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	355080	A. BUILDING _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

(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 An unannounced onsite complaint survey was completed on June 14-15, 2018. The sample included five (5) sampled residents and three (3) closed records for focused review. An unannounced extended survey was completed on June 20-21, 2018.	F 000		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of the facility's policy, and staff interview, the facility failed to provide oversight and monitoring to ensure that staff implemented the facility's abuse/neglect policy during the provision of care and services for 1 of 1 sampled resident (Resident #5) and 3 discharged residents (Resident #6, #7, and #8) who eloped from the facility. The facility failed to ensure Resident #5, #6, #7, #8, and other residents remained free from neglect. The facility failed to put systems in place to provide the necessary supervision and/or monitoring to prevent Resident #5, #6, #7, and #8 from eloping	F 607	1.) Resident #6,7,and 8 have been discharged from facility. Resident #5 and other residents who elope will be investigated thoroughly and DON and Administrator will determine if negligence had occurred. The staff will assure all other residents are protected if any resident/staff becomes verbally/physically aggressive towards other residents/staff. 2.) All residents/staff have potential to be affected by this deficient practice. 3.) The IDT team and all staff will be in-serviced on elopements to decrease risk of neglect for residents with	7/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/12/2018

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F 607	Continued From page 1 from the facility, and failed to conduct a thorough investigation into each elopement, protect other residents during the investigations, and provide staff training related to decreasing the risk of neglect for residents with behaviors and how to respond if/when residents eloped. Findings include: Review of facility policy titled "Abuse, Neglect, Exploitation, Physical/Chemical Restraints - Investigation and Reporting" occurred on 06/15/18. This policy, revised 09/05/17, stated, ". . . Neglect - means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This includes . . . failure to give proper attention to residents . . . Since residents are vulnerable, every member of this facility has the responsibility . . . to protect and defend them, especially during any period of reporting and investigation . . . Administration coordinates the facility's investigation . . . The Administrator, Director of Nursing, Director of Social Services, or Charge Nurse will make a report to the State Health Department immediately. 'Immediately' means as soon as possible, but ought not exceed 24 hours after discovery of the incident . . . Investigations will be done on a timely basis, and the investigation (along with documentation of actions taken and safeguards that are implemented) will be forwarded to the State Health Department within 5 working days of the initial reporting of the . . . neglect situation. . . ." The facility failed to: * Initiate an investigation following five of Resident #8's eight elopements,	F 607	behaviors, prevention of elopements, and how to respond/if when residents elope. This in-service will be implemented with current staff on July 19th, reviewed yearly at annual in-service training and upon new hire orientation. The DON/Designee will provide a checklist with each elopement to assure all elopements were thoroughly investigated. 4.) A quality monitor will be implemented starting July 19, 2018 to assure all elopements are investigated thoroughly. This will be reviewed with IDT team, and monitored by the DON/Designee for a total of 1 year for every elopement. The results of the monitoring will be reviewed at the scheduled Quality Assurance Meeting and revised as needed . 5.) 07/20/2018	

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F 607	Continued From page 2 * Complete a thorough investigation following each of Resident #5, #6, #7 and #8's elopements, * Focus the investigations on determining if neglect had occurred as a result of insufficient supervision and/or monitoring, * Immediately protect other residents by restricting Resident #5, #7, and #8's access to them after they had consumed alcohol and/or became verbally/physically aggressive towards other residents and/or staff between May 2-June 11, 2018, and * Provide staff training related to decreasing the risk of neglect for residents with behaviors and how to respond if/when residents eloped. Refer to F689.	F 607		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care	F 609		7/20/18

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F 609	Continued From page 3 facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure all alleged violations involving neglect were reported immediately to the administrator and the State Survey Agency and the results of all investigations were reported within five working days of each incident for 1 of 1 sampled resident (Resident #5) and 3 discharged residents (Resident #6, #7, and #8) who eloped from the facility. Failure to identify elopement as an alleged violation involving neglect, and failure to report each alleged violation, and the results of each investigation to the State Survey Agency per the facility's policy, placed Resident #5, #6, #7, #8, and other residents at risk for possible neglect and/or injury. Findings include: Facility staff failed to immediately report Resident #5, #6, #7, and #8's numerous elopements to the State Survey Agency and failed to report the results of the investigations within five working days of each elopement/incident. Refer to F689.	F 609	1.) Resident #6, 7, 8 have been discharged from facility. Resident # 5 and other residents who elope from the facility will be reported immediately to the State Health Department. A follow investigation will reported within five working days for each elopement. 2.) All residents have potential to be affected by this deficient practice. 3.) The IDT- team and nursing staff will be in-serviced on the proper way to report a elopement immediately to the State Health Department. DON/Designee will follow up on investigation within five working days of elopement. Director of Nursing and Administer will revised elopement policy. In-service will be completed on 07/19/2018. 4.) A Quality monitor will be implemented to assure all elopements are reported immediately and a followed up investigation was completed. The DON/Designee will monitor all elopements starting 7-20-18 and the monitor will be completed one year from the start date. The results will be review	

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F 609	Continued From page 4	F 609	at the scheduled Quality Assurance Meeting and revise as needed. 5.) 07/20/2018	
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to thoroughly investigate alleged violations involving neglect, prevent further neglect from occurring while each investigation was in progress, and take appropriate corrective actions for 1 of 1 sampled resident (Resident #5) and 3 discharged residents (Resident #6, #7, and #8) who eloped from the facility. Failure to thoroughly investigate alleged violations of neglect, ensure residents were protected during each investigation, and implement corrective actions/evaluate their	F 610	1.) Resident #6, 7, and 8 have been discharged. Resident #5 and other residents who elope will be investigated thoroughly. Preventive actions and interventions will be implemented for each resident who is at risk for elopements. 2.) All residents have potential to be affected by this deficient practice. 3.) IDT Team and nursing staff will be in-serviced/trained on prevention strategies of residents who are at risk for elopement. In-service training will be	7/20/18

