

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Viewcrest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Church Street Duluth, MN 55811	
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 - 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 record review the facility failed to follow its policy to adequately supervise 1 of 3 residents (R1) prior to a successful elopement who was reviewed for accidents. R1 eloped from the facility wearing a WanderGuard system, was found four blocks away and was hospitalized with abrasions. Findings include: Upon observation on 6/2/26 at 8:30 a.m. the facilities camera recording revealed at 3:52 p.m. on 5/19/26 the maintenance director checked the WanderGuard that was going to be placed on R1. The WanderGuard set off the door alarm, a staff member in the front office heard the alarm and ran to the door. At 5:35 p.m. R1 walked up to the front door and the magnetic light came on. R1 turned around and walked away. The footage had no audio so it could not be confirmed if the alarm sounded. No staff arrived at the door. At 5:42 p.m. R1 walked up to the door, no staff or visitors were in sight of the [NAME]. R1 opened the door and walked through it taking a left turn and proceeded down the sidewalk outside the door. The magnetic light came on. The footage had no audio so it could not be confirmed if the alarm sounded. No staff arrived at the door. R1's elopement risk dated 5/6/26 indicated R1 was not physically mobile, was new to the facility, and had no history of elopement. Analysis of the risk and interventions indicated R1 was in the facility for respite with her husband, sitting with her husband all day as he is the primary caregiver. R1 was not an elopement risk at the time of assessment. R1's care plan dated 5/6/26 - 5/19/26 lacked any interventions of staff supervision for R1. R1's progress note dated 5/6/26 indicated R1 was chronically confused and disoriented. R1 had severe cognitive impairment (affecting all areas of judgement). She was coherent with clear speech and no language barrier and was able to make herself understood. R1 was at the facility as a respite resident due to her husband who was admitted for rehabilitation, and he was her primary caregiver. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMS) score was a six indicating severe cognitive impairment. R1 was independent with dressing, hygiene, and transferring. R1's pertinent diagnosis was dementia. R1's admission assessment dated [DATE] indicated R1 had cognitive concerns that could affect her ability to leave the facility independently. She did not have physical concerns that could affect her ability to leave the facility independently. She was unable to identify where she was going or with whom she was going. R1 did not have the ability to utilize the call pendant or cellphone if she needed assistance outside the facility. R1 needed staff or family with her to leave the facility as her dementia had progressively made her more confused. R1's nursing progress note dated 5/15/26 at 11:25 a.m. indicated R1 was walking in and out of her room wanting to know where her husband was. R1 was redirected and told he was in the hospital. R1 was redirectable and asked if she could walk up and down the unit. The effectiveness of the intervention and follow-up was R1 was calm and redirectable, walking the unit and did not leave the unit area. R1's nursing progress note dated 5/15/26 at 3:40 p.m. indicated R1 was repeatedly asking where her husband was and would forget in a few seconds and asked again. R1 was redirected with activities, meals, and visitors. R1's nursing progress note dated 5/19/26 at 12:52 a.m. indicated R1 had lots of anxiety that shift. She had been wandering the halls looking for her husband. Staff verbally redirected her as able. (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: 245414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Viewcrest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Church Street Duluth, MN 55811	
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 - Actual harm Residents Affected - Few	She was assured her husband was safe. R1 had wandered into other resident rooms to look for her husband.R1's nursing progress note dated 5/19/26 at 4:48 a.m. indicated R1 was confused about where her husband was. She stated she wanted to go home and packed her and her husband's room. Staff tried to keep her from hauling it out into the hallway. She was offered snacks and encouraged to go to bed. She had been up all night and refused to lay down. R1's nursing progress note dated 5/19/26 at 2:26 p.m. indicated R1 had been wandering up most of the shift looking for her husband and a ride home. R1's son had visited that morning and had explained to her she had to stay at the facility. Staff continued to redirect R1 and attempted to engage her in activities which she would attend for a very short time.R1's nursing progress note dated 5/19/26 at 4:00 p.m. indicated R1 had a WanderGuard placed on her right ankle due to increased