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	05/06/2026

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 - Minimal harm or potential for actual harm 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 observation, interview and document review the facility failed to thoroughly investigate and failed to comprehensively assess in an effort to identify risks and hazards associated with an elopement for 1 of 3 residents (R1) reviewed after R1 removed his wander alert bracelet and left the facility unsupervised by staff. In addition, the facility failed to ensure a system for all staff to identify who was at risk for elopement. Findings include:R1 quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and mental status had not acutely changed from baseline. No behaviors were indicated. R1 was independent with transfers and used a wheelchair. R1's diagnoses included hypertension, arthritis, aphasia (language disorder affecting ability to communicate effectively), CVA (stroke), Non-Alzheimer's dementia, and seizure disorder.Facility Incident Audit Report dated 4/12/26, indicated on 4/12/26, R1 had been seen around 4:00 p.m., by staff seated by the reception desk and had been observed again around 4:30 p.m. in the lobby. Staff noted R1 was missing around 4:45 p.m. R1 was located at 5:00 p.m., outside, just down from the assisted living. R1 stated he had been chasing the dead bodies in the ambulance. R1 was re-assessed for elopement, and a wander alert device was placed. IDT met and reviewed on 4/15/26. R1 had been exhibiting increased confusion, had gone outside and was on the sidewalk when staff found him. R1's progress note dated 4/12/26, indicated R1 was anxious and wandering, believed there were dead bodies being escorted out of the facility and he needed to help the police solve the crime.R1's Elopement Risk Evaluation dated 4/12/26, indicated R1 was ambulatory or able to self-propel his wheelchair, had a habit/history of wandering or attempts to leave the building and asked to go home or to other specific destinations.R1's care plan revised 4/13/26, identified cognitive loss/dementia and elopement/wander risk and identified the use of a wander alert bracelet. The care plan directed staff to check wander device function daily and ensure proper placement observe and document potential triggers to increased attempts at wandering/ elopement. The care plan identified limited physical mobility and indicated R1 required supervision/touching assistance for ambulation and required staff to propel him to and from all destinations in his wheelchair. R1's progress note dated 4/13/26, indicated IDT met and reviewed R1 exhibiting increased confusion. R1 went outside and was located on the sidewalk when staff located him. R1 had delusion thoughts and stated he was helping the police. R1 had cognitive impairment but had not previously displayed exit seeking behaviors. Past assessments indicated no risk for elopement. New assessment completed with increased risk. Wander alert device was placed.Facility resident sign out sheet indicated on 4/25/26, R1 signed himself out at 9:33 a.m.R1's Elopement Risk assessment dated [DATE], indicated R1 was ambulatory or able to self-propel his wheelchair, had a habit/history of wandering or attempts to leave the building and asked to go home or to other specific destinations.Facility Incident Audit Report dated 4/26/26, indicated R1 eloped from the facility on 4/25/26. Nursing description written 4/26/26, indicated Dietary aide (DA)-A notified registered nurse (RN)-A he had seen R1 outside in the parking lot. RN-A alerted staff members who searched the parking lot. R1 was seen with a bystander with his vehicle. R1 was not wearing his wander alert bracelet. R1 was brought back to the facility and told (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

