STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belgrade Nursing Home	103 School Street Belgrade, MN 56312

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure survey results were provided to 1 of 1 residents (R4) upon request. Findings include: R4's quarterly Minimum Data Set, dated [DATE], identified intact cognition. During interview on 6/12/25 at 4:05 p.m., R4 stated she had requested the results from the last re-certification survey and said they tell me they don't have the results yet. R4 stated she had concerns about infection control practices as she had been sick three times this year already, and wanted to know the facility had been dinged for infection control. R4 said she had asked the activity director most recently at the resident council meeting the previous week. During interview on 6/12/25 at 4:32 p.m. the director of nursing stated the survey results were available and hanging on a bulletin board near the dining room. During observation on 6/12/25 at 4:35 p.m., the survey results posted on the bulletin board only contained the results of the recertification survey from 2024 and started on page 9. (The most recent re-certification survey was completed 2/20/25). During an interview on 6/13/25 at 9:32 a.m., the activity director stated on 6/10/25, R4 had asked if the most recent survey results had been posted. The activity director stated she had passed on the request to the social services designee and the administrator. Facility policy Resident Rights dated 12/17/24, indicated federal and stated laws guarantee certain basic right to all residents in the facility. These rights include the resident's right to: Examine survey results.

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 - 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 supervisor 1 of 3 residents (R1) at risk for elopement when R1 was able to leave the facility (remained on campus) without staff knowledge despite wearing a working wander guard device. Findings include: R1's admission Record indicated he admitted to the facility 9/11/20. Diagnosis included anxiety, unsteadiness on feet, history of falls and weakness. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated he did not wander. The MDS indicated R1 required supervision to stand and ambulate and did not require the use of personal alarms. R1's facility Progress Notes indicated on 5/9/25, R1 was pleasantly confused, telling everyone he did not live at the facility and had just arrived the previous day. 5/11/25, The first time R1 went outside, nursing assistant (NA) was alerted he was outside the building. The NA said he was on his way back in so NA assisted him into the building. The second time R1 went outside he made it to the parking lot before he was returned back inside the building. Facility Incident Investigation dated 5/10/25, indicated R1 was seen leaving the building out the front door two times. Each time R1 was seen by another resident who alerted staff. R1's Elopement/Wandering Risk assessment dated [DATE], identified severe cognitive impairment and indicated he could ambulate without assistance and was able to communicate. The assessment indicated R1 did not wander aimlessly and did not have a history of wandering. The assessment indicated prior to 5/10/25 had not attempted to leave the facility, however, on 5/10/25, R1 walked out the front door twice. It was felt R1 became confused. A wander alert device was placed on 5/10/25. R1's care plan dated 5/13/25, indicated he was at risk to wander related to confusion, cognitive impairment and impaired safety awareness. The care plan directed staff to locate wander alert device each shift on body, wheelchair or walker and test each night to ensure divide was in working condition. The care plan identified the use of a wander alert on his left wrist. R1's Progress Note created 6/5/25, indicated on 6/4/25, physical therapy aide (PTA)-A alerted nurse that resident was outside of facility at 4:20 p.m. The wander alert alarm malfunctioned and did not alert staff when resident exited the facility. When nurse returned resident back inside the facility the alarm was working. The administrator was notified at 4:30 p.m., that the wander guard did not work when he exit the facility but worked when he returned to the facility. The administrator replaced the wander alert device. Facility Incident Investigation dated 6/9/25, indicated on 6/4/25, at approximately 3:15 p.m., PTA-A notified licensed practical nurse (LPN)-A that R1 was outside alone. Wander alert in place at the time but malfunctioned and was replaced. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility report titled Full Event Report, Call Statistics printed 6/10/25, indicated the following: 6/4/25 at 3:21 p.m., Peripheral Disc (R1) at room [ROOM NUMBER], indicating the wander alert device on R1's wrist triggered the alarm. 6/4/25 at 3:21 p.m., messages sent to five alert boxes. 6/4/25 at 3:26 p.m., messages sent to the same five boxes. 