statements of wanting to leave the facility. R1 was agreeable and chose the location of the placement. R1's nursing progress note dated 5/19/26 at 11:59 p.m. indicated R1's morning nurse, licensed practical nurse (LPN)-A stated she had placed a WanderGuard on R1 in the afternoon due to her persistent exit seeking behaviors. R1 was last seen walking by the nursing station at around 6:00 p.m. All staff were looking for R1 after 6:00 p.m. and were unable to locate her within the facility. The director of nurse (DON) called 911 at 6:20 p.m. and reported R1 could not be located in the facility and a description of her was given to the officer. The facility staff within the facility and the nearby vicinity outside the facility and a nearby church. R1's family member (FM)-A was called, and he stated R1 would try to walk home. The DON received a call from the police at 7:00 p.m. saying R1 had been found several blocks away and ambulance personnel had assessed R1 and had taken her to the emergency department (ED) for evaluation. At 11:47 p.m. the DON was updated that R1 had been admitted to the hospital.R1's admission hospital note dated 5/19/26 indicated R1 resided at a nursing facility where she walked out the door. R1 had a tracker/device that would monitor her. Somehow the alarm did not go off or alert the facility. R1 was found to be missing and found approximately four blocks away on a gravel road and had fallen on the ground. She had numerous abrasions and bruising. R1 was given pain medication and admitted to the hospital. R1's assessment and plan indicated R1 had a fall with numerous abrasions, most notable on her right forehead and knee. She did not have any fractures. She would continue to be reassessed as she was at a high risk for fractures. Her plan was to have physical therapy (PT), occupation therapy (OT), pain control, and a social worker for her unclear disposition for a new facility vs. home vs. other arrangements.R1's care plan revised dated 5/20/26 indicated R1 was an elopement risk with goal not to elope from the facility. Interventions included changing the WanderGuard device per manufacture recommendations, performing WanderGuard checks per facility policy, using distraction from wandering, offering diversions, structured activity such as toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes, food, television, books. Staff observe for wandering and redirecting if attempting to enter another resident's room without permission. Identified wander alert and elopement risk.Upon interview on 6/1/26 at 1:59 p.m., nursing assistant, (NA)-A stated she worked with R1 the morning she eloped, and it was difficult to redirect her that day and ever since her husband went to the hospital a few days prior to that. NA-A denied any formal supervision of R1. She stated she was not aware that a WanderGuard had been placed on R1.Upon interview on 6/1/26 at 2:15 p.m. (NA)-B stated 5-6 days before R1 was admitted to the hospital she was hard to contain, she would pack her bags. She would look for and ask about her husband and stated she was going home. NA-B stated she tried to redirect R1 or give her a snack but had never been told any specific interventions by the nursing staff.Upon interview on 6/1/26 at 2:41 p.m. registered nurse, (RN)-A stated when R1's husband was at the facility she was fine; she barely left his side. When he went to the hospital her exit seeking behavior got worse by the day. RN-A stated she gave R1 reassurance that her husband was alright and returning. On the day R1 eloped the facility placed a WanderGuard on her hours before the elopement happened, and the alarm failed.Upon interview on 6/1/26 at 4:10 p.m. LPN-A stated she worked the evening R1 eloped. She was the nurse who initiated the WanderGuard after attempting visiting one-on-one with her, calling her husband to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Viewcrest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Church Street Duluth, MN 55811	
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 - Actual harm Residents Affected - Few	the hospital, and giving her activities. She stated around 4:00 p.m. she reached out to maintenance and had a WanderGuard placed on R1. LPN-A stated R1 had tried to get out the back doors of the facility, but the alarm sounded and R1 was redirected back to her room. She last saw R1 at 5:45 p.m. in the dining room. LPN-A stated she went to give medications to another resident and around 6:00 p.m. she asked staff where R1 was. The staff searched the unit. The facility called (FM)-A to see if he had taken her out and forgot to sign the book. When she realized he did not take her out she called the DON and reported R1 as missing. LPN-A stated she did not check the WanderGuard when it was placed on R1, however maintenance had checked it prior to giving it to her. She denied telling other staff to supervise R1 due to her exit seeking behaviors since she had placed the alarm on her. Upon interview on 6/1/26 at 4:38 p.m. registered nurse (RN)-B stated R1 was