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F 610	Continued From page 5 effectiveness following each investigation, placed Resident #5, #6, #7, #8 and other residents at risk for possible neglect and/or injury. Findings include: The facility failed to: * Thoroughly investigate Resident #5, #6, #7, #8's numerous elopements from the facility (alleged violations of neglect), * Immediately protect other residents by restricting Resident #7 and Resident #8's access to them; and * Implement corrective actions/interventions to eliminate Resident #5, #6, #7, and #8's risk of elopement/access to alcohol and evaluate the effectiveness of those interventions following each investigation. Refer to F689.	F 610	implemented on 07/19/18. This in-service will also be reviewed annually at the staff annual in-service and upon new hire orientation. 4. Quality Monitor will be implemented to assure all new hire staff and all current nursing staff will be in-serviced and trained properly for residents who are risk for elopements/ or residents who have eloped. The quality monitor will start 07/20/18. DON/Designee will maintain this quality monitor 1x weekly for 3 months, than 1x biweekly for 3 months, than 1x monthly for 6 months for a total of one year. 5. 07/20/2018	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		7/20/18

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F 657	Continued From page 6 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's policy, and staff interview, the facility failed to ensure staff reviewed and revised comprehensive care plans to reflect each resident's current status for 2 of 5 sampled residents (Resident #1 and #5) and 3 residents discharged from the facility (#6, #7, and #8). Failure to review and revise the care plan to reflect each resident's current status limited the staff's ability to communicate needs and ensure continuity of care for the residents. Findings include: Review of the facility policy "Elopements and Wandering Residents" occurred on 06/15/18. This policy, revised 01/17/18, stated, ". . . The interdisciplinary team will . . . develop a person-centered care plan . . . Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff . . . The effectiveness of	F 657	1.) Resident #1's care plan has been updated to include additional interventions that staff should utilize if he is acting in an aggressive manner towards other residents and/or staff; Resident #5's care plan has been updated to address his history of alcohol abuse, interventions necessary to prevent him from further elopements and interventions staff should utilize if he is acting in an aggressive manner towards other residents and/or staff; Resident's #6,7, & 8 have been discharged. 2.) All residents with behavioral issues have the potential to be affected by this deficient practice. 3.) All residents care plans will be reviewed by the Care Plan Coordinator/Designee to ensure that interventions are in place to reflect each resident's current status to ensure the staff's ability to communicate needs and to ensure continuity of care for our residents. To ensure that staff have	

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F 657	Continued From page 7 interventions will be evaluated, and changes will be made as needed . . ." - Review of Resident #1's medical record occurred on all days of the survey. Resident #1 has a history of physical aggression and uncontrolled behaviors, both physical and verbal. The interdisciplinary team's progress notes, dated 11/24/17 through 05/23/18, identified incidents during which Resident #1 displayed the following behaviors: * pushing on a door, repeatedly triggering the alarm, * standing, repeatedly triggering his chair alarm, * hollering, * swearing (verbally and through gestures) at other residents and staff, and * kicking the back of a resident's wheelchair. The care plan identified, " . . . I have a history of physical aggression, uncontrolled behaviors and agitation . . . staff to monitor my behaviors for situations that may trigger physical aggression . . . I had a physically aggressive incident with a resident . . . I have been observed shaking my fists at a resident. . . ." The care plan failed to identify interventions staff should utilize when Resident #1 interacted in an aggressive manner towards other residents. - Review of Resident #5's medical record occurred on all days of the survey. The current care plan identified, " . . . I have a history of leaving the facility and coming back intoxicated. I have a history of elopement . . .	F 657	reviewed each resident's care plan quarterly and with any change, a sign off form will be implemented for staff to initial after they have reviewed. The nursing staff will be inserviced on the DCNH Care Plan Policy and the sign off form on 07-19-18. 4.) The Care Plan Coordinator/Designee will monitor the sign off form weekly for 3 months, monthly for 9 months for a total of 1 year. This will begin 07-19-18. This information will be presented at the scheduled quality assurance meeting for review, revisions to the procedure will be made as needed. 5.) 07/20/18	

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F 657	Continued From page 8	F 657		

Staff to monitor my whereabouts frequently. Wander guard bracelet applied per guardian request. I have refused to wear bracelet and have cut it off frequently. Staff to monitor wander guard placement frequently . . . I had a physical aggression incident with staff . . . I was intoxicated . . . I was sexually inappropriate with the nursing staff . . . staff to stay away from me if I am acting in a threatening manner. Call law enforcement if unable to calm down. . . ."

The interdisciplinary team's progress notes, dated 05/23/18 through 06/06/18, identified incidents during which Resident #5 became intoxicated and displayed the following behaviors:
* pushed the front doors off their tracks,
* cupping a female staff member's breasts,
* swinging at staff as they attempted to provide cares,
* yelling at other residents and staff, and
* swearing at other residents and staff.

The care plan failed to address Resident #5's high-risk behaviors (history of alcohol abuse), identify interventions necessary to prevent him from further elopements and/or interacting in an aggressive manner towards other residents.

- Resident #6's medical record occurred on all days of survey. Diagnoses included behaviors related to advanced dementia and nicotine dependence.

The interdisciplinary team's progress notes, dated 04/15/18 through 04/23/18, identified one incident during which Resident #6 reported feeling suicidal, and incidents of elopement or

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F 657	Continued From page 9	F 657		

incidents where he walked away from the facility with a staff members, but refused to return to the facility.