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	05/06/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	facility staff he had been going to the farm and had signed himself out. When asked where his bracelet was, R1 stated he had removed it in his room and threw it away. Interdisciplinary team (IDT) met to review the incident 4/26/26. R1 was located across the street from the facility with a bystander who was placing R1 in his car for safety. Staff replaced R1's wander alert bracelet upon return to the facility and placed him on 15-minute checks.R1's quarterly MDS dated [DATE], identified severe cognitive impairment, indicated he was independent with the use of a manual wheelchair and indicated he displayed wandering behaviors. The MDS identified the use of a wander alarm.R1's progress note dated 5/4/26, indicated IDT met and reviewed R1's attempt to remove wander alert bracelet from wrist. R1 had been redirected and continued on 15-minute checks. R1 had a plan for what he wanted to do and where he wanted to go but was confused.During observation on 5/5/26 at 2:45 p.m., R1 was seated at the front entry in wheelchair talking with a visitor. R1 had a black wander alert bracelet on his right wrist.During interview on 5/5/26 at 4:20 p.m., licensed practical nurse (LPN)-A stated when she worked the station at the front of the facility, she did a lot of walking back and forth to monitor the residents. LPN-A said unless a resident was new, she knew who to watch and stated there was a binder at the front desk with the residents who were at risk for wandering. During interview on 5/5/26 at 4:51 p.m., RN-B stated they kept an eye on the residents who were known to wander. RN-B stated on the evenings and weekends it was really hard to keep an eye on the people going in and out of the facility but stated if a resident was wearing a wander alert bracelet the door would alarm if they were near the door.Video surveillance was viewed on 5/6/25 at 11:29 a.m., The surveillance video dated 4/25/26, showed R1 talking to another resident by the front door of the facility at 10:01 a.m. At 10:11 a.m., R1 left through the front door. R1 appeared again on the sidewalk at 10:16 a.m. and began propelling himself in his wheelchair to the parking lot on the south side of the building. At 10:20 a.m., R1 headed toward two dumpsters at the far end of the parking lot, stood up and left his wheelchair between the dumpsters and continued on foot. At 10:28 a.m., Staff headed to R1's location. R1 was observed on the video across the street and in front of an apartment building near an intersection of the street and the highway.Social services progress note dated 5/6/26, indicated social services spoke with R1's family regarding potential move to a facility with a secured unit due to increased wandering and attempts to remove wander alert device.During interview on 5/6/26 at 7:54 a.m., RN-B stated on 4/25/26, when R1 had left the facility he had been his usual self, wheeling around in his wheelchair. RN-A said DA-A had approached her and said he saw R1 outside by the apartments across the street. RN-A stated she went outside and R1 was with a bystander who had pulled over and was assisting R1 into his car. RN-A noted R1 did not have a wander alert bracelet on and when he was brought back to the building R1 told her he had taken it off and thrown it away and said he had signed out of the facility. RN-A stated the facility had discussed moving R1 to a facility with a secure unit because they didn't feel the facility was appropriate due to R1 having a plan to leave and removed the wander alert bracelet. RN-A stated R1 broke the clasp off of the bracelet. RN-A said they were keeping an eye on R1 but said he's definitely looking for stuff he can get it off with.During interview on 5/6/26 at 8:52 a.m., LPN-B said R1 was on 15-minute checks and said it was hard because he was all over the place. LPN-B said if R1 was hanging out up front, she would go check on him. LPN-B said, we have a lot of people.During interview on 5/6/26 at 8:585 a.m., DA-A said on 4/25/26, he had been on break and when he returned to the facility he saw R1 by the stop sign at the highway. DA-A said he had recognized R1 but said he did not have a wander alert device, so DA-A was not sure if R1 was at risk or not. DA-A said he notified nursing and had gone with to get R1. DA-A said they found R1's wheelchair in the parking lot by the trash. DA-A said if a resident was wearing a wander alert bracelet, that meant the resident was not safe to be outside unsupervised. DA-A said he was almost certain there was a list of residents who required supervision outside of the facility but did not know where to find it.During interview with the director of nursing (DON) and the administrator on 5/6/26, at 9:04 a.m., the DON said all staff were educated during monthly meetings regarding the missing resident protocol. DON said the wander alert bracelet alerted (continued on next page)

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	05/06/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	staff to who was at risk. The administrator said they had wander alert binders but said, I would not think every staff would memorize everyone, and said if a resident was new, staff may not know the person was at risk.During interview on 5/4/26 at 10:10 a.m., The DON stated on 5/5/26, when R1 was observed attempting to remove his wander alert bracelet, she did not know which staff had seen it. She said it may have been reported on one of the 15-minute check sheets but was not sure. The DON said R1 would try to find something to remove the wander alert bracelet and said he was on 15-minute checks because he was still actively trying to remove it. The DON said they did not know what he was using to attempt to remove the bracelet but said he has activities, pens, his own nail clipper, etc. in his room and said there were many different tactics R1 could take. The DON indicated they had not made any efforts to removed objects from R1's room and not specified the need to staff to monitor R1 for removal of items accessed in the dining room or activities which could be used to remove the bracelet. The DON stated currently they felt the 15-minute checks were successful. DON stated R1's case was different and said R1 had knowledge to know what to do. The DON said staff interviews were not a part of the investigation when R1 removed and/or attempted to remove the bracelet and said she did not know when he had last been seen prior to the elopement on 4/25/26.Facility policy Elopements and Wandering Residents dated 4/16/26, indicated the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements.