turned left then right into the nurse's station. She looked through the open window located between the nurse's station and the lounge/dining room/commons area. At 4:51 p.m. she sat down in front of computer in the nurse's station on the telephone. -At 4:54 p.m. staff pushed R2 in a wheelchair back into the facility building through the exit door located at the end of the east hallway. R2's right foot did not have a shoe on it. -At 4:56 p.m. LPN-B was located at the nurse's station hung up phone and NA-A and NA-B ran back out of building through the east hallway exit door. LPN-B stood in east hallway next to R2 located just outside his room in his wheelchair. -At 4:57 p.m. LPN-B walked back to nurse's station -At 4:49 p.m. LPN-B walked down to the end of the east hallway, gave the door a push, did not open, and sat down on the couch located underneath the window at the end of the hallway. -At 5:00 p.m. NA-C approached the outside exit door located at the east end of the hallway, unable to enter building, LPN-B opened inside and outside exit doors and allowed NA-C entrance. LPN-B pulled the exit doors closed and sat back down on the couch. -At 5:02 p.m. LPN-B pushed R1's walker down	F 689		

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F 689	Continued From page 18	F 689		

the hallway from the end of the east hallway located by the exit door towards the nurse's station. R1 entered the memory care unit escorted by five staff without a walker. An unidentified female staff held his left hand while he walked down the hallway towards his room.
-At 5:03 p.m. LPN-B, NA-A, and NA-B were at the nurse's station.

During an interview on 3/7/25 at 2:15 p.m. NA-A stated the memory care unit was a locked unit and staff were expected to have checked on residents at least every 15 to 20 minutes. There were at least three residents in the unit that were at risk for elopement. R1 and R2 sat together at the end of the east hallway and had conversations. She had noticed R1 pressed numbers on the code pad by the exit door many times located at the end of the east hallway days prior to the incident on 2/27/25. She informed the nurse and closely watched R1 and R2 when they talked about leaving the facility. R2 talked about leaving the facility at least two to three times a shift, wanted to get his car back. R1 had told her he thought he was in jail and wanted fresh air. R1 and R2 move around the unit frequently and when they saw someone leaving, one of them, tried opening the door. She stated the day of the 2/27/25 incident, R1 had approached her and asked to be let outside, continued to walk the hallways, sat at the end of the east hallway by the exit door. She updated LPN-A and was informed R1 was not allowed go outside by himself, and staff would be expected to stay with him in the courtyard. R2 had a visitor/volunteer and had requested to go outside and smoke. LPN-A informed the volunteer he no longer smoked. R2 would not be safe outside by himself, was frequently forgetful, unable to walk independently,

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F 689	Continued From page 19 and dependent upon a wheelchair for mobility. At approximately 4:20 p.m. she informed LPN-A and NA-B she was taking a quick break, left the floor, and returned approximately 4:30 p.m. LPN-A sat at the nurse's station and AD stopped by the memory care unit and yelled out R2 was outside. Prior to her break R2 was in his room visiting with a volunteer. NA-A and NA-B ran down the east hallway and left the building through the exit door located at the end of the hallway. She located R2 at the front of the building in his wheelchair off the side of the road stuck in the snow. R2 was upset, refused to go with back inside building, spit on her, and stated he was a grown person, did not have to stay, and wanted to go. Just after 4:30 p.m. R2 was brought back to the facility and entered the building through the east hallway exit door. R1's walker was left at the end of the hallway. LPN-A was on the phone and informed her and NA-B R1 was out of the building also and found at the apartments next door. Along with NA-B she ran back down the hallway and exited the building through the east hallway exit door. R1 was walked back to the facility and all residents in the memory care unit were checked on. She was not aware R1 and R2 were missing. During an interview/observation on 3/7/25 at 2:30 p.m. maintenance (M) stated and demonstrated on the end of the east hallway exit door when the code was entered into the code pad located on the wall right side of the inside exit door at eye level, the button turned green, within three seconds the button turned red and the door latched and locked. M pushed on door and demonstrated the door locked within three seconds. M verified all the codes were changed on 2/27/25 immediately after the incident with R1 and R2. Wander guards/door alarms were not	F 689		

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used in the memory care unit. M stated wander guards would be acceptable and would have provided an alarm to alert staff the exit door was opened and/or exited by a resident. Staff would be expected to have checked the exit door prior to leaving the building and looked for any resident that may have been located close by assure they did not leave the building unattended. Residents left outside unsupervised would be at risk for falls and injury from cars that passed by.

During an observation on 3/7/25 at 3:20 p.m. R1 ambulated independently with a walker towards an exit door at the end of the hallway where his room was located. R1 pushed the bar located on the door and tried to open it. Door did not open. Staff approached him immediately and redirected him.

During an observation on 3/7/25 at 3:32 p.m. R1 ambulated independently with a walker down to the end of the east hallway and sat on the couch near the exit door.

During an interview on 3/7/25 at 3:38 p.m. R1 stated he was unable to visually see out of his right eye. He was restricted as to where he went, unable to come and go as he liked, and wished he could have spent more time outside. He had exited out of the memory care unit door, walked around the corner, and realized he was unable to get back into the building. He walked outside down the road without his walker, legs felt wonderful, and he felt great. He did not mean to hurt anything by going outside, just wanted some fresh air, and was sorry now.

During an interview on 3/7/25 at 4:10 p.m. DON stated our company did not like wander guards

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F 689	Continued From page 21 and they were not being used. Wander guard usage would be the best solution in the memory care unit so that an incident such as the one on 2/2/7/25 did not occur again. R1 had a history of exit seeking and when his family visited increased, at risk for elopement, lacked short term memory, left his walker inside the building, at risk for falls especially outside without a walker, a vulnerable adult, and could have been taken advantage of. R2 was at risk for falls and elopement, unable to stand and take steps independently, could have possibly been hit by a car and/or stuck in a spot outside. Neither R1 nor R2 would be considered safe outside in the community alone. She would have expected when the nurse left the facility, turn around and looked behind her, make sure the resident had not followed her outside, secured the inside exit door so that it was closed and locked behind her prior to leaving through the outside exit door. Staff were expected to monitor residents closely when they were made aware they were down by an exit door and verbalized they wanted to leave. The resident may have required redirection and could have potentially avoided him leaving the building. During an interview on 3/10/25 at 9:00 p.m. LPN-B stated was unable to see the east and south hallways (the two hallways where resident rooms were located) in the memory care unit while she was in the nurse's station. R1 was mobile, ambulated in hallway frequently, sat down at the end of the east hallway on the couch by the exit door, approached doors, tried to place codes on the pads to open doors. R2 verbalized frequently he was leaving the facility. She worked at 2:00 p.m. on 2/27/25. At 3:00 p.m. she passed medications to residents and NA's completed	F 689		

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F 689	Continued From page 22 their rounds. She had called LPN-A and asked her to come back to sign narcotic book. LPN-A arrived back at the facility between 4:30 p.m. and 4:45 p.m., we talked, she signed the book and had taken 15 minutes. She had seen R1 between 4:15 p.m. and 4:30 p.m. ambulating with his walker by the nurse's station. NA-A left the floor at 4:30 p.m. for a 15-minute break and returned at 4:45 p.m. NA-B was in a resident's room located in on the right side of the hallway with about two doors down. Between 4:45 p.m. and 4:50 p.m. AD came down to the memory care unit and asked if she knew R2 was outside in front of the building. She was surprised and unaware he had been missing. NA-A and NA-B ran down the hallway and outside to find R2. She walked down to the end of the east hallway, looked out the window, and noticed R1's walker had been left in the hallway outside the last room on the right. She thought, where was R1 and looked in the room at the end of the hallway, walked back down to nurse's station, looked in other rooms, and the commons/dining room. She stated had not remembered if she sat on the couch at the end of the east hallway by the exit door. R2 was brought back to the building. She had seen R2 last between 4:20 p.m. and 4:25 p.m. at the nurse's station, he requested pop. R2 was not at risk for elopement, had tried to exit the building prior to the incident on 2/27/25 (according to other staff), unable to ambulate, at risk for falls, was delusional, had memory problems, and would not be safe outside in the community by himself. She had received a telephone call from a woman that lived at the apartments next door and was informed R1 had walked over there. She called upstairs and requested assistance from staff. R1 had left his walker in the hallway in the memory care unit, unable to ambulate safely	F 689		

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without it, legally blind, hard of hearing, was at risk for elopement, there was snow on the ground, and anything could have happened. She was the nurse on duty, and it was her responsibility to have kept the residents safe. She was not made aware by staff, R1 or R2 requested to leave on 2/27/25 prior to the incident. Would have been important to monitor the residents frequently, kept tabs and an eye on them to see what they were doing and where they were. Staff were expected to have looked around prior to exiting a door from the memory care unit to make sure a resident was not located behind them and keep them safe.

Facility policy Elopement Risk and Prevention dated 6/2/22, identified all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that placed them at risk for wandering/elopement and would have these issues address in their individual care plan. Wandering resident was defined as random or repetitive locomotion that may be goal-directed (e.g., person appeared to be searching for something such as an exit) or maybe non-goal directed or aimless. Residents identified at risk for possible elopement shall be accompanied by staff or responsible party, when outside of the facility and would include on and off the facility grounds. Even when all precautions are taken, a resident may walk away from the facility and cannot be located by staff. In such instances, the following procedures shall be put into action immediately: call code yellow (or code based on facility a protocol) initiate an all staff searches of the building interior including the basement. All staff is responsible to respond and assist. Search every room and bathroom, including basements,

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F 689	Continued From page 24 offices, and locked rooms. During the initial 15 to 30 minutes, cover the radius of approximately one mile from the facility. Interview staff and determine who last saw the resident and what they were wearing.	F 689		

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2 000	Initial Comments	2 000		

*****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 3/6/25 through 3/7/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders

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2 000	Continued From page 1	2 000		

and identify the date when they will be completed.

The following complaints were reviewed: H55818981C (MN00111116) and H55818922C (MN00111115) with a licensing order issued at 0830.

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions to provide adequate monitoring and supervision for 2 of 3 residents (R1, R2) who reside on a memory care unit. R1 and R2 identified with wandering, elopement behaviors, and left the facility without staff being aware of where they were. Findings included:	2 830	Corrected	3/21/25

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R1's elopement risk assessment completed on 1/5/25, identified he was ambulatory, had a history of wandering/elopement/exit seeking, dementia, wandered within the home without leaving grounds, and experienced sundowners (increased confusion, difficulty sleeping, anxiety, agitation, hallucinations, pacing and disorientation people living with dementia may experience from dusk throughout the night). He scored 10 on the assessment (0-8 low risk, 9-10 at risk to wander, 11-above high risk to wander) and was at risk to wander.