The care plan failed to address Resident #6's high-risk behaviors (history of nicotine use), identify interventions to address his suicidal ideation, and prevent him from eloping from the facility.

- Resident #7's medical record occurred on all days of survey. Diagnoses included behaviors related to advanced dementia.

The interdisciplinary team's progress note, dated 05/09/18, identified one incident during which Resident #7 reported feeling suicidal after returning to the facility.

The care plan failed to identify interventions to address Resident #7's suicidal ideation.

- Resident #8's medical record occurred on all days of survey.

A physician's progress note, dated 04/03/18, identified, ". . . no etoh [alcohol] intake since incarceration. NH [nursing home] placement to ensure safety and continued abstinence. . . ."

The interdisciplinary team's progress notes, dated 04/05/18 through 06/11/18, identified incidents of elopement and documented incidents during which Resident #8 became intoxicated and displayed the following behaviors:
* repeatedly slamming a door,
* pushing a housekeeping cart into a staff

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F 657	Continued From page 10 member, * threatening staff (verbally and through gestures), * pacing hallways with a scowl on his face, * hollering/yelling at other residents and staff, and * swearing at other residents. A "Incident Reports/Post Elopement Form," dated 06/12/18, identified "one-on-one's" as an intervention staff should utilize to prevent Resident #8 from eloping. During an interview on 06/15/18 at 10:40 a.m., when asked questions pertaining to care planning, a social service staff member (#2) indicated the facility looks at each resident "holistically;" considering their "diagnoses, family [dynamic, and spiritual needs]." They consider "activities, strategies to help them, behavior modification; rewards, praise, [and] explain when behaviors are not appropriate." Resident #8's care plan failed to address his high-risk behaviors (history of alcohol abuse and recent incarceration) and the affect his wandering and aggressive behaviors had on other residents. The care plan also failed to identify "behavior modification" techniques and/or "one-on-one's" as additional interventions staff should utilize to prevent Resident #8 from eloping from the facility.	F 657		
F 689 SS=K	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	F 689		7/20/18

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F 689	Continued From page 11 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: During the complaint survey on June 14-15, 2018, the team determined a potential Immediate Jeopardy (IJ) situation existed. The IJ potential resulted from review of Resident #5, #6, #7, #8's medical records which showed the residents were placed in avoidable dangerous situations after they eloped from the facility. After record review and interview with facility staff, the survey team met at 1:30 p.m. on 06/15/18 and determined corrective action needed to occur. At 1:40 p.m., the team contacted the managerial staff at the State Survey Agency (SSA) to report the findings and to discuss a potential IJ situation. At 2:00 p.m., the survey team notified facility administration of the IJ and that they must develop a plan for removal of the immediate jeopardy situation. At 3:15 p.m., the facility provided a written plan to remove the IJ. The team reviewed and accepted the written plan which included checks every 15 minutes, updates to the care plan, additional staffing, and staff education. At 3:25 p.m., the team determined the IJ situation removed, reduced the scope and severity level to "E," and informed the facility administration of this action. Based on information provided by the complainant, record review, review of facility's policy, and staff interview, the facility failed to	F 689	1.) Resident #6, 7, and 8 have been discharged from facility. Resident #5 continues to be monitored with 15 min checks. A schedule has been implemented with one to one supervision to assure resident # 5 does not elope the facility. Resident #5 has not had any elopements since schedule has been implemented. The facility will not allow any residents to be outdoors without staff supervision. 2.) All residents have the potential to be affected by these deficient practices. 3. The IDT-Team and all staff will be In-serviced on July 19th, 2018 to educated and train staff with prevention strategies to avoid possible elopements. All staff will be in-serviced on how to respond if a resident does elopement. This in-service will be implemented on July 19th, 2018. 4.A quality monitor will be implemented by DON/Designee to monitor if staff are following the one on one schedule and Resident #5 15 min checks. DON/Designee will monitor to assure all nursing staff are following the elopement policies per facility policies. The quality monitor will start 07/20/19. Quality Monitor will be monitored 3x weekly for 1 month, than 2x weekly for 1 month, 1x weekly for 4 months for a total of 6	

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F 689	Continued From page 12 ensure residents received adequate supervision and/or monitoring to prevent safety elopements from the facility for 1 of 1 sampled resident (Resident #5) and 3 residents who were discharged from the facility (Resident #6, #7, and #8). Failure to acknowledge the high-risk behaviors of the residents upon admission, identify each resident's risk of elopement, implement, monitor, and modify individualized resident-centered interventions when necessary, and demonstrate a commitment to the residents' overall safety, resulted in Resident #5, #6, #7, and #8 being placed in avoidable dangerous situations after they eloped from the facility. Findings include: Information provided by the complainant indicated residents were repeatedly eloping from the nursing home, and in many instances police intervention was required in locating them. Review of facility policy titled "Elopements and Wandering Residents" occurred on 06/15/18. This policy, revised 01/17/18, stated, ". . . 'Elopement' occurs when a resident leaves the premises or a safe area without authorization . . . or . . . [the] necessary supervision to do so . . . The facility is equipped with door locks/alarms to help avoid elopements . . . Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner . . . The facility shall establish and utilize a systematic 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 risks, implementing interventions to	F 689	months. Results of the monitor will be reviewed at the scheduled Quality Assurance Meeting and Revised as needed. 5. 07/20/2018	

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reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary . . . Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be . . . . communicated to appropriate staff . . . Adequate supervision will be provided to help prevent accidents or elopements . . . The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff . . . Charge nurse will complete the Elopement Incident Report . . . A social service worker will set up a care plan meeting to address approaches, modifications and goals that are appropriate for the resident . . . Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. . . ."

