

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355128		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2024	
NAME OF PROVIDER OR SUPPLIER MISSOURI SLOPE				STREET ADDRESS, CITY, STATE, ZIP CODE 4916 N WASHINGTON ST BISMARCK, ND 58503			
(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
F 000	INITIAL COMMENTS			F 000			
F 600 SS=G	An unannounced onsite investigation survey regarding a facility reported incident was completed on October 15, 2024. During the investigation the facility was found noncompliant with regulatory requirements. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of the facility reported incident and investigation reports, record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from mental and/or physical abuse for 1 of 1 sampled resident (Resident #1) who was witnessed receiving physical and verbal abuse. Failure of facility staff to immediately report a witnessed incident of staff to resident abuse to the appropriate supervisor delayed the removal of the accused abuser, the start of the facility investigation, and assessment of the resident for			F 600	1. For resident #1, CNA was immediately put on administrative leave pending investigation. CNA's employment was terminated at the completion of the investigation. 2. All residents have the potential to be affected. 3. All facility staff re-education completed by November 1, 2024 on abuse, neglect, and misappropriation of property including definition and reporting. 4. Department Directors, Charge Nurses,		11/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/29/2024

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.

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F 600	Continued From page 1 injury. This delay placed Resident #1 at risk for further abuse, fear, anxiety, and/or psychosocial harm and placed other residents at risk for abuse. Findings include: Review of the facility policy titled "Abuse" occurred on 10/15/24. This policy, reviewed September 2024, stated, ". . . All employees receive education during orientation and at least annually throughout their employment on what constitutes abuse, neglect . . . and their responsibilities to protect the resident from these crimes. . . . Abuse is defined as . . . intimidation, or punishment with resulting physical harm, pain, or mental anguish, or deprivation of . . . services that are necessary to attain or maintain physical, mental, or psychosocial well-being. . . . Physical abuse is defined as . . . controlling behavior through corporal punishment. . . . Mental abuse is defined as . . . harassment, and threats of punishment . . . Allegations of mistreatment may be identified by anyone who witnesses or receives a report of possible mistreatment toward anyone. . . ." Review of the facility's initial investigation report, dated 10/11/24, identified on 10/11/24 a certified nurse aide (CNA) (#1) reported to the nurse manager (#2) he/she observed a CNA (#3) slap and disrespect Resident #1 on 10/10/24 during evening cares. Review of Resident #1's medical record occurred on 10/15/24. Diagnoses included anxiety disorder, dementia with mood disturbances, and Alzheimer's disease.	F 600	and Lead CNA will be responsible to monitor/audit. The Infection Preventionist/QAPI Director and Vice President of Resident Services will compile QAPI data and monitor for effectiveness. The first quality assurance monitor will be compiled on November 1. QAPI monitoring will be performed weekly for 4 weeks, monthly for 3 months, and then quarterly thereafter for one year. After that time, continuation of monitoring will be determined by facility performance. Monitoring will continue until performance demonstrates sustained compliance and discontinuation is approved by the QAPI committee and medical director. If concerns are identified, immediate action will be taken to reeducate staff. Monitoring results will be reviewed by the QAPI committee at each scheduled meeting.		

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F 600	Continued From page 2 The current care plan identified, ". . . [Resident #1] has potential to demonstrate verbal behaviors r/t [related to] dementia. . . . Document observed behaviors and attempted interventions in behavior log. . . . has the potential to demonstrate physical behaviors hitting out at staff r/t dementia. . . . document observed behaviors . . . When [Resident #1] becomes agitated: Intervene before agitation escalates; Guide away from source of distress, engage calmly in conversation; if response is aggressive, staff to walk away calmly, and approach later. . . ." Review of Resident #1's behavior log, dated October 1-15, 2024, occurred on 10/15/24. The behavior log lacked documentation of any resident behaviors. During an interview on the morning of 10/15/24, a CNA (#1) stated, while he/she and CNA (#3) provided cares to Resident #1 on the evening of 10/10/24, the resident yelled at the CNA (#3) to, "get out," and spit at her. The CNA (#1) identified hearing a spitting sound and turned around to see the CNA (#3) slap the resident in the face and cover the resident's head with a blanket. The CNA (#3) stated, "This is how you calm [resident] down." When the CNA (#3) pulled the blanket down, the resident spit, and the CNA (#3) slapped the resident again, made faces, and stuck her/his tongue out at the resident. The CNA (#1) stated Resident #1 continued to yell at the CNA (#3). The CNA (#1) reported being "shocked," and "scared," during the abuse incident and feared retaliation from CNA #3. The CNA (#1) confirmed not reporting the incident immediately on the evening of 10/10/24 until	F 600			

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F 600	Continued From page 3 reported to the evening nurse on 10/11/24. During an interview on 10/15/24 at 12:48 p.m., a managerial staff member (#4) stated, "Education given was to [CNA #1] that [CNA #1] should have reported the incident immediately."	F 600			