completely fine at the facility until her husband was hospitalized. On 5/19 at around 4:00 p.m. (LPN)-A requested R1 to have a WanderGuard because R1 was attempting to leave the facility. A WanderGuard was placed on her immediately. RN-A was not certain of any supervisory interventions for R1 from the time the behaviors started until the elopement. Upon interview on 6/1/26 at 6:30 p.m. R1's family member (FM)-B stated she was aware R1 had been packing her bags at the facility and threatening to leave ever since her husband was in the hospital. The family visited her often to tell her where her husband was, and she had to stay at the facility until he returned. She was not aware the facility had placed a WanderGuard on R1. FM-B started on the night R1 eloped (FM)-A called her and told her, so she met R1 at the hospital. She described R1 as being banged up. Her face was a mess, one of her eyes could not been seen due to the swelling and R1 was complaining about knee pain. She had to use a walker while in the hospital which she had never used prior. Upon interview on 6/2/26 at 11:49 a.m. the director of nursing (DON) stated R1 required a lot of redirection and activities. R1 liked movies. The DON was aware the staff had to reiterate again that her husband was in the hospital, and she could not leave the facility. Her family visited often. She stated she was updated that staff had placed a WanderGuard on R1 that failed at the time of the elopement. The DON denied any supervision interventions on R1's care plan. Upon interview on 6/2/26 at 12:55 p.m. the Administrator stated he was aware R1 had been packing her bags, wandering with exit seeking. He stated his expectation was that staff reassess with any changes and update the care plan as needed to keep residents safe. He was not certain whether R1 had supervision on her care plan or not. A facility policy titled Elopement with a revision date of 7/29/25 indicated that when a resident is determined at risk for elopement, an elopement risk assessment will be performed (see electronic health record (EHR)) and a corresponding care plan developed that addresses the following: Cognitive status Ambulation and Mobility Status: Includes evaluation of ambulation or wheelchair use, as well as their ability to open doors independently, since greater independence may increase risk. History of wandering and/or attempts to leave the building. Wandering patterns: Frequency, specific locations, time(s) of day, and duration of wandering episodes. Supervision: The level of oversight required when leaving the building. Prevention strategies may involve measures such as: Placing the resident's room in proximity to the nursing station or in an area farther from exit doors. Incorporating activity-based programs during peak wandering periods. Conducting more frequent checks or scheduling them at times when the resident is most likely to wander. Equipping the residents and/or their mobility aid (e.g., walker or wheelchair) with a WanderGuard bracelet that alerts staff if the resident attempts to leave. The nurse will document this plan into the resident's care plan in the EHR. Findings include: R1's care plan dated 5/6/26 - 5/19/26 lacked any interventions of staff supervision for R1. R1's progress note dated 5/6/26 indicated R1 was chronically confused and disoriented. R1 had severe cognitive impairment (affecting all areas of judgement). She was coherent with clear speech and no language barrier and was able to make herself understood. R1 was at the facility as a respite resident due to her husband who was admitted for rehabilitation, and he was her primary caregiver. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMS) score was a 6 indicating severe cognitive impairment. R1 was independent with dressing, hygiene, and transferring. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Viewcrest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Church Street Duluth, MN 55811	
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 - Actual harm Residents Affected - Few	R1's pertinent diagnosis was dementia. R1's admission assessment dated [DATE] indicated R1 had cognitive concerns that could affect her ability to leave the facility independently. She did not have physical concerns that could affect her ability to leave the facility independently. She was unable to identify where she was going or who she was going with. R1 did not have the ability to utilize the call pendant or cellphone if she needed assistance outside the facility. R1 needed staff or family with her to leave the facility as her dementia had progressively made her more confused. R1's nursing progress note dated 5/15/26 at 11:25 a.m. indicated R1 was walking in and out of her room wanting to know where her husband was. R1 was redirected and told he was in the hospital. R1 was redirectable and asked if she could walk up and down the unit. The effectiveness of the intervention and follow-up was R1 was calm and redirectable, walking the unit and did not leave the unit area. R1's nursing