| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E166 | A. Building<br>B. Wing | 07/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Birchwood Care Home | 715 West 31st Street<br>Minneapolis, MN 55408 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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 |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure episodes of leaving the building unsupervised were evaluated or assessed to determine what, if any, additional supervision or monitoring was needed to help prevent subsequent exits from the building for 1 of 3 residents (R1) reviewed for elopement and whom had cognitive impairment. R1 left the care center without staff knowledge was found outside in an adjacent alleyway.Findings include: R1's quarterly Minimum Data Set (MDS), dated [DATE], identified R1 had moderate cognitive impairment but demonstrated no delusional thinking. The MDS outlined R1 demonstrated no wandering behaviors, however, did have dementia and Alzheimer's Disease. Further, the MDS recorded R1 as being independent with most mobility tasks (i.e., walking, transferring). R1's Wander Risk Assessment, dated 3/6/25, identified R1 had been in the care center for less than 30 days, was un-familiar with the surrounding area(s), and had both short and long-term memory loss. The evaluation identified R1 was unable to safely cross streets and did not have the skills to navigate independently in the community. The evaluation added these points and others for a combined score which read, 25 pts [points], with dictation adjacent, High Risk. A summary was listed which read, Resident high risk, she is unable to leave facility unsupervised. The evaluation outlined R1's care plan was updated with this information on 3/13/25.R1's care plan, printed 7/29/25, identified R1's actual or potential problems as of that date along with each' respective initiation and revision date. The care plan outlined a section labeled, ASSESSMENT OF RESIDENT'S ABILITY TO LEAVE THE FACILITY SAFELY, which dictated R1 was deemed unsafe to leave the facility unsupervised. The care plan outlined, 5/22/25 Deemed unable to sit outside unsupervised. The care plan listed several interventions to help ensure R1 didn't leave the facility unsupervised including having social services provide reminders to R1, working to find a memory care setting and, SS [social services] and TR [therapeutic recreation] will do Wandering Risk Assessment Annually [sic] and/or as needed. IDT [interdisciplinary team] will determine if resident is able to leave the facility unsupervised. This section was last revised on 6/11/25; with no interventions being revised since 3/13/25.The care plan continued and outlined a section labeled, VULNERABLE ADULT STATUS, which dictated, 7/17/25: Resident found coming out of alley off facility property by SSD [social services director]. Brought to nurses station. The interventions listed outlined R1 as being on hourly checks and reminders since 4/10/25 and reporting incidents to the common entry point (CEP) as required. On 7/17/25, an intervention which read, Staff will stay with resident at all times when door is unlocked, was initiated.On 7/29/25 at 9:12 a.m., a tour of the second floor of the care center was completed. The unit consisted of a single, long hallway with resident' rooms on each side and a central commons area. The North side of the hallway opened into an open stairwell which lead to the main entrance of the care center. The main entrance had signage posted which directed residents to sign out before leaving, and about hours which the door would best be used for safety reasons. The South side of the unit had a closed, un-alarmed door which opened to another stairwell. This lead down to an exterior door which opened to a back alleyway with cars parked outside. The exterior door had a red-colored, alarm-type stop sign placed which was deactivated at this time. An unidentified male resident was seen walking through the door to outside and the door did not alarm. R1's progress notes, dated 3/1/25 to 7/21/25, identified the following: On 3/1/25, R1 admitted to the care center and presented as confused and/or forgetful. The note outlined R1 was placed on hourly checks. On 3/13/25, the IDT met to review R1's Wandering Risk Assessment. R1 was determined to be unsafe to leave the facility unsupervised. On 3/17/25, R1 was found sitting outside the facility on a bench around 6:25 a.m. without staff present. The note outlined R1 was looking for a lighter and added, . was reminded that she cannot be out smoking without staff . came into building with staff. On 4/3/25, R1 was . up a number of times going into other rooms looking for cigarettes . was redirected to go back in her room. On 5/22/25, the IDT reviewed R1's ability to leave the facility unsupervised or sit outside without staff present. The note outlined, . in consensus that she would not be safe unsupervised . will incorporate supervised times to sit outside and encourage to participate in TR activities and walking. On 6/10/25, R1 was again found outside in front of the building. The note outlined, . reminded [R1] that she is unable to sit outside unsupervised . redirected and came inside of the building right away. On 7/17/25, R1 was seen outside without staff coming out of the alley way onto the sidewalk next to an adjacent building. R1 stated she was going for a walk. A subsequent note, dated 7/17/25, identified the IDT discussed R1 leaving the facility unsupervised to go for a walk adding, SS director will follow up with [R1] |