

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355053		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/10/2025	
NAME OF PROVIDER OR SUPPLIER KNIFE RIVER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 118 22ND ST NE , BEULAH, North Dakota, 58523			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident and a complaint was completed on December 11, 2025. During the report investigation, the facility was found non-compliant with regulatory requirements. During the complaint investigation, the facility was found in compliance with regulatory requirements.			F0000			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the facility reported incident (FRI) investigation, and staff interview, the facility failed to ensure residents received adequate supervision and/or monitoring to prevent elopements from the facility for 1 of 1 sampled resident (Resident #1) Failure to provide adequate supervision and monitoring and respond to door alarms immediately resulted in Resident #1's elopement from the facility and may result in injury from prolonged exposure to cold temperatures. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the elopement. Findings include: The surveyor determined a deficient practice existed on 11/22/25. The facility implemented immediate corrective action and completed additional action/education on			F0689	"Past Noncompliance - no plan of correction required"		

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 reverse for further 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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F0689 SS = D	Continued from page 1 11/27/25. Review of the facility's elopement policy, titled "Knife River Care Center Resident Elopement and Wandering Policy, and dated 03/13/25, stated, "Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents . . . Policy Explanation and Compliance Guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements. . . . 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risk, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing Resident at Risk for Elopement or unsafe wandering . . . b. Residents at risk of wandering and elopement will be placed in Whispering Winds or in a room at least three rooms away from exits at the end of the hall whenever possible. . . . d. Adequate supervision will be provided to help prevent accidents or elopements. Frequent location checks may need to be implemented for high-risk wanderers. . . . 5. Procedure for Locating Missing Resident a. Any staff member becoming aware of a missing resident will alert personnel using facility walkie talkie. b. The designated facility staff will look for the resident. . . ." Review of Resident #1's quarterly elopement assessments dated, 06/13/25 and 09/11/25, identified "At risk for elopement." Resident #1's care plan stated, "The resident is an elopement risk/wanderer r/t [related to] Disoriented to place, Impaired safety awareness, Resident wanders aimlessly. Wander guard present x [times] 2 [two] . . . The resident's safety will be maintained through the review date . . . Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. . . . Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. . . . Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. . . . WANDER ALERT . . ."			F0689			

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F0689 SS = D	Continued from page 2 Review of Resident #1's nurses notes occurred on 12/10/25 and identified the following: *11/22/25 at 1:09 p.m. "Nurse alerted approx. [approximately] at 10:15 [a.m.] by CMA [certified medication aide] that resident had been found outside the facility in the SW [southwest] parking lot fully dressed/wander guard in place/shoes on/sitting in WC [wheelchair] attempting to get in an employee's parked car. The employee/CNA [certified nurse aide] on Shady Lane recognized resident and wheeled her back into building transferring care to Harvest Lane nursing staff." *11/22/25 at 1:10 p.m. "Following return of resident to facility nurse took vital signs and performed head to toe/neurological/pain/cognitive assessments. Resident found to have no pain/injuries or COC [change of condition]. Resident vital signs within baseline. Resident unable to explain why she was in parking lot. Nurse initiated facility protocol notifying MD [medical doctor]/unit manager/on call nurse/family. Resident wander guard replaced. Resident old wander guard appeared to be working. Elopement documentation initiated. Social Services to notify state health department . . ." *11/22/25 at 1:37 p.m. "This writer followed up with incident. Resident has no injuries noted. Resident currently sleeping in her chair in the day room. Resident placed on 15-minute checks. Staff education being completed on resident being placed on 15-minute checks as well as responding to the door alarm. No signs of abuse or neglect noted." Review of the facility's final FRI investigation report stated, ". . . Facility protocol was initiated. . . . The resident's Wander Guard was replaced; the original device appeared to be functioning appropriately. Staff replaced device during the time of investigation. Social Worker investigated the wander guard; wander guard was in good working order. Elopement documentation was initiated according to the facility protocol. [Resident #1] was placed on 15-minute checks for duration of the investigation. Cameras were reviewed; [Resident #1] was seen holding the door to disarm the locking system and [Resident #1] leaving. [Resident1] returned with staff." During an interview on 12/10/25 at 1:45 p.m., two administrative staff members (#1 and #2) stated the wander guard alarm was working when Resident #1 left the building and the alarm went to staff all		F0689				

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F0689 SS = D	Continued from page 3 walkie-talkies. During an interview on 12/11/25 at 11:57 a.m., a social service staff member (#3), who conducted the investigation of the elopement, stated the wander guard alarm on Resident #1 was working and the alarm went to staff on their walkie-talkies. The staff member stated the employee in the parking lot was alerted on his/her walkie-talkie, saw the resident outside and returned her to the building. The staff member (#3) stated when viewing the camera footage, the incident (going into the entryway and then outside to the parking lot) lasted ten minutes and the resident was outside for approximately five minutes. Based on the following information, non-compliance is considered past non-compliance. The facility implemented corrective actions for the resident and other residents who may be affected by the deficient practice as follows: * Immediately initiated 15 minute checks on Resident #1. * Immediately provided education to all staff working on 11/22/25 about the 15-minute checks, the importance of immediately responding to door alarms, and required staff to read the Elopement Policy/Procedure. * Completed investigation of Resident #1's elopement. * Added a second wander guard alarm to Resident #1's wheelchair. * Initiated wander guard checks every four hours. * Provided education to all other staff members prior to return to work about responding to door alarms and to read the Elopement Policy/Procedure.		F0689				