STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Health Care Center	444 North Cordova Le Center, MN 56057

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review, the facility failed to conduct comprehensive elopement risk assessments for 2 of 3 residents (R1, R3) identified as an elopement risk. Additionally, the facility did not promptly respond to a sounding Wanderguard alarm or ensure proper functioning of alarmed exit doors. This resulted in an immediate jeopardy when R1 left the facility and was found half a mile from the facility.The IJ began on [DATE], when it was identified R1 had eloped through the facilities south door, with the alarm sounding and walked 0.5 miles away from the facility. On [DATE] at 1:26 p.m., the director of nursing (DON) and business office manager were notified of the IJ. The IJ was removed on [DATE] at 12:55 p.m., after it could be verified the facility had implemented an acceptable removal plan. However, non-compliance remained at a D for isolated scope and severity which indicated no actual harm, with potential for more than minimal harm. Findings include: R1's face sheet dated [DATE], identified R1 admitted to the facility 4/2025, with diagnoses of dementia (decline in cognitive function), morbid obesity (overweight), aphasia (language disorder that affects communication and comprehension), and signs and symptoms involving cognitive functions and awareness (encompass a range of mental processes including memory, attention, language, and problem-solving abilities).R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 did not talk and was rarely/never understood but sometimes understood others. R1 had severely impaired daily decision-making skills. Wandering occurred 1-3 days but did not trigger a significant risk of getting to a potentially dangerous place or outside of the facility but intruded on privacy/activities of others. R1 was able to walk without assistive devices, dependent on staff for lower body dressing and substantial assistance with upper body dressing. R1's Brief Interview for Mental Status (BIMS) dated [DATE], identified R1 was unable to complete the interview, which indicated staff completed the interview and identified a memory problem with short- and long-term memory, and moderate impairment with decisions.R1 did not have a comprehensive elopement risk assessment completed.R1's care plan dated [DATE], identified behaviors related to dementia and at risk for wandering. Interventions included: address wandering behavior by walking with or attempt to redirect from inappropriate area, engage in divisional activity ([DATE]); intervene wandering as needed to protect rights and safety of others, approach in a calm manner, divert attention, remove from situation/take to another location ([DATE]); Wanderguard placed on ankle, staff to ensure placement each shift ([DATE]).R1's physician orders dated [DATE], identified a Wanderguard was placed on left ankle and make sure Wanderguard was in place and functioning daily. Additional orders dated [DATE], identified to document frequency of R1 wandering into other resident's rooms and if R1 was redirectable.R1's progress notes from [DATE]-[DATE], identified R1 wandered into other resident rooms and walked a significant amount around the building. R1 was not always redirectable for staff.R1's progress note dated [DATE] at 2:49 p.m., identified at approximately 10:46 a.m., R1 eloped from the facility via the south door. The alarm was sounding. NA-A notified by a resident that R1 had walked past her door but did not come back around and pass her door again. NA-A alerted staff of elopement. Staff searched outside, asked community members that were in the area, and were directed on where R1 was seen. R1 was assessed for injuries and offered water upon return to facility, Wanderguard assessed and working properly. South door examined and noted that it would not sound if the door was not fully closed. R1 placed on 15-minute checks. Physician, family member, and DON notified of incident.R1 was found as 0.5 miles from the facility. The Weather Channel identified the temperature on [DATE] to be ranged from 60-79 degrees Fahrenheit with stray thunderstorms.R1's Resident Safety assessment dated [DATE], identified 15-minute checks began on [DATE] at 11:45 a.m., and ended on [DATE] at 10:00 p.m. when the door was fixed. During an observation on [DATE], R1's room was located on the north hall, near the nurses station. At 9:37 a.m., activity staff was observed walking down the hall and met R1, who was walking the north hall independently and began to dance next to him down the hall. At 9:41 a.m., R1 walked to the end of the hall and entered the chapel, with an exit door and keypad next to the door, R1 sat in a recliner. No staff were present in chapel. Another resident was looking out the window, next to the exit door. R1 appeared short of breath and had a white band sticking out of the top of his right sock, consistent with a Wanderguard bracelet. At 9:45 a.m., R1 stood up and went to the exit door and looked out the glass door, turned around and began walking back down the hall. At 9:55 a.m., R1 continued to walk down hallways. During a phone interview on [DATE] at 3:26 p.m., housekeeper (HSK)-A stated she witnessed R1 walking around the facility earlier in the morning on [DATE]

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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. Based on interview and document review the facility failed to maintain a complete and accurate medical record for 1 of 1 residents (R1) reviewed for complete and accurate medical record. Findings include:R1's face sheet dated 7/31/25, identified R1 admitted to the facility 4/2025.R1's vital sign record dated 5/2025, did not identify recorded vital signs after he returned from elopement.A facility paper dated 5/3/25, listed a nurse and three nursing assistants (NA)'s names and a list of resident names with boxes to write in. R1's name was handwritten with a first name only and had vital signs listed, without a time, as temperature 97.2, pulse 73, respirations 18, blood pressure 130/68, oxygen 96%, and no pain.During an interview on 8/1/25 at 12:41 p.m., Director of Nursing (DON) stated she was not able to locate the vital signs in R1's electronic medical record. DON looked through old nurse assignment sheets and found the one dated 5/3/25 and will enter them in the electronic health record.The facility Medical Records Policy undated, identified all paper records will be stored securely in a locked medical records room or filing cabinets within the facility.