R1's care plan dated 1/6/25, identified activity of daily living (ADL) self-care deficit and high risk for falls related to weakness, blind in right eye, hearing difficulty, and impaired cognition. He was independent with straight care (walker per DON) in halls, room, and transfers and required guidance for orientation. He was an elopement risk/wanderer/at risk to leave facility without notice/unauthorized related to dementia. Staff were directed to monitor for exit seeking, wandering, talking about leaving facility, document episodes, and offer activities for distraction, toileting, walking inside/outside, call family, structured activities, food, conversation, television, and books. He lived in the special care/secured unit and staff were directed to monitor for tailgating when visitors were in the building and provide a safe and secure environment.

R1's Cognitive Performance Test (CPT) (a standardized occupational therapy (OT) assessment initially developed as a research instrument to assess cognition in daily tasks performance and change over time with Alzheimer's disease) dated 1/8/25, identified and

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an average CPT score of 4/4 out of 5/6 and indicated the need for 24-hour supervision.

R1's admission Minimum Data Set (MDS) dated 1/9/25, identified continent of bowel and bladder. His diagnoses included congestive heart failure (CHF), kidney failure, diabetes mellitus (DM), dementia, anxiety, and no falls. Admitted to facility on 1/3/25, from a hospital. He had moderately impaired cognition, no behaviors, and sometimes socially isolated himself. He required set-up/clean up assistance with toileting hygiene, supervision/cues for eating, independent with oral hygiene, dressing himself, sit to stand, all transfers, ambulated up to 150 feet in corridor, walking on uneven surface and steps/curbs not attempted due to medical condition or safety concerns, used a walker for mobility. His medications included antipsychotic, antidepressant, diuretic, opioid antiplatelet, and hypoglycemic (lowers blood sugar). A wander guard or alarm system was not used.

R1's OT evaluation dated 2/7/25, identified he had demonstrated a physical decline and OT services would be restarted to improve activities of daily living (ADLs) participation and safety. History included legally blind right side, high risk for falls, moderate/severe cognitive performance, moderately impaired decision making, and impaired safety awareness. He moved slowly and demonstrated impaired balance at evaluation. OT was started three times a week with a duration of 30 days.

R1's physical therapy (PT) evaluation dated 2/7/25, identified he had difficulty this week with sit to standing and order was placed for evaluation to be completed. Medical history identified gait abnormalities, unsteadiness on

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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) COMPLETE DATE
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feet, and dementia with behavior disturbances. PT was started three time a week with a duration of 30 days.

R1's progress notes from 2/26/25 through 2/27/25, identified:

-On 2/26/25 at 9:54 a.m. R1 stated to writer his legs were not working and needed help getting up. He was able to get up out of bed with assist of two. Once he was up out of bed was able to ambulate and used front wheeled walker, gait belt, and standby assist. . . Hard of hearing (HOH) wore hearing aids in both ears and refused to wear ... continued to work the physical/occupational therapy during the week.

-On 2/27/25 at 6:51 p.m. nurse noticed R1's walker at the end of the hallway. This nurse started to look for him and alerted other staff to search for him. When this nurse came up towards the nurse's station the phone rang, answered phone and the caller stated "I believe I have one of your residents here (she was from the apartments next door). This nurse immediately sent a staff member over to the apartments to bring him back to the facility. Once he was back into the facility, this nurse asked him how and where he ended up outside. He stated he pressed the numbers, and it turned green, so opened the door and went out. This nurse asked him where he was going and he replied I do not know, nowhere. Skin was checked for injuries, none noted. Maintenance still here in the building and changed the code on the door. He was placed on 15-minute checks until further notice. Director of nursing (DON) was updated via phone call. This nurse called guardian (phone message stated she was on vacation). Did attempt to call the stand in guardian, unable to reach her. Will

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attempt to reach her tomorrow. Physician will be updated via fax.

-On 2/27/25 at 9:32 p.m. R1 had been started on 15-minute checks this earning. He has been wandering the hallways with his walker and sitting in recliner chairs in a variety of areas. When he was seen going down to the east hallway with the walker, staff had asked him to go to the lounge area or his room to get his mind off going towards the door at the end of the hallway. He has been closely monitored by staff of his whereabouts.

R2's PT evaluation dated 7/22/24, identified was discharged from PT a few months ago, placed on walking program with caregivers assist of one and front wheeled walker (FWW), had not been walking anymore and had declined in his mobility. He required supervision or touching assistance with ambulation up to 50 feet and unable to attempt 150 feet due to medical conditions or safety concerns. His gait pattern included a very short and shuffling steps where his feet caught on each other, walked very narrow base of support (BOS), and flexed knees.

R2's OT evaluation dated 12/11/24, identified moderately impaired decision making, impaired safety awareness, and muscle weakness. He had fallen once in the past year and felt unsteady when he walked.