- Review of Resident #5's medical record occurred on all days of the survey. Diagnoses included hyperglycemia and history of alcohol abuse.

An elopement risk assessment, dated 05/08/17, stated, " . . . Client returned from [family leave] now has elopement bracelet to right ankle per guardians request-client only able to sign out with certain family members- due to alcohol abuse. . . ."

The most recent care plan identified the following:
* 05/09/18, "History of alcohol/drug abuse . . . I have a history of leaving facility and coming back intoxicated. I have a history of elopement . . . I

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F 689	Continued From page 14 have a history of having bottles of different alcohols in my room . . . staff to monitor my whereabouts frequently. Wanderguard bracelet applied per guardian request. . . ." * 05/09/18, "Behavioral symptoms . . . I often want to leave without safe transportation . . . I am only able to sign out of facility with certain people. . . ." The care plan failed to identify interventions necessary to prevent Resident #5 from interacting in an aggressive manner towards other residents. The interdisciplinary team's progress notes identified the following: * 05/23/18 at 9:15 p.m., ". . . client fell outside . . . lying on his back on the ground just outside the doors . . . client is under the influence of alcohol . . . speech slurred . . . client became physical. Client grabbed CNA [cupped her breast] . . . client swung at her . . . grabbing writers shirt pulling it down-almost ripping it off" . . . at 10:25 p.m., "[nearby town] ambulance called per [physician] to take client to emergency room [ER] to detox" . . . and at 10:45 p.m., ". . . ambulance arrived . . . client combative-swinging at staff, kicking and grabbing staff in inappropriate places . . . speech still slurred. Client very intoxicated. . . ." * 05/24/18 at 3:30 p.m., ". . . [late entry] on 05/23/18 at approximately 8:00 p.m., resident was seen getting into a pick-up . . . police visited our facility . . . Police were notified that resident was unauthorized to leave . . . after about 35 to 40 minutes resident returned . . . he and fellow resident passed around a Gatorade bottle which contained alcohol . . . shortly after is when resident fell. . . ."	F 689		

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F 689	Continued From page 15 * 05/25/18 at 1:45 p.m., "resident returned from hospital. . . ." * 05/30/18 at 9:45 p.m., "resident was sitting outside with another resident . . . 5 minutes later noticed they were not sitting there . . . resident found one block over. . . ." * 05/31/18 at 11:20 a.m., "care conference held to discuss recent elopements. Discussed concerns and interventions to put in place . . . Care plan reviewed/revised as needed. . . ." * 06/06/18 at 8:30 p.m., "CNA smelled alcohol on client . . . CNA went into resident's room . . . A water bottle resident had in his hand and when asked what was in it client said water and drank the remaining liquid left in bottle. CNA smelled an empty water bottle and it smelled of alcohol" . . . at 10:00 p.m., "client trying to leave facility . . . client pushed on door until it went off track and he went outside . . . Client wanted a cigarette became angry and yelled I don't give a [explicative] what time it is I want to smoke . . . client was slurring his speech . . . found an empty Grande Canadian bottle . . . in client's closet" . . . and at 11:56 p.m., "client in room with another resident. Client is yelling and swearing . . . being disruptive of other residents . . . client appears to be intoxicated . . . 'he doesn't have to go anywhere this is my [explicative] house' Attempted to take dirty cups out of room. Client said 'leave my [explicative] cup.' . . . police called. . . ." * 06/09/18 at 11:45 p.m., "Client in room with another resident. Client is yelling and swearing . . . client appears to be intoxicated . . . [he doesn't have to go anywhere this is my (explicative) house . . . attempted to take dirty cups out of room client said [leave my (explicative) cup] police called. . . ."	F 689		

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F 689	Continued From page 16 * 6/10/18 at 12:55 a.m., client was on floor . . . hit head on bed side dresser causing a laceration 4 cm x 0.1 cm and an abrasion to right shoulder 8 cm x 5 cm . . . Empty vodka bottle found in bottom of garbage. . . ." Facility staff completed "Incident Reports/Post Elopement Forms" following three of Resident #5's three related incidents/elopements (one with a fall). Following the elopement on 05/23/18, they identified "closer supervision" as an intervention to keep Resident #5 from eloping. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included traumatic brain injury (TBI) and history of alcohol abuse. The admission Minimum Data Set (MDS), dated 04/09/18, identified moderate cognitive deficits, independence with locomotion on/off the unit, and wanders; significantly intruding on the privacy/activities of others. The most recent care plan identified the following: * 04/03/18, "Risk of elopement . . . Wanderguard placed. Removed. Resolved. Staff to monitor whereabouts frequently. Staff to try to redirect [Resident #8], be non-judgmental, keep environment calm, frequent reminders as [Resident #8] has limited memory." * 05/24/18, "[Resident #8] may not leave facility [without] assistance. He has lost his privilege to check in [and] out on his own because of his behavior on 05/23/18 per [guardian]. This is for his own safety. Wanderguard placed. . . . Staff to accompany when outdoors . . ." A physician's progress note, dated 04/03/18,	F 689		