6/4/25 at 3:28 p.m., Peripheral Disc (R1) canceled at 134, indicating it was canceled at the device on his wrist. During interview on 6/12/25 at 12:32 p.m., PTA-A stated she was in the therapy room and saw R1 wheeling himself in the parking from the main entrance to the south. PTA-A said he was alone so she found LPN-A and reported it. During interview on 6/12/25 at 1:14 p.m., the director of nursing (DON) stated staff ensured the wander alert was working by pushing the button on the device on the residents arm or chair. The DON said the device displayed a blinking red light. She said if a resident was near a door with an alarm box the boxes would display who was near the door and beep quietly. The DON said after 30 seconds the beep would get louder. The DON said staff tested the individual devices placed on the resident but they did not test to ensure the individual alarm boxes were working. During interview on 6/12/25 at 1:34 p.m., the social services designee (SSD) states she assisted in the investigation following R1's elopement. The SSD stated she had interviewed NA-A who had checked the R1's device that day and confirmed the device had been working properly and PTA-A. The SSD said none of the other staff who worked that shift had been interviewed. During interview on 6/12/25 at 1:44 p.m., a representative (R)-A from Ideacom (company who installs and maintains the wander alert system) stated the company installs and maintains the system. R-A said if there were any issues they would trouble shoot remotely and if needed would send someone out. R-A said the last ticket submitted at the facility had been 47 days prior due to the report software. R-A said in order for the alarm to fail, the battery would have to be low or if the device was hidden (meaning the resident would have removed the device). R-A said if there was a low battery, the device would signal a low battery alert. R-A said if the door did not alarm when R1 went outside it would not have alarmed when he went back in the door. R-A further stated he would recommend testing of the gingival alarm boxes located at the doors. During interview on 6/12/25 at 2:03 p.m., NA-A stated at the time of the elopement, she had been working in another resident room and only heard about the incident from other staff. NA-A stated R1 liked to pack up his belongings and did that a lot. During interview on 6/12/25 at 1:58 p.m., NA-B said the wander alert device were checked daily. NA-C was present and said staff located the device on the resident and pushed the button on the device. NA-C said a blinking light indicated it was working. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/25 at 2:13 p.m., NA-D said she had been working when R1 had eloped. NA-D said she was in a resident room and was unable to hear any alarms. During interview on 6/12/25 at 2:14 p.m., LPN-A stated the wander alert was tested by bringing the resident near the door and said if the device was working, the alarm would sound. LPN-A said she never saw a low battery warning on the device. During interview on 6/12/25 at 2:20 p.m., NA-E said he had been working when R1 exited the building. NA-E said he had been down the hall in a room at the time and was unable to hear an alarm from the room he was in. NA-E said he heard about the incident an hour after it happened. During interview on 6/13/25 at 9:26 a.m., registered nurse (RN)-A stated she was in the facility the day R1 exited the building. RN-A stated she had been down the south hall and when she returned to the office she heard PTA-A tell LPN-A that R1 was outside. LPN-A said she had not heard the alarm until R1 was returned to the building. RN-A said R1 returned willingly with LPN-A and said LPN-A turned off the alarm about a minute after they re-entered the building. During observation on 6/12/25 at 3:02 p.m., an observation using R1's old wander alert device (the one he was wearing at the time of the elopement) was completed with the DON. The DON brought the old device to each door that had an alarm box. When brought to all five door that had a wandering alert box, each time the device signaled an alarm, indicating the battery in the device was working. During interview on 6/13/25 at 9:51 p.m., the DON stated they felt R1's device had malfunctioned. The DON said she was unable to explain why the old device was still functioning properly or why it would signal only when R1 returned inside the building. The DON further stated she did not know why it would have taken seven minutes to shut the alarm off after R1 returned. The DON further stated the facility had not implemented and increased supervision or staff training because if the alarm had malfunction, staff did everything correctly. Facility policy Elopement/Missing Resident/Wander Management dated 10/23/21 and reviewed 6/13/21, indicated staff will check and document the testing of the wander management alarms that are in use daily. If the systems failed, staff will contact the plant operations manager or licensed nursing staff. The systems will be maintained under the manufacturers recommendations. An operation manual for the wander alert system was requested however the facility was unable to provide one.