STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifecare Roseau Manor	715 Delmore Drive Roseau, MN 56751

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** 35569 Based on interview and document review the facility failed to adequately supervise and respond to an alarm sounding exit door for 1 of 3 residents (R1) reviewed for elopement risks. R1 exited the facility without staff knowledge and was found by a visitor on the ground with WC next to them outside the facility door. R1 had abrasions and bent glasses. The immediate jeopardy began on 3/13/25, at approximately 12:45 p.m., when R1 was found outside the facility on the ground next to his wheelchair. The IJ was identified on 3/21/25, and the administrator was notified of the IJ on 3/21/25, at 12:50 p.m. The immediate jeopardy was removed on 3/17/25, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. Findings include: On 3/21/25 at 8:53 a.m. video footage of the R1's elopement on 3/13/25 was reviewed. The video showed R1 at a set of closed double doors approximately six feet from the nurses' station and dining room entrance at 12:34 p.m. At 12:35 p.m., R1 was seen on the video opening the double doors and going through toward the front entry a few feet away. R1 was able to push on the door and go outside at 12:36 p.m. At 12:37 p.m., housekeeper (HK)-A approached the door and turned off the alarm that was sounding then left the area. R1's Admission Record indicated he admitted to the facility 9/21/23. Diagnosis included Alzheimer's and dementia. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated use of a wander alarm. The MDS indicated R1 had hallucinations, displayed physical and verbal behaviors and no wandering behaviors during the assessment period. The MDS indicated R1 was independent with transfers and wheelchair mobility. R1's Elopement Risk Screening dated 2/20/25, indicated R1 was alert and oriented, voiced a desire to leave and had previous elopement attempts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's care plan dated 12/30/24, identified target behaviors that included argumentative, resistant to assistance with activities of daily living, verbal aggression and identified him as an elopement risk. The care plan directed staff to allow him to vent his frustration, distract with activities such as a marble game and call family if needed to assist with redirection. The care plan indicated R1 was independent with transfers and ambulation in his room and indicated he could self-propel his manual wheelchair. Facility incident reports identified the following: 11/28/24 at 1:23 p.m., visitor alerted nursing there was a man (R1) in a wheelchair outside the building. Visitor reported the man pushed on the front door as it was beeping until it opened, then went out the door. The visitor cleared the door alarm and alerted staff. R1 stated he was going to the store to get chewing tobacco. Nursing staff found him self-propelling his wheelchair behind the handicap parking area. There were cars driving around the area at the time. R1 was brought back into the building safely. Staff were notified and told to monitor R1's location. The incident report indicated R1 may have been disoriented/confused due to many residents and family members being in and out of the building for a holiday meal. 1/25/25, Staff was alerted to door alarm sounding and observed R1 outside attempting to get back in the building. A plow truck driver stopped and said he saw resident outside before staff arrived. He had been plowing snow at the time R1 eloped. R1 was wearing a heavy flannel shirt and shoes but no jacket. Will continue to monitor and ensure hourly checks for safety are completed. Double doors between nursing station and front door to be shut. 3/13/25 at 12:45 p.m., exit door alarm sounded when a visitor left the facility. Staff went to shut off the alarm and saw R1 sitting on the cement next to his wheelchair with a visitor attempting to assist him to sit up. R1 was seated on the curb straight out from the front door. R1 had abrasions to the right side of his forehead, his glasses were bent up against his face and he had a laceration to his nose, abrasions to thumb, both knees, elbow, and wrist. When asked what happened, R1 said I was going around and down. When asked where he was going R1 said, well, home. Immediate action taken included: hourly checks to monitor whereabouts, education provided to staff who had shut off the initial alarm and education initiated for all other staff. During interview on 3/21/25 at 7:26 a.m., the director of nursing stated she had been in the building on 3/13/25, when R1 eloped. The DON said she had viewed the camera footage and said the double doors had been closed since R1's last elopement but he had been able to open them. The DON said R1 had also attempted to go through the family dining room to get to the front door in the past. The DON said after the incident on 3/13/25, she sent education related to alarms to all facility staff and to all staff at the attached hospital. The DON said they had collaborated with the fire Marshall and set up the door so it would not open if a wander alert was in the vicinity. The DON said the door had been wander alert activated but said if someone went through the door and a resident followed them out, the door would not alarm. The DON said now the door alarmed if a wander alert was nearby. The DON said the door had also been changed to alarm if open for 10 seconds compared to the previous 30 seconds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 3/21/25 at 7:36 a.m., HK-A stated on 3/13/25, she heard the alarm sounding at the entrance to the facility. HK-A stated the set of double doors between the nurses station and the entrance had been closed so she went through them, did a quick glance, and turned off the alarm and went back to what she had been doing. HK-A stated she had not gone outside to see if a resdient had left the building. During interview on 3/21/25 at 8:53 a.m. The quality specialist said part of the video footage was no longer available. She said when she viewed the footage the previous week it showed R1 got to the edge of the sidewalk and flip forward out of his wheelchair on the curb. During interview on 3/21/25 at 9:25 a.m. licensed practical nurse (LPN)-A stated R1 was confused and wanted to go home. LPN-A stated R1 would often sit by the front door and watch people come and go. LPN-A said on 3/13/25, she had been passing medications. She said her medication cart was right outside the dining room and the last time she had seen R1 he had been eating. LPN-A said the double doors leading to the entrance were shut and said she saw a visitor leave and heard the alarm. LPN-A stated she looked outside and saw R1 sitting on the curb outside the door. She said R1 had several abrasions, a laceration to his nose and said his glasses were smooshed. During interview on 3/21/25 at 11:14 p.m., the director of nursing (DON) identified the root cause of the elopement being the staff member shut off the alarm without looking to see if a resident had exited the building. The DON said R1 could have been more seriously injured. She stated if the weather had been colder, he could have suffered from hypothermia or death. An elopement policy was requested but not received. The past noncompliance immediate jeopardy began on 3/13/25. The immediate jeopardy was removed 3/17/25, and the deficient practice corrected after the facility implemented a systemic plan that included the following actions: - 3/13/25, Immediate education provided to the staff member that shut off the alarm. - 3/13/25 through 3/21/25,Education to all staff about alarms and process of checking outside for residents prior to shutting off an alarm and notification to nursing staff. - 3/17/25, Maintenance evaluated the door alarm and collaborated with the Fire Marshall to decrease the amount of time door opened if pushed. Maintenance also changed the wander alert alarm so it would activate when resident was near the door.