STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Health Care Center	604 1st Street NE Forest Lake, MN 55025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review the facility failed to provide adequate supervision resulting in the likelihood of serious harm, injury, impairment, or death for 1 of 3 residents (R1) who was assessed to be at risk for elopement, had exit seeking behavior, and wore a WanderGuard (security device that prevents residents at risk of wandering from a designated area). The facility's failure resulted in an immediate jeopardy when R1 exited the building without staff knowledge and was returned to the facility by a community member (CM)-A.The immediate jeopardy began on [DATE] when R1 exited the facility chapel door at 6:25 p.m. The facility was made aware of R1 missing after CM-A arrived at the facility at 6:44 p.m., with R1 who was found two blocks away. The facility director of nursing (DON), administrator, regional nurse consultant (RNC), and regional director of operations (RDO) were notified of the immediate jeopardy on [DATE] at 5:02 p.m. The facility had implemented corrective action and therefore being cited as past non-compliance. Findings include: R1's admission Minimum Data Set (MDS) assessment, dated [DATE], indicated R1 had severe cognitive impairment, diagnoses of dementia, muscle weakness, required a wheelchair for locomotion, and had wandering behavior 1-3 days in the 7-day look back period. The facility Office of Health Facility Complaint (OHFC) report dated [DATE] at 9:00 p.m., indicated CM-A was driving and saw R1 on [DATE] at approximately 5:45 p.m., sitting in a wheelchair on the side of the road two blocks from the facility, in the dark, waving her hands frantically. CM-A indicated in the report R1 stated she was from another town, and didn't know how she got to her current location. CM-A noticed a sticker on R1's wheelchair identified the facility name, CM-A walked R1 back to the facility. A staff came to the door to let R1 in and stated they had no idea R1 was out of the facility. R1's care plan dated [DATE], indicated R1 was an elopement risk and used a WanderGuard. The care plan further indicated R1 had impaired physical mobility and required a wheelchair for locomotion and had cognitive loss/dementia with deficits in memory/recall ability, judgement, decision-making and thought process related to anoxic brain damage (brain loses oxygen supply) with an intervention to supervise and assist with all decision-making. R1's orders dated [DATE], indicated check WanderGuard on right wrist every night. R1's progress notes dated [DATE] at 9:11 p.m., indicated R1 eloped out of the chapel doors and neighbors brought R1 back. 1:1 supervision was implemented when resident was out of bed, and 15-minute checks when in bed. R1's Elopement Risk assessment dated [DATE] indicated a score of 6. A score of 4 or greater indicates the potential for elopement. On [DATE] at 11:35 a.m., review of facility surveillance revealed on [DATE] the following occurred:-6:26:40 p.m. R1 was observed exiting the chapel door, activating WanderGuard alarm-6:27:03 p.m. R1 was observed to push on keypad button and then pushed on secured exit door handle-6:29:38p.m. R1 was observed to push secured exit door greater than 30 seconds, engaging fire safety feature and exited the building.-6:29:58 p.m. (3 minutes, 18 seconds from first alarm activating) NA-A appeared, silenced alarm, briefly looked through the door outside (did not step outside).-6:30:35 p.m. NA-A proceeds back to work. -6:40:10 p.m. (11 minutes 12 seconds) R1 returned to the facility by CM-A to front entry way.- In the video footage, R1 was noted in the video to be wearing a flannel shirt with gray undershirt, black (continued on next page)

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.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sweatpants, slippers and socks. Additionally, R1 had what appeared to resemble a throw or light blanket covering her thighs to just below her knees.Review of the weather on [DATE] from the Weather Channel revealed the daily temperature in Forest Lake was 29 degrees Fahrenheit with possibility of some snow flurries. During an observation on [DATE] at 1:12 p.m., R1 was observed in a wheelchair, wearing a WanderGuard on her right wrist, and used her arms to propel the wheelchair to move around the facility hallways and moved very quickly. R1 attempted to wander into the kitchen, but staff intervened before R1 could enter. During an interview on [DATE] at 1:45 p.m., registered nurse (RN)-B stated she was notified on [DATE] at 6:56 p.m., of R1's elopement after R1 returned, and RN-A informed her a neighbor brought R1 back to the facility. RN-B notified the director of nursing (DON) at 7:01 p.m., and the administrator at 7:39 p.m. The DON called RN-B at 9:14 p.m., and instructed RN-B to educate staff to not turn off the alarms until all risks (residents who wore WanderGuard bracelets) were accounted for. RN-B started the education on [DATE], as instructed. RN-B stated most of the time when the alarm was activated, the resident was nearby. RN-B was not sure why a Code [NAME] was not initiated. Further, RN-B stated R1 was very quick, and very impulsive. During an interview on [DATE] at 3:22 p.m., R1's family member (FM)-A stated he was notified of R1's elopement on [DATE] at 7:15 p.m., and staff had notified him four days ago, on [DATE], the facility needed to move R1 to another facility because R1 kept trying to get out of the facility. R1 was not injured, but if she had kept going straight she would have gotten behind the church and they wouldn't have found her. FM-A said that Sunday night ([DATE]) it was very windy and cold. During an interview on [DATE] at 3:35 p.m., RN-A stated she was working on [DATE] when R1 eloped. RN-A stated she was on break and received a call from staff when R1 was brought back to the facility by a neighbor. RN-A checked her phone and saw R1's Wander Guard alarm activated at 6:29 p.m. and R1 exited through the chapel doors. RN-A interviewed staff and found nursing assistant (NA)-A disabled the alarms, and did not go outside to look for a missing resident. RN-A stated NA-A acknowledged he turned off the outside door alarm but not the chapel door alarm, but both would have required a code to deactivate. RN-A further acknowledged a Code [NAME] (missing resident) was not initiated because staff was not aware R1 was missing. RN-A stated she met with all five NAs working, explained elopement was serious and if it had been