progress note dated 5/15/26 at 3:40 p.m. indicated R1 was repeatedly asking where her husband was and would forget in a few seconds and asked again. R1 was redirected with activities, meals and visitors. R1's nursing progress note dated 5/19/26 at 12:52 a.m. indicated R1 had lots of anxiety that shift. She had been wandering the halls looking for her husband. Staff verbally redirected her as able. She was assured her husband was safe. R1 had wandered into other resident rooms to look for her husband. R1's nursing progress note dated 5/19/26 at 4:48 a.m. indicated R1 was confused about where her husband was. She stated she wanted to go home and packed her and her husband's room. Staff tried to keep her from hauling it out into the hallway. She was offered snacks and encouraged to go to bed. She had been up all night and refused to lay down. R1's nursing progress note dated 5/19/26 at 2:26 p.m. indicated R1 had been up wandering most of the shift looking for her husband and a ride home. R1's son had visited that morning and had explained to her she had to stay at the facility. Staff continued to redirect R1 and attempted to engage her in activities which she would attend for a very short time. R1's nursing progress note dated 5/19/26 at 4:00 p.m. indicated R1 had a wander guard placed on her right ankle due to increased statements of wanting to leave the facility. R1 was agreeable and chose the location of the placement. R1's nursing progress note dated 5/19/26 at 11:59 p.m. indicated R1's a.m. nurse, licensed practical nurse (LPN)-A stated she had placed a wander guard on R1 in the afternoon due to her persistent exit seeking behaviors. R1 was last seen walking by the nursing station at around 6:00 p.m. All staff were looking for R1 after 6:00 p.m. and were unable to locate her within the facility. The director of nurse (DON) called 911 at 6:20 p.m. and reported R1 could not be located in the facility and a description of her was given to the officer. The facility staff within the facility and the nearby vicinity outside the facility and a nearby church. R1's family member (FM)-A was called, and he stated R1 would try to walk home. The DON received a call from the police at 7:00 p.m. saying R1 had been found several blocks away and ambulance personnel had assessed R1 and had taken her to the emergency department (ED) for evaluation. At 11:47 p.m. the DON was updated that R1 had been admitted to the hospital. R1's admission hospital note dated 5/19/26 indicated R1 resided at a nursing facility where she walked out the door. R1 reportedly had a tracker/device that would monitored her. Somehow the alarm did not go off or alert the facility. R1 was found to be missing and found approximately four blocks away on a gravel road and had fallen on the ground. She had numerous abrasions and bruising. R1 was given pain medications and admitted to the hospital. R1's assessment and plan indicated R1 had a fall with numerous abrasions, most notable on her right forehead and knee. She did not have any fractures. She would continue to be reassessed as she was at a high risk for fractures. Her plan was to have physical therapy (PT), occupation therapy (OT), pain control, and a social worker for her unclear disposition for a new facility vs. home vs. other arrangements. Upon interview on 6/1/26 at 1:59 p.m., nursing assistant, (NA)-A stated she worked with R1 the morning she eloped, and it was difficult to redirect her that day and ever since her husband went to the hospital a few days prior to that. NA-A denied any formal supervision of R1. She stated she was not aware that a wander guard had been on placed on R1. Upon interview on 6/1/26 at 2:15 p.m. (NA)-B stated 5-6 days before R1 was admitted to the hospital she was hard to contain, she would pack her bags. She would look for and ask about her husband and stated she was going home. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Viewcrest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Church Street Duluth, MN 55811	
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 - Actual harm Residents Affected - Few	NA-B stated she tried to redirect R1 or give her a snack but had never been told any specific interventions by the nursing staff. Upon interview on 6/1/26 at 2:41 p.m. registered nurse, (RN)-A stated when R1's husband was at the facility she was fine; she barely left his side. When he went to the hospital her exit seeking behaviors got worse by the day. RN-A stated she mainly gave R1 reassurance that her husband was alright and returning. On the day R1 eloped the facility placed a wander guard on her hours before the elopement happened, and the alarm failed. Upon interview on 6/1/26 at 6:30 p.m. R1's family member (FM)-B stated she was aware R1 had been packing her bags at the facility and threatening to leave ever since her husband was in the hospital. The family visited her often to tell her where her husband was, and she had to stay at the facility until he returned. She was not aware the facility had placed a wander guard