R2's care plan dated 1/2/25, identified limited physical mobility, unsteady gait, weakness, and other abnormalities of gait and mobility. Staff were instructed to have provide assistance of one with ambulation/locomotion and independent with wheelchair-based pivot transfers in room. R2 had purpose driven wandering and tried to get outside to smoke. Staff were directed to monitor for exit

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seeking or wandering behaviors, attempting to push on doors, type numbers into mag lock, and threatening to leave. Additionally, staff were directed to redirect, assess for needs, take outside for a walk as able, and offer food/drink. R2 had a history of delusions of needing to go to court and wandering/exit seeking increased when someone visited and then left. R2 lived in the special care unit that was secured and staff were directed to monitor for tailgating when visitors were in the building, identify when pattern of wandering was purposeful, aimless, or escapist and intervene as appropriate. R2 had impaired cognition function related to dementia and short-term memory loss. Staff were directed to cue, reorient, and supervise as needed. R2 benefited/required a secure memory care unit due to impaired cognition, dementia with psychotic disturbances, and behaviors. Staff were directed to monitor for changes in behaviors and provide a safe environment.

R2's CPT dated 1/8/25, identified an average CPT score of 4.0/5.6 and indicated moderate cognitive impairment and the need for 24-hour supervision and assistance.

R2's quarterly MDS dated 1/27/25, identified admitted to facility on 10/4/22. from a hospital. He had severely impaired cognition, sometimes socially isolates self, rejection of care happened 4 to 6 days out of 7 during look back period, and delusions (misconceptions or beliefs that are firmly held, contrary to reality). He had bilateral lower extremity impairment and used a wheelchair for mobility. He required supervision/touching with toileting hygiene, upper, lower body dressing, sit to stand, and all transfers, wheel 150 feet once seated in wheelchair in corridor or similar space, set-up or

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clean-up for personal hygiene, and walk at least 10 feet once standing was not attempted due to medical condition or safety concerns. He was frequently incontinent of bladder and always continent of bowel. R2's diagnoses included cancer, dementia, and psychotic disorder. Medications included antipsychotic antiplatelet, and no falls. A wander guard or alarm system was not used.

R2's elopement risk assessment completed on 2/12/25, identified he could move without assistance while in wheelchair, had a history of wandering/elopement/exit seeking (past hospitalization or history from resident/family), dementia diagnosis and severely impaired cognition, several times a week making statements of leaving for Billings, Montana wheeling self in wheelchair to the exits. He scored seven on the assessment and identified at low risk to wander.

R2's progress notes from 2/24/25 through 3/4/25, identified:

-On 2/24/25 at 11:13 a.m. activities brought him up to the main floor for church services in the chapel. He did fine during the service, when it was time to go back downstairs, he had behaviors. He wanted to go down the stairs to go outside and leave. He did not want to go on the elevator, activity director (AD) said Well, we will go up, she pressed the lower floor button, and he noticed that they were going down and not up. He swore at the AD and tried to get out of wheelchair. AD got him off elevator and blocked the elevator until it shut. He wanted to go back up; AD told him that she did not remember the code. He got upset, swore at the staff member again and AD walked away.

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2 830	Continued From page 9 -On 2/26/25 at 1:36 p.m. he came up to nurse's station several times this shift wanted to speak with business office and call was made per his request. He stated he needed money to get to Billings, Montana to pick up his car parked in Billings, and he was going to need gas money. -On 2/27/25 at 5:54 p.m. at approximately 4:57 p.m. AD stated to this nurse R2 was outside. This nurse alerted staff and two staff went to bring him back into the facility. At 5:04 p.m. R2 and staff are back into the facility, and he was asked where and how her got out. He replied he knew the code to the door and opened the door and went out. He stated I was going to the sheriff's office to go report his care missing. This nurse checked skin for injuries, none noted. He was placed on 15-minute checks. Door code was changed by maintenance . . . DON updated via phone. -On 2/27/25 at 9:14 p.m. he was on 15-minute checks this evening (p.m.) shift. He had been in his room playing cards, watching television (TV) and up to nurse's station for pop several times. . . he told the nurse he was on his way to Billings, Montana to go get his car and just stopped here for the night to get some rest, did not think he would be arrested. The nurse stated he was not under arrest this was not a jail, and he was in the nursing home. He stated you could have fooled me this is not a jail; then why could he not have left earlier like he did. Those two girls ran right towards him, and he did not know what he was going on. The nurse stated again he was not in jail or under arrest they brought you back so you could eat supper. He was ok with this explanation and continued his card game. -On 3/4/25 at 9:18 p.m. He had his all belongings	2 830		

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packed in a suitcase in his room. He stated he was going to Billings, MT in the morning. He was going to check out the casinos there and get his car.

During an interview on 3/6/25, at 12:13 p.m. licensed practical nurse (LPN)-A stated she had worked 2/27/25 day shift, gave report, and left for the day. She returned to facility at approximately 4:45 p.m. and entered the memory care unit through the east hallway door located at the end of the hallway. R1 stood at the end of the hallway with his walker by the exit door when she entered, dressed in a flannel shirt, jeans, shoes, and was legally blind in one eye. He frequently told staff he wanted to go home and tried to exit the facility. R2 was in the hallway by the nurse's station in his wheelchair, was delusional, frequently asked for his car, wanted to leave the facility, and told us he was going to Billings, Montana. No wander guards were used in the memory care unit. Two NAs were at the nurse's station and the evening nurse was in the medication room located across from the nurse's station. She entered the medication room, talked with the nurse, and signed some papers for a total of about 15 minutes. She walked down to the exit door located at the end of the east hallway and R1 remained standing with his walker by the exit door. She stood in front of the exit door and located on the wall on the left side of the door was a code pad. R1 stood approximately seven feet behind her. She used her left hand, covered the code pad, punched in the numbers with her right hand, the light on the pad turned green, pushed the door open, entered the stairwell. The door sounded like it latched, kept walking, did not look back to see where R1 was located, opened the outside exit door, and walked out of the building in two seconds, and did not see a