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F 689	Continued From page 17 identified, ". . . He has guardian and no etoh [alcohol] intake since incarceration. NH [nursing home] placement to ensure safety and continued abstinence . . ." The interdisciplinary team's progress notes identified the following: * 04/03/18 at 3:00 p.m., "Resident was admitted to facility". . . and at 9:00 p.m., "wanderguard placed on ankle to alert staff of his whereabouts; may be forgetful at times . . ." * 04/05/18 at 12:15 p.m., "Resident left facility without approval . . . returned with a bag of food . . . was told by nurse that he cannot leave facility . . . Nurse stated that law enforcement will be called if he continues to not follow policy. Resident voiced understanding." A social service progress note, dated 04/11/18, identified, ". . . moderately impaired [cognition] . . . Resident went to the store after being told that he could not. Wandering did not endanger anyone . . ." The interdisciplinary team's progress notes identified the following: * 04/19/18 at 3:40 p.m., ". . . resident will sign in [and] out of facility" . . . and at 8:40 p.m., "New wanderguard placed on right wrist. . . ." * 05/08/18 [time not identified], "Resident has been compliant with cares and facility policies due to elopements. Wanderguard has been removed. Guardian has approved to take wanderguard off." * 05/23/18 at 9:15 p.m., ". . . Client's words were slurred. Writer noticed client had a [sic] off yellow drink in a Gatorade [sic] bottle that smelled strong of alcohol. Client seemed very intoxicated	F 689		

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unsteady gait when trying to walk . . ."
* 05/24/18 at 9:15 a.m., "Called [guardian] . . . Resident is not to leave facility [without] assistance, he has lost that privilege because of his behavior . . ."

A social service progress note, dated 05/24/18, identified, ". . . Informed [guardian] of recent incident and that the local bar reports that [Resident #8] has been buying alcohol on other occasions . . ."

The interdisciplinary team's progress notes identified the following:
* 05/30/18 at 9:56 p.m., "[Resident #8] was sitting outside with another resident . . . 5 minutes later . . . noticed they were not sitting there . . . CNA [certified nursing assistant] found [Resident #8] one block over. [Resident #8] refused to come back to [nursing home]. CNA kept encouraging client to return. Client . . . walked back to nursing home . . ."
* 05/31/18 at 2:30 p.m., "Notified [guardian] regarding resident's elopement yesterday. No concerns at this time."
* 06/07/18 at 11:20 p.m., "Care conference held for elopement. Care plan reviewed and revised as indicated. Guardian aware and involved in planning care to prevent further elopements. Interventions in place to prevent elopement . . ." Record review showed no further updates were made to Resident #8's care plan after 05/24/18.
* 06/09/18 at 2:35 p.m., "Received phone call from community member stating that resident was observed walking east of Dunseith" . . . at 3:00 p.m. (25 minutes later), "Resident was escorted back to facility by [deputy]" . . . at 4:25 p.m., "Resident has left again . . . Returned [at]

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F 689	Continued From page 19 5:00 p.m. (35 minutes later) [with] alcohol on breath. Had been found drinking at [local bar/cafe]. Readily admitted such to sheriff. Sheriff strongly advised that if this happens again stronger measures would be taken" . . . at 9:00 p.m., "Resident again attempted to leave the facility, but CNA spotted him walking down street to the north . . . When CNA got to him, he said, 'I almost got free.' Will lock front door to discourage further leaving" . . . at 9:30 p.m., "Citizen called and said she saw resident race out of kitchen door to the east and take off at a fast pace going south. Apparently he ended up at [local bar/cafe] and police were called. Showed up at 10:00 p.m. (30 minutes later) Door locked [no further escapes" . . . at 11:45 p.m., "Client in another clients room . . . very intoxicated, yelling, making noise, swearing, being very disruptive to other clients . . . Client and other client continue to yell and swear. Writer asked them to keep it down. Police called" . . . (During an interview on 06/15/18 at 11:45 a.m., when asked questions pertaining to the Resident #8's behaviors, an administrative nurse (#1) reported, "We had a resident who was dying next door. [We] called the police to get him to go [back to his room].") . . . and at 12:15 a.m., ". . . Police officer entered and told [Resident #8] he needed to go to his own room. Police officer told client, 'This is ridiculous to have to be called how many times today because of you. Let's go to your room or your [sic] going to jail . . . Before leaving police officer told writer, 'Client belongs somewhere else - a locked down unit or his [sic] going to end up going to jail.' [Resident #8] had left the facility earlier and was picked up at [bar/cafe] where he purchased the vodka."	F 689		

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F 689	Continued From page 20 The interdisciplinary team's progress notes identified the following: * 06/10/18 at 10:20 a.m., "Resident came out of room and started digging through the housekeeping cart . . . stating, 'Where the [explicative] is my jug?' . . . Resident started hollering at nurse saying 'You better watch yourself.' . . . Resident pushed cart towards nurse, causing water to spill on floor. Nurse hollered for housekeeper (male) to assist with calming down resident. . . . Resident continued to holler. Prior to incident CNA and nurse confiscated a powerade bottle with clear liquids inside. Nurse smelled bottle finding a strong smell of alcohol" . . . at 10:30 a.m., "Resident would walk by nurses' station and hold his fists up at charge nurse. Charge nurse had locked herself in nurses' station due to resident verbally threatening, stating to nurse, 'You better watch it.'" . . . at 10:35 a.m., "Resident was standing by his door and started slamming door. He slammed door 3 times causing staff at the nurses station to hear sound. Immediately the housekeeper got up and attempted to calm resident down. Resident was hollering loudly, stating, 'I'll fight you, where's my jug?' . . . Resident continued to holler loudly [sic]. Resident did go into his room. Charge nurse [and] other staff members observed this incident" . . . at 10:36 a.m., [Guardian was] notified . . . [Guardian was] in agreement for charge nurse to call authorities" . . . at 10:50 a.m., "Two police officers arrived at facility. Resident was very resistant with the officers. Officers had to use extreme force with tazing approx [approximately] 3 times. The 2 officers escorted resident out of building and transported resident to police station" . . . and at 11:25 a.m., ". . . [Physician] was in agreement to call authorities due to the	F 689		