on R1. FM-B stated on the night R1 eloped (FM)-A called her and told her, so she met R1 at the hospital. She described R1 as being banged up. Her face was a mess, one of her eyes could not be seen due to the swelling and R1 was complaining about knee pain. She had to use a walker while in the hospital which she had never used prior. Upon interview on 6/1/26 at 4:10 p.m. LPN-A stated she worked the evening R1 eloped. She was the nurse who initiated the wander guard after attempting visiting one-on-one with her, calling her husband in the hospital, and giving her activities. She stated around 4:00 p.m. she reached out to maintenance and had a wander guard placed on R1. LPN-A stated R1 had tried to get out the back doors of the facility, but the alarm sounded and R1 was redirected back to her room. She last saw R1 at 5:45 p.m. in the dining room. LPN-A stated she went to give medications to another resident and around 6:00 p.m. she asked staff where R1 was. The staff searched the unit. The facility called (FM)-A to see if he had taken her out and forgot to sign the sign out book. When she realized he did not take her out she called the DON and reported R1 as missing. LPN-A stated she did not check the wander guard when it was placed on R1, however maintenance had checked it prior to giving it to her. She denied telling other staff to supervise R1 due to her exit seeking behaviors since she had the placed the alarm on her. Upon interview on 6/1/26 at 4:38 p.m. registered nurse (RN)-B stated R1 was completely fine at the facility until her husband was hospitalized. On 5/19 at around 4:00 p.m. (LPN)-A requested R1 have a wander guard because R1 was attempting to leave the facility. A wander guard was placed on her immediately. RN-A was not certain of any supervisory interventions for R1 from the time the behaviors started until the elopement. Upon observation on 6/2/26 at 8:30 a.m. the facilities camera recording revealed at 3:52 p.m. on 5/19/26 the maintenance director checked the wander guard that was going to be placed on R1. The wander guard set off the door alarm, a staff member in the front office heard the alarm and ran to the door. At 5:35 p.m. R1 walked up to the front door and the magnetic light came on. R1 turned around and walked away. The footage had no audio so it could not be confirmed if the alarm sounded. No staff arrived at the door due to hearing an alarm sound. At 5:42 p.m. R1 walked up to the door, no staff or visitors were in sight. R1 opened the door and walked through it taking a left turn and proceeded down the side walk outside the door. The same small magnetic light was visualized as it was 5:35 p.m., again no staff arrived at the door due to hearing an alarm. Upon interview on 6/2/26 at 11:49 a.m. the director or nursing (DON) stated R1 required a lot of redirection and activities. R1 liked movies. The DON was aware the staff had to reiterate over and over that her husband was in the hospital, and she could not leave the facility. Her family visited often. She stated she was updated that staff had placed a wander guard on R1 that failed at the time of the elopement. The DON denied any supervision interventions on R1's care plan. Upon interview on 6/2/26 at 12:55 p.m. the Administrator stated he was aware R1 had been packing her bags, wandering with exit seeking. He stated his expectation was that staff reassess with any changes and update the care plan as needed to keep residents safe. He was not certain if R1 had supervision on her care plan or not. A facility policy titled Elopement with a revision date of 7/29/25 indicated that when a resident is determined at risk for elopement, an elopement risk assessment will be performed (see electronic health record (EHR)) and a corresponding care plan developed that addresses the following: Cognitive status Ambulation and Mobility Status: Includes (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Viewcrest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Church Street Duluth, MN 55811	
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 - Actual harm Residents Affected - Few	evaluation of ambulation or wheelchair use, as well as their ability to open doors independently, since greater independence may increase risk. History of wandering and/or attempts to leave the building. Wandering patterns: Frequency, specific locations, time(s) of day, and duration of wandering episodes. Supervision: The level of oversight required when leaving the building. Prevention strategies may involve measures such as: Placing the resident's room in proximity to the nursing station or in an area farther from exit doors. Incorporating activity-based programs during peak wandering periods. Conducting more frequent checks or scheduling them at times when the resident is most likely to wander. Equipping the resident and/or their mobility aid (e.g., walker or wheelchair) with a wander guard bracelet that alerts staff if the resident attempts to leave. The nurse will document this plan into the resident's care plan in the EHR.		