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resident. She did not look through the window located in the inside door before she left, the door closed and latched, and she thought it was locked. She was unaware the door had taken up to three to five seconds to be locked. The east end hallway exit door was not a designated employee entrance/exit door. She was in a hurry, had parked close to that door, and ran in and out quickly. The exit door was not to be used by staff or visitors after the incident on 2/27/25. She heard R1 had caught the door before it locked, placed his foot, and held it while he flagged down R2. R1 and R2 exited the facility together and when they were found and brought back to the facility and placed on every 15-minute checks for at least five days. She was aware R1 and R2 had talked about leaving and tried to exit the memory care unit. The east hallway and exit door were not visible from the nurse's station. The staff would be expected to monitor and keep the resident within site so that they were kept safe.

During an interview on 3/6/25 at 12:33 p.m. nursing assistant (NA)-B stated the memory care unit was a locked unit and when a resident indicated they wanted to leave they would be monitored frequently every 15 to 30 minutes. R1 was admitted to the memory care unit not too long ago, paced the hallways and talked about leaving. Recently R1 talked more about leaving and pushed on exit doors. R2 was admitted quite a while ago and stated frequently, he did not have to be there, was held against his will, and had not signed any papers to be there. R2 talked almost daily about leaving. On 2/27/25 R1 was restless at 2:45 p.m. and provided a snack. Just after 3:45 p.m. R2 requested to go outside to smoke and was informed by LPN-B he no longer smoked. NA-A had asked LPN-B if R 1 was able to go outside. LPN-B stated R1 could not go outside

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alone. At 4:15 p.m. NA-A went on a short break, and she completed cares with a resident from 4:15 p.m. to 4:30 p.m. NA-A returned to the memory care unit at 4:30 p.m. and along with her walked back to nurse's station. She stated the last time she saw had R2 was between 4:00 p.m. and 4:30 p.m. Between 4:30 p.m. and 4:45 p.m. AD informed us R2 had gotten out of the building. NA-B along with NA-A immediately went outside to get R2. We found R2 in the front of the building by the archway off the side of the road stuck in a mud puddle in his wheelchair. R2 was angry, fought staff, stated he planned on calling the police station to get his keys to his truck, and had taken three staff to get him back to the building. R2 was unable to walk. We arrived back to the building at about 5:00 p.m. LPN-A had received a phone call from the apartments located on campus approximately 200 feet away. NA-A and NA-B stood in the apartment entry way with two female residents without his walker. R1 had poor vision, could only see out of one eye, unsteady gait, would fallen if he had taken a wrong step, and required the assistance of a walker when ambulating. R1 would not be safe out in the community by himself, had dementia, and a poor memory. The double doors were closed earlier in the shift, tried to redirect him, he had placed hand sanitizer on his hands, and attempted to put a code in to open the exit door. There could have been more supervision of the residents during that time on 2/27/25. The nurse that exited the door at the end of the east hallway should have checked the door prior when she left the building. Staff needed to be more aware of their surroundings to keep the residents safe in the memory care unit. We are not able to see the exit door in the east hallway from the nurse's station.

During an interview/observation on 3/6/25 at 1:17

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p.m. R2 sat in his wheelchair in his room, well groomed, fully dressed in shoes, and television and radio on. He played cards by himself on a small desk. He stated he had waited for the sheriff to come and visit, trying to get out of here. He stated he stopped in here about one year ago and did not get sent here. He had parked his car here, was stolen, someone rolled it and got wrecked. They changed the combination on the door at the end of the hallway and he was unable to get out of the building.

During an interview on 3/6/25 at 3:54 p.m. NA-D stated R1 ambulated independently with a walker and staff were expected to redirect him if he showed signs and/or talked about exit seeking. Today R1 told me he did not want to be here and tried to get out through the locked ½ door located at the entrance of the memory care unit, redirection was provided. Staff were expected to monitor R1 at least every 20 minutes when he walked the hallways and/or sat down by the exit door to keep him safe. R1 was at risk for elopement, falls, frequently confused, and would have not been safe outside, in a parking lot or ambulating on uneven ground by himself. R2 frequently talked about wanting to leave the building. We were expected to redirect him with snacks and acknowledge his whereabouts, both usually worked. She checked on him at least every hour and he often visited the nurse's station. She had seen him frequently down at the end of the east hallway by the exit door. R2 attempted self-transfers, unable to walk independently, used a wheelchair for mobility, refused assistance with cares, and required help with hygiene.

During an interview on 3/7/25 at 9:15 a.m. activity director (AD) stated she clocked out for the day