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F 689	Continued From page 21 safety of staff [and] residents." * 06/11/18 at 9:30 a.m., "Received phone call from . . . officer . . . She then explained that they are unable to care for someone [with] his medical condition. Writer asked officer what about the safety of the other residents [and] staff at [nursing home]? She again stated they cannot pick him up or arrest him. Resident returned to [nursing home] around 9:30 p.m. on 06/10/18. Resident is currently pacing hallways going outside without permission and has a scowl on his face. Staff is frightened to communicate [with] resident as unknown how he will react . . ." * 06/12/18 at 10:00 a.m., "Resident was found missing" . . . at 10:20 a.m., "Resident was still missing and charge nurse called 911" . . . at 10:50 a.m., "[Guardian] was notified and they said to attempt to keep resident in facility" . . . at 2:30 p.m. (4 hours 30 minutes later), "Resident has been found by local residents of Belcourt and the police have been notified to pick up resident [approximately six miles from the nursing home]" . . . and at 3:00 p.m., "Resident has been . . . sent to a facility in [name of another town]." During an interview on 06/15/18 at 10:00 a.m., when asked questions pertaining to the elopements, an administrative nurse (#1) reported Resident #8's physician directed staff to "let [Resident #8] leave [the facility], because of his aggression. He was a large guy. Staff [were] afraid of him, afraid [they'd] get hit." Facility staff completed "Incident Reports/Post Elopement Forms" following three of Resident #8's eight elopements. Following the elopement on 06/12/18, they identified "one-on-one's" as an intervention staff should use to keep Resident #8	F 689		

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from eloping. According to the administrative nurse (#1) one-on-one's had been in place since the first week of May.

- Resident #7's medical record occurred on all days of survey. Diagnoses included stroke with expressive aphasia (communication deficit) and dementia. The admission MDS, dated 04/25/18, identified severe cognitive deficits and independence with locomotion on/off the unit.

An admission nursing assessment, dated 04/19/18, identified, ". . . Family report that resident was living at retirement home [and] would elope numerous times . . . Resident will walk from door to door and set off alarms at times. . . ."

The most recent care plan identified the following:
* 04/20/18, ". . . I am at risk of elopement . . . Wanderguard, staff to monitor whereabouts frequently . . . Listen to my concerns in a calm, non-judgmental [sic] manner . . . Staff to supervise me if I go outside. If I try to leave [without] supervision try to redirect me to come indoors, if not successful - call law enforcement for assistance while keeping me within staff's field of vision . . ."
* [undated], "hx [history] of Elopement on 05/01/18."

An interdisciplinary team's progress note, dated 04/19/18 at 1:00 p.m., identified, "Resident admitted to the facility . . . Resident is an elopement risk, wanderguard was placed to resident's right wrist. . . ."

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DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

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F 689	Continued From page 23 A social service progress note, dated 04/29/18, identified, ". . . He has had a long history of wandering, which necessitated Nursing Home placement. . . . [Resident #7] has delusions. Misconceptions and beliefs that are firmly held contrary to reality. He has been returned to his previous address several times by the police in the middle of winter and still thinks he can walk outdoors by himself. . . ." The interdisciplinary team's progress notes identified the following: * 05/01/18 at 7:45 p.m. "Phone call from community alerting staff that [Resident #7] was out in community trying to get a ride to [nearby town]. Good samaratin brought [him] back to facility. Missing approx 7:25 p. [sic] Found [at] 7:45 p. [sic] (20 minutes). He stated that his car was broken and he had to fix it. . . ." * 05/02/18 at 7:00 p.m., "CNA was supervising resident outdoors . . . [Resident #7] was refusing to come in . . . At 7:10 she told me [Resident #7] was refusing to come in. By this time [Resident #7] was behind the nursing home [and] I ran to catch up to bring him back. I told him to stop and he only increased his pace. I followed him and he would not stop. At one point I touched his arm to turn him around and he hit me with a closed fist. He then kept walking. CNA was trying to raise the police to come help and they never came. Resident kept walking at a quick pace out to [road] and turned east. Trying to keep him out of center of road was a challenge as he was determined to do exactly what he wanted to do. All CNA and I could do was follow and attempt to warn cars of his presence. Several more calls made to police who assured us they were coming to our rescue. Time [and] passed [and] no police.	F 689		

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Frustrated to the maximum I dialed 911 and emphatically stated that they send help 'NOW' as I was in a situation that was critical. Three or so miles down the road the police finally came and police calmly directed resident into the car. Police returned resident . . . Resident crying as he didn't want to be brought back . . . Front door locked to prevent any further problems. Family notified of plans to set up a psych appt [appointment] in Belcourt for tomorrow . . . Throughout this ordeal Resident told this nurse to 'fuck off.' When I told him to stop. He was defiant, resistive, and unmanagable [sic]."
* 05/04/18 at 1:30 p.m., "[Physician] notified facility regarding resident [and] new orders. [Physician] ordered Risperadone 1 mg [milligram] po [by mouth] BID [twice daily] . . ."
* 05/05/18 at 11:38 a.m., "Resident kicked open front doors of facility knocking door off track. Resident eloped facility. In route walking north on Main Street . . . Charge nurse notified 911 regarding resident's elopement" . . . at 11:15 a.m., ". . . [son] called. Charge nurse informed him of resident's elopement [and] being sent to ER [emergency room]" . . . at 12:29 p.m. (31 minutes later), "Officer stated she located resident on [name of road] and would be bringing resident back to facility. . . ."