colder and she had not been found, R1 would have died. RN-A instructed the NAs to check for missing residents with each activated alarm. During an interview on [DATE] at 10:01 a.m., NA-A acknowledged he was working when R1 eloped. NA-A was coming out of a room when he heard the alarm, deactivated the alarm, looked around, and looked out the door to the parking lot but didn't see anyone. NA-A stated he deactivated the alarm to the door that led to the parking lot, but not the chapel door alarm, as it had not activated. NA-A stated he did not call a Code [NAME] because he didn't know anyone was gone. During an interview on [DATE] at 11:29 a.m., the administrator stated video footage indicated NA-A deactivated the WanderGuard alarm for R1 on [DATE]. During an interview on [DATE] at 11:38 a.m., the DON stated NA-A turned off both alarms, looked for a resident without going outside, did not alert any other staff, and NA-A failed to call a Code [NAME] (missing resident) per the facility policy, and should have. The facility staff learned R1 was missing after a community member brought R1 back. The DON stated R1 was not safe to be outside alone, which was why she wore a WanderGuard. The DON stated staff education started on [DATE], after the elopement, to ensure staff would account for each resident who wore a WanderGuard prior to deactivating a WanderGuard alarm. During an interview on [DATE] at 1:37 p.m., NA-B stated staff education started on [DATE], to leave the alarm on until all the residents who wore Wander Guards were accounted for, and that had always been the policy. We are supposed to call a code green when the alarm goes off and a resident is not accounted for near the alarm. The Elopement Risk policy dated 5/24, indicated residents who scored 4 or more on the Elopement Risk Assessment required interventions that may include using a Wander Guard. Residents who had an attempted elopement required a new review, and all residents who wore the WanderGuard were not to be outside the building without staff or family members. The past non-compliance (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediate jeopardy began on [DATE]. The immediate jeopardy was removed and the deficient practice corrected by [DATE], after the facility implemented a systemic plan that included the following actions:Upon R1 returning to the facility, R1 was assessed for injuries.R1 was placed on 1:1 staffing upon return. 15-minute observations following.Nursing assistant (NA)-A was suspended, was verbally retrained but remains on suspension until he gets a full retraining.All Wander Guard systems (exits and bracelets) were tested and found to be in working condition. (Testing continues to meet Manufacturer's recommendations).Training started [DATE], to ensure alarms are not shut off before residents at risk for elopement and wearing a Wander Guard are accounted for.R1's care plan was updated to include 1:1 initially, then 15 min checks when R1 went to bed.Activity staff increased activity options for R1 to assist with distraction.Doors to R1's unit to be shut at night to limit R1's movement to her own unit for increased supervision.Staff was educated on the care plan revisions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to accurately assess elopement risk for 1 of 3 residents (R1) reviewed for elopement. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment, diagnoses that included dementia, and had wandering behavior 1-3 days in the 7-day look back period. R1's orders dated 10/29/25, indicated check Wander Guard on right wrist every night. R1's progress notes dated 11/9/25 at 9:11 p.m., indicated R1 eloped out of the chapel doors and neighbors brought R1 back. R1's Elopement Risk assessment dated [DATE], indicated R1 was at risk for elopement with a score of 6 because R1 was able to self-propel her wheelchair, had a history of wandering, exhibited pacing or agitated behavior, was asking to go home, had a diagnosis of dementia, and was currently taking medications which may cause confusion. R1's Elopement Risk assessment dated [DATE], indicated R1 was at risk for elopement with a score of 5 because R1 was able to self-propel her wheelchair, had a history of wandering, exhibited pacing or agitated behavior, was asking to go home, and had a diagnosis of dementia. The assessment lacked indication R1 had just eloped from the facility, family had just voiced concern about R1's elopement, and R1 was taking a medication that may cause confusion. R1's care plan dated 10/29/25, indicated R1 was an elopement risk and used a Wander Guard (security device that prevents residents at risk of wandering from leaving a designated area). The care plan further indicated R1 had impaired physical mobility and required a wheelchair for locomotion and had cognitive loss/dementia with deficits in memory/recall ability, judgement, decision-making and thought process related to anoxic brain damage with an intervention to supervise and assist with all decision-making. During an interview on 11/12/25 at 3:35 p.m., registered nurse (RN)-A stated after R1 eloped on 11/9/25, she performed an updated Elopement Risk assessment with R1, per policy after an elopement. RN-A stated R1 scored a 5, indicating elopement risk. RN-A acknowledged she had not reviewed the previous assessment, in which R1 scored a 6. Upon review of the assessment, RN-A stated she should have indicated R1 was taking a medication that was sedating because R1 was taking Seroquel which could contribute to an altered mental state. RN-A further acknowledged she should have scored a point for the elopement that just occurred, and should have scored a point for family who voiced concerned as R1's husband voiced concerns when RN-A notified him of R1's elopement. RN-A acknowledged it was not an accurate assessment, and stated she would update it. During an interview on 11/13/25 at 11:38 a.m., the director of nursing (DON) stated R1's elopement triggered RN-A to perform a new Elopement Risk Assessment, so RN-A should have known to assign a point for the elopement. The DON stated RN-A should have reviewed R1's medication list when it was completed to ensure accuracy of the assessment. The DON acknowledged the assessment was not accurate and had not been updated yet. The Elopement Risk policy dated 5/24, indicated residents who scored 4 or more on the Elopement Risk Assessment required interventions that may include using a Wander Guard, and further stipulated a new assessment would be completed every 90 days and with attempted elopement.