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2 830	Continued From page 14 between 4:50 p.m. and 5:00 p.m. She left the facility building, got into her car, drove north to leave the parking lot, and when she went around the corner saw R2. He was located between the front and the east parking lot on the side of the road in his wheelchair approximately 100 feet from the building. He had pushed himself backwards with his feet going north. R2 wore a coat, tennis shoes, pants, and a shirt. She did not talk to him, re-entered the facility building and once she reached the memory care unit she saw LPN-B, NA-A and NA-B located in the nurse's station. She informed the staff R2 was outside, and they stated were surprised and unaware he had been missing. NA-A and NA-B ran down to the end of the east hallway and out the exit door. R2 had pushed himself 100 more feet down the road when she arrived back outside. R2 resisted and refused to come back inside the building, locked his feet down on the ground, one shoe came off, and staff pushed him back to the facility. Earlier in the week he had talked about going to Billings, Montana to get his car, was frequently confused, and at risk for elopement. Once they returned to the memory care unit, LPN-B stated she had received a phone call from the apartments located approximately 300 feet away, R1 had left the memory care unit also and walked over there. Along with NA-A and NA-B, she walked over to the apartments and assisted the staff. The NA's stood on each side of R1, placed their arm underneath his arm pits and walked him back to the facility. During an interview on 3/7/25 at 9:49 a.m. administrator stated she was notified on 2/27/25 at 4:50 p.m. by DON R2 was located outside of the building. She received another phone call shortly after that and R1 was located at the apartment building next door. R1 and R2 were	2 830		

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appropriately dressed, outside temperature was around 45 degrees and both were outside for approximately 12 minutes. She had reviewed the video recording of the incident and LPN-A exited the east hallway door, R1 stood close by, door looked closed but slightly gaped/open. R1 reached for the door may have caught it before it latched (took three seconds to lock). R1 was a pacer and walked the hallways frequently but she was unaware he had exiting seeing behaviors prior to this incident. Three staff had worked the shift on the memory care unit, NA was on a short break, nurse and NA were on the floor. Staff were unaware R1 and R2 were missing or when they were seen last. Staff provided sufficient supervision on 2/27/25 and continued to. She was unsure whether staff were able to see residents from the nurse's station in the east hallway. Her focus was on how the residents got out of the facility. Staff would be expected to monitor residents with an elopement risk located by an exit door with staff entered and exited the door. There should have been increased supervision prior to this incident when R1 was located by the east hallway exit door. R1 would have not been safe outside by himself, walking on uneven ground, and was at risk for falls.

Review of a camera recording on 3/7/25 at 10:39 a.m. with human resource director (HRD) of the facility memory care unit recorded on 2/27/25, from 4:33 p.m. to 5:03 p.m. identified:

-At 4:33 p.m. LPN-A and LPN-B were in the medication room across from the nurse's station and both exited the room.
-At 4:34 p.m. R1 was seen ambulating independently with a walker down the east hallway towards the exit door and no staff were seen in this hallway until he reached the end of

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the hallway. LPN-A walked down to the end of the east hallway where there was an exit door located on the left side. R1 was standing with his walker approximately four feet away from the exit door fully dressed in a cap, striped shirt, pants, and shoes on. LPN-A positioned herself in front of the exit door, did not cover up the pad while she punched in the code on the pad located off to the right of the exit door on the wall. HRD verified LPN-A did not cover up the code pad while R1 stood close by looking over her shoulder. The code pad light turned green, and LPN-A glanced to her right briefly, pushed the inside door open, and two seconds later could be seen exiting the building from the outside exit door. There was a window located on the inside exit door approximately 12 inches long by 6 inches wide. LPN-A did not look back or check to see if the resident was tail gating. R1 let go of his walker and grabbed the inside exit door handle and pushed it open. R1 stood in the doorway, held door open, his lips moved, and appeared he talked to someone. LPN-B and NA-B were at the nurse's station.
-At 4:35 p.m. R2 pushed himself in the wheelchair out of his room located in the same hallway and down to the end of the hallway to the exit door. No staff was seen in the hallway at this time. R2 wore a black jacket, gray t-shirt, jeans, and shoes. R2's approached R1, and his lips were moving and appeared he talked to R1. NA-A and NA-B were at nurse's station.
-At 4:36 p.m. R1 held open the inside exit door while R2 pushed himself in his wheelchair out into the stairwell entry. R2 opened the exit door and pushed himself with his feet on the ground outside of facility building. R1 looked toward his unreachable walker located inside the building at the end of that hallway in front of a couch below the large window, then paused for a few seconds.

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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) COMPLETE DATE
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-At 4:37 p.m. R2 was located outside, pushed himself in the wheelchair with his feet over to the white railing on his left side, grabbed a hold of and tried to control how fast he went down the sloped sidewalk. Once he reached the end of the railing released his grip, turned to the left, and tooled down the road. Snow was observed on the ground. R1 closed the inside door, opened the outside exit door, and stood in the doorway. R2 turned wheelchair around and pushed with his feet backwards down the parking lot road.
-At 4:38 p.m. R1 let go of the outside exit door and slowly walked away to from the building without his walker to the right. The outside exit door closed and R1 was no longer viewable on the camera. R2 continued to push himself away from the building while he sat in the wheelchair with his feet, turned himself around, went forward then turned himself backwards again. HR stated he moved faster going backwards. R2 followed the parking lot road that ran alongside the facility building.
-At 4:39 p.m. R2 pushed himself in the wheelchair down the center of the parking lot. There was parked vehicle located on both sides of him: white truck and a black car parked on the left side and an SUV, white van, and a car parked on the right side. R2 went off camera at 4:40 p.m.
-At 4:40 p.m. LPN-B pushed a cart out of the nurse's station and entered the medication room and exited the medication room at 4:41 p.m.
-At 4:41 p.m. NA-A walked off the elevator located next to the exit door at the end of the east hallway, turned right, and walked towards the nurse's station. NA-B walked from the nurse's station area down the east hallway approximately two doors down and entered a resident's room. LPN-B sat at nurse's station.
-At 4:42 p.m. activity director (AD) walked outside to her van located in the parking lot. NA-A and