The emergency room progress note, dated 05/05/18, identified, ". . . male presents via ambulance after eloping from the [nursing home] . . . Discharge in stable condition. . . ."

The interdisciplinary team's progress notes identified the following:
* 05/07/18 at 1:35 p.m., "Wander guard placed to resident's right ankle."

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* 05/08/18 at 11:10 a.m., "Resident had walked out of front doors of facility at 10:50 a.m. and proceeded south of building and was approached by 3 staff members. Resident would not reply to staff . . . started heading north of facility. Charge nurse then called police to assist with getting resident back to the facility. Staff continued to walk north with resident until reaching Highway 21. Staff then attempted to . . . [redirect] him back to facility and resident struck CNA in the face and then charge nurse in the face as well. A bystander then pulled up on scene and also helped to redirect resident back to facility . . ."

The social service progress notes, dated 05/08/18 at 10:40 a.m., identified, "Care Conference . . . Assurance was given to [sons] that we will work on these problems [anger and elopements]. That transfer and discharge is the last option" . . . and at 11:05 a.m., ". . . Reviewed checklist for meetings on physical aggression concerns. Concluded that protocol is being followed. . . ."

The interdisciplinary team's progress note, dated 05/10/18, identified, ". . . [Hospital] . . . suggested to start medications that were previously ordered . . . If medications don't help, they suggested to have him transferred to a lock down unit since most behaviors are related to elopements. . . ."

A physician's progress note, dated 05/24/18, identified, ". . . He has a history of severe dementia . . . He . . . was outside in the winter without proper clothing, decision was made to have him . . . placed in the nursing home . . . He eloped from the facility in spite of having a wander guard, likes to walk a lot, staff doing their

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best to try to keep an eye on him, keep him from leaving the facility. . . ."

The interdisciplinary team's progress notes identified the following:
* 05/25/18 at 7:28 a.m., "Client eloped. Another resident informed writer that he seen [Resident #7] walking towards main street . . . Writer checked front doors and they were locked . . . Writer went and told CNA to go and look for [Resident #7]. CNA located [Resident #7] by [local bar/cafe]. [Resident #7] would not get in CNA's vehicle. CNA seen a Border Patrol officer sitting by [local bar/cafe] and asked for his help . . . [Resident #7] proceeded to walk down the road . . . Border Patrol officer followed [Resident #7] until police arrived . . . [Administrator] was also present. [Administrator] stated [Resident #7] fell x 2 . . . [Resident #7] told writer 'to get the (explicative) away from him."
* 05/28/18 at 11:45 a.m., "At 11:15 a.m., CNA was having difficulty with resident returning into the building . . . Nurse went outside to talk to the resident . . . when asked resident to come back in resident said, 'Can you just leave me alone? You just like to run your (explicative) mouth don't you?' Nurse . . . softly put their hand on his shoulder and resident stood up and pushed nurse back and said, '. . . Get away from me or I'll hit you' . . . and proceeds into facility . . ."
* 05/29/18 at 8:25 a.m., "Resident was found outside walking around the block. Charge nurse asked resident if he could come back into the building and resident said,'I'm going to walk if I want to walk. Why don't you get out of my (explicative) way?' . . . Nurse walked with resident around the building . . . asked resident to return into building and resident said, 'Don't tell

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me what to do, get the (explicative) out of my face before I (explicative) hit your big head.'" . . . at 8:40 a.m. (15 minutes later), "Resident . . . came back into facility . . . and at 12:00 p.m., ". . . At 11:20 a.m. CNA reminded resident again that it was time for dinner and resident said, "Get the (explicative) out of my face and leave me the (explicative) alone.' Resident then went outside and did not want to be disturbed. Resident came back into the facility at 11:50 a.m. (30 minutes later) . . ."
* 05/30/18 at 12:20 p.m., "Community member called [nursing home] stating resident walk [sic] walking north of Dunseith by [store]" . . . at 12:30 p.m., "Police (911) authorities were notified of resident's elopement" . . . at 12:35 p.m. (15 minutes later), "Resident walked back into facility . . ."
* 06/07/18 at 11:15 a.m., ". . . Resident is continually walking away from facility [without] any concerns for his own safety. He walks in middle to road unaware of on-coming traffic . . . Interventions in place to try [and] prevent elopement. Family aware of situation [and] working [with] [nursing home] to come [with] a plan that is best for resident's safety."

Facility staff completed "Incident Reports/Post Elopement Forms" following each of Resident #7's five elopements. Following the elopements on 05/01/18 and 06/12/18, they identified "do not allow outdoors without close supervision and one-on-one's" as interventions staff should use to keep Resident #7 from eloping.

- Review of Resident # 6's medical record occurred on all days of survey. Diagnoses included dementia, agitation and nicotine

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F 689	Continued From page 28 dependency. The most recent care plan identified the following, "04/23/18, "Elopement . . . wear wanderguard. . . ." The interdisciplinary team's progress notes identified the following: * 04/15/18 at 9:00 p.m., "I'm feeling anxious and suicidal. . . ." * 04/23/18 at 3:15 a.m., ". . . "anxious, can't sleep, . . . out of his room several times, worried about a cig [cigarette] . . . at 8:00 a.m., " . . . I need a taxi. I can't stay here . . . resident had left the facility and proceeded to walk towards the street . . . redirected inside" . . . at 12: 40 p.m., "resident left facility at 11:50 a.m. . . . nurse followed the resident into a grocery story . . . nurse walked around town with resident to make sure he would not get hurt . . . resident walked into a bar and bought cigarettes . . . two police officers then assisted resident back to nursing home" . . . at 1:30 p.m., "resident attempted to leave facility again" . . . at 3:45 p.m., "Police notified [facility] staff resident was at the [bar]" . . . and at 4:00 p.m., "Resident once again left facility. Police notified us [facility staff] of the elopement. . . ." During two interviews on 06/15/18 at 10:00 a.m. and 11:45 a.m., when asked questions pertaining to wanderguards, an administrative nurse (#1) reported, "The wanderguards were not working. This is not a locked facility. If you push [on the front door], it goes right off the track." When asked questions pertaining to monitoring expectations, the nurse (#1) reported hiring an additional staff member the first weekend in May.	F 689		