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NA-B entered nurse's station together. LPN-B sat in a chair by a computer. NA-A sat in a chair and NA-B prepared ice and water for residents, both located in the nurse's station. HRD stated staff are unable to see residents in the east hallway while the staff where in the nurse's station.
-At 4:45 p.m. LPN-B, NA-A and NA-B were in the nurse's station and AD approached them (per HRD was when AD informed staff she had found R2 located outside in his wheelchair). NA-A and NA-B ran down the east hallway and left the building through the exit door. LPN-A walked out of the nurse's station, down the east hallway, looked in R2's room, and to the exit door at the end of the hallway. LPN-A lifted a walker (R1's, confirmed by HRD) located by the exit door, moved it aside then sat down on the couch located below the large window, and looked outside.
-At 4:48 p.m. LPN-B stood up from the couch, walked quickly down the hallway towards the nurse's station.
-At 4:50 p.m. LPN-B turned around in hallway, walked back down to the end of the east hallway and looked in the last room located on the right side of the hallway across from the exit door. She walked back down the east hallway to the other end, turned left then right into the nurse's station. She looked through the open window located between the nurse's station and the lounge/dining room/commons area. At 4:51 p.m. she sat down in front of computer in the nurse's station on the telephone.
-At 4:54 p.m. staff pushed R2 in a wheelchair back into the facility building through the exit door located at the end of the east hallway. R2's right foot did not have a shoe on it.
-At 4:56 p.m. LPN-B was located at the nurse's station hung up phone and NA-A and NA-B ran back out of building through the east hallway exit

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door. LPN-B stood in east hallway next to R2 located just outside his room in his wheelchair.
-At 4:57 p.m. LPN-B walked back to nurse's station
-At 4:49 p.m. LPN-B walked down to the end of the east hallway, gave the door a push, did not open, and sat down on the couch located underneath the window at the end of the hallway.
-At 5:00 p.m. NA-C approached the outside exit door located at the east end of the hallway, unable to enter building, LPN-B opened inside and outside exit doors and allowed NA-C entrance. LPN-B pulled the exit doors closed and sat back down on the couch.
-At 5:02 p.m. LPN-B pushed R1's walker down the hallway from the end of the east hallway located by the exit door towards the nurse's station. R1 entered the memory care unit escorted by five staff without a walker. An unidentified female staff held his left hand while he walked down the hallway towards his room.
-At 5:03 p.m. LPN-B, NA-A, and NA-B were at the nurse's station.

During an interview on 3/7/25 at 2:15 p.m. NA-A stated the memory care unit was a locked unit and staff were expected to have checked on residents at least every 15 to 20 minutes. There were at least three residents in the unit that were at risk for elopement. R1 and R2 sat together at the end of the east hallway and had conversations. She had noticed R1 pressed numbers on the code pad by the exit door many times located at the end of the east hallway days prior to the incident on 2/27/25. She informed the nurse and closely watched R1 and R2 when they talked about leaving the facility. R2 talked about leaving the facility at least two to three times a shift, wanted to get his car back. R1 had told her he thought he was in jail and wanted fresh air. R1

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and R2 move around the unit frequently and when they saw someone leaving, one of them, tried opening the door. She stated the day of the 2/27/25 incident, R1 had approached her and asked to be let outside, continued to walk the hallways, sat at the end of the east hallway by the exit door. She updated LPN-A and was informed R1 was not allowed go outside by himself, and staff would be expected to stay with him in the courtyard. R2 had a visitor/volunteer and had requested to go outside and smoke. LPN-A informed the volunteer he no longer smoked. R2 would not be safe outside by himself, was frequently forgetful, unable to walk independently, and dependent upon a wheelchair for mobility. At approximately 4:20 p.m. she informed LPN-A and NA-B she was taking a quick break, left the floor, and returned approximately 4:30 p.m. LPN-A sat at the nurse's station and AD stopped by the memory care unit and yelled out R2 was outside. Prior to her break R2 was in his room visiting with a volunteer. NA-A and NA-B ran down the east hallway and left the building through the exit door located at the end of the hallway. She located R2 at the front of the building in his wheelchair off the side of the road stuck in the snow. R2 was upset, refused to go with back inside building, spit on her, and stated he was a grown person, did not have to stay, and wanted to go. Just after 4:30 p.m. R2 was brought back to the facility and entered the building through the east hallway exit door. R1's walker was left at the end of the hallway. LPN-A was on the phone and informed her and NA-B R1 was out of the building also and found at the apartments next door. Along with NA-B she ran back down the hallway and exited the building through the east hallway exit door. R1 was walked back to the facility and all residents in the memory care unit were checked on. She was not aware R1 and R2 were missing.

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During an interview/observation on 3/7/25 at 2:30 p.m. maintenance (M) stated and demonstrated on the end of the east hallway exit door when the code was entered into the code pad located on the wall right side of the inside exit door at eye level, the button turned green, within three seconds the button turned red and the door latched and locked. M pushed on door and demonstrated the door locked within three seconds. M verified all the codes were changed on 2/27/25 immediately after the incident with R1 and R2. Wander guards/door alarms were not used in the memory care unit. M stated wander guards would be acceptable and would have provided an alarm to alert staff the exit door was opened and/or exited by a resident. Staff would be expected to have checked the exit door prior to leaving the building and looked for any resident that may have been located close by assure they did not leave the building unattended. Residents left outside unsupervised would be at risk for falls and injury from cars that passed by.

During an observation on 3/7/25 at 3:20 p.m. R1 ambulated independently with a walker towards an exit door at the end of the hallway where his room was located. R1 pushed the bar located on the door and tried to open it. Door did not open. Staff approached him immediately and redirected him.

During an observation on 3/7/25 at 3:32 p.m. R1 ambulated independently with a walker down to the end of the east hallway and sat on the couch near the exit door.

During an interview on 3/7/25 at 3:38 p.m. R1 stated he was unable to visually see out of his right eye. He was restricted as to where he went,

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unable to come and go as he liked, and wished he could have spent more time outside. He had exited out of the memory care unit door, walked around the corner, and realized he was unable to get back into the building. He walked outside down the road without his walker, legs felt wonderful, and he felt great. He did not mean to hurt anything by going outside, just wanted some fresh air, and was sorry now.

During an interview on 3/7/25 at 4:10 p.m. DON stated our company did not like wander guards and they were not being used. Wander guard usage would be the best solution in the memory care unit so that an incident such as the one on 2/2/7/25 did not occur again. R1 had a history of exit seeking and when his family visited increased, at risk for elopement, lacked short term memory, left his walker inside the building, at risk for falls especially outside without a walker, a vulnerable adult, and could have been taken advantage of. R2 was at risk for falls and elopement, unable to stand and take steps independently, could have possibly been hit by a car and/or stuck in a spot outside. Neither R1 nor R2 would be considered safe outside in the community alone. She would have expected when the nurse left the facility, turn around and looked behind her, make sure the resident had not followed her outside, secured the inside exit door so that it was closed and locked behind her prior to leaving through the outside exit door. Staff were expected to monitor residents closely when they were made aware they were down by an exit door and verbalized they wanted to leave. The resident may have required redirection and could have potentially avoided him leaving the building.

During an interview on 3/10/25 at 9:00 p.m.

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2 830	Continued From page 23 LPN-B stated was unable to see the east and south hallways (the two hallways where resident rooms were located) in the memory care unit while she was in the nurse's station. R1 was mobile, ambulated in hallway frequently, sat down at the end of the east hallway on the couch by the exit door, approached doors, tried to place codes on the pads to open doors. R2 verbalized frequently he was leaving the facility. She worked at 2:00 p.m. on 2/27/25. At 3:00 p.m. she passed medications to residents and NA's completed their rounds. She had called LPN-A and asked her to come back to sign narcotic book. LPN-A arrived back at the facility between 4:30 p.m. and 4:45 p.m., we talked, she signed the book and had taken 15 minutes. She had seen R1 between 4:15 p.m. and 4:30 p.m. ambulating with his walker by the nurse's station. NA-A left the floor at 4:30 p.m. for a 15-minute break and returned at 4:45 p.m. NA-B was in a resident's room located in on the right side of the hallway with about two doors down. Between 4:45 p.m. and 4:50 p.m. AD came down to the memory care unit and asked if she knew R2 was outside in front of the building. She was surprised and unaware he had been missing. NA-A and NA-B ran down the hallway and outside to find R2. She walked down to the end of the east hallway, looked out the window, and noticed R1's walker had been left in the hallway outside the last room on the right. She thought, where was R1 and looked in the room at the end of the hallway, walked back down to nurse's station, looked in other rooms, and the commons/dining room. She stated had not remembered if she sat on the couch at the end of the east hallway by the exit door. R2 was brought back to the building. She had seen R2 last between 4:20 p.m. and 4:25 p.m. at the nurse's station, he requested pop. R2 was not at risk for elopement, had tried to exit the building	2 830		

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prior to the incident on 2/27/25 (according to other staff), unable to ambulate, at risk for falls, was delusional, had memory problems, and would not be safe outside in the community by himself. She had received a telephone call from a woman that lived at the apartments next door and was informed R1 had walked over there. She called upstairs and requested assistance from staff. R1 had left his walker in the hallway in the memory care unit, unable to ambulate safely without it, legally blind, hard of hearing, was at risk for elopement, there was snow on the ground, and anything could have happened. She was the nurse on duty, and it was her responsibility to have kept the residents safe. She was not made aware by staff, R1 or R2 requested to leave on 2/27/25 prior to the incident. Would have been important to monitor the residents frequently, kept tabs and an eye on them to see what they were doing and where they were. Staff were expected to have looked around prior to exiting a door from the memory care unit to make sure a resident was not located behind them and keep them safe.

Facility policy Elopement Risk and Prevention dated 6/2/22, identified all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that placed them at risk for wandering/elopement and would have these issues address in their individual care plan. Wandering resident was defined as random or repetitive locomotion that may be goal-directed (e.g., person appeared to be searching for something such as an exit) or maybe non-goal directed or aimless. Residents identified at risk for possible elopement shall be accompanied by staff or responsible party, when outside of the facility and would include on and off the facility

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grounds. Even when all precautions are taken, a resident may walk away from the facility and cannot be located by staff. In such instances, the following procedures shall be put into action immediately: call code yellow (or code based on facility a protocol) initiate an all staff searches of the building interior including the basement. All staff is responsible to respond and assist. Search every room and bathroom, including basements, offices, and locked rooms. During the initial 15 to 30 minutes, cover the radius of approximately one mile from the facility. Interview staff and determine who last saw the resident and what they were wearing.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days.