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The staff member was hired to sit with residents who wanted to be outside between the hours of 3:00 p.m. and 9:00 p.m., "the time period most of the elopements were occurring." She (#1) did not respond when it was pointed out that a number of the elopements occurred between 3:00 p.m. and 9:00 p.m. when the additional staff member was present, and the remainder of the elopements occurred outside the newly hired staff member's scheduled hours. When asked questions regarding how frequently residents were being monitored, the administrative nurse (#1) stated, "Just frequently. [Staff] fill out a form if [there is a] doctor's order." When asked questions pertaining to staff education, the nurse (#1) reported, "We had training on elopement in April, and a drill." (Review of CNA education rosters showed the inservice took place in January 2018.) When asked questions pertaining to admitting high-risk residents to their facility, she (#1) stated, "We were forced by the board to take these residents. [We had a] low census."
When asked questions pertaining to the the facility's abuse/neglect policy, the administrative nurse (#1) indicated she "wasn't aware [they] were supposed to notify the State agency."

The facility failed to demonstrate a commitment to Resident # 7 and #8's overall safety, when they failed to:
* Acknowledge the high-risk behaviors of Resident #5 (history of alcohol abuse), Resident #7 (history of elopements), and Resident #8 (history of alcohol abuse and recent incarceration) upon admission,
* Provide the necessary supervision/monitoring to prevent Resident #5 and #6 from eloping and accessing alcohol on two occasion, Resident #7

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F 689	Continued From page 30 from eloping on five separate occasions (whereabouts unknown for 31 minutes), and Resident #8 from eloping on eight separate occasions (whereabouts unknown for 4 hours 30 minutes, found 6 miles from the facility) and accessing alcohol on at least two occasions, * Determine if Resident #5, #6, #7, and #8 were able to elope as a result of insufficient supervision and/or monitoring (wanderguard/staff observation), * Restrict Resident #5, #7, and #8's access to other residents after they had consumed alcohol and/or became verbally/physically aggressive towards other residents and/or staff between May 2-June 11, 2018, * Implement, monitor, and modify Resident #5, #6, #7, and #8's individualized interventions when necessary, and * Educate nursing staff regarding Resident #5, #6, #7, and #8's elopements and possible strategies for avoiding such behavior in the future per facility policy.	F 689		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F 740		7/20/18

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F 740	Continued From page 31 Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary behavioral health care services to ensure each resident attained/maintained their highest practicable emotional/mental well-being for 2 of 2 sampled resident (Resident #1 and #5) and 2 residents discharged from the facility (Resident #6 and #8). Failure to provide an environment conducive to each resident's emotional/mental well-being, including the prevention and treatment of substance disorders, resulted in Resident #1, #5, #6, and #8 being placed in avoidable dangerous situations and/or situations in which they had access to alcohol after they eloped from the facility. Findings include: Review of the facility policy titled "Resident Behavior Log and Physical Aggression" occurred on 06/15/18. This policy, revised October 2017, stated, ". . . When staff observes or are involved with residents experiencing behavioral symptoms they will record the encounters on the Behavior Log . . . When an incident of aggression is received, a meeting will be conducted with the Administrator, SS [Social Service] Director, and DON [Director of Nursing] . . . The incident will be reviewed along with the interventions and response to determine if the interventions were successful. Revisions to interventions may be necessary . . . The interventions will be communicated to appropriate staff . . . The incident will be reviewed at the Empowerment Mtg [meeting] for alternative interventions if needed . . . A Care Plan will be developed to reflect the interventions. . . ."	F 740	1.) Resident #1's care plan has been updated/revised to include triggers that may affect his behaviors and additional interventions to address his behaviors. Resident #5's care plan has been updated/revised to identify his history of alcohol abuse and to include additional interventions to address his physical/verbal behavioral needs. It has also been revised to include additional interventions to prevent his elopement from facility and to promote his safety. Mental Health Services has been contacted for both residents for their behavioral health care needs. Resident #1 mental health appointment has been scheduled for July 26th, 2018 at 1pm. Resident #5 received Mental Health Services on February 8, 2018. Recommendations and Mental Health Noted have been placed in residents #5 file. Resident #5 was then referred by mental health services at IHS for a neuro-psychological consult. Appointment is scheduled October 2nd, 2018 at St Alexius, Bismarck ND with Dr. Brooks. Resident's #6 & 8 have been discharged. 2.) All residents with behavioral health needs have the potential to be affected by this deficient practice. 3.) Residents that are identified with behavioral health care needs will be provided with behavioral health services. All current residents will be assessed by Social Service/Designee for their behavioral health care needs and referral will set up if needed. Assessments will be completed by July 20, 2018. Residents	

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F 740	Continued From page 32 - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included traumatic brain injury (TBI) and personal history of other mental and behavioral disorders. The interdisciplinary team's progress notes identified the following: * 11/24/17 at 6:00 p.m., " . . . Resident wants to go out to smoke . . . went to back door and pushed door until alarm sounded . . . this nurse told him to stop, he kept pushing the alarm . . . nurse left and told resident she would have to call the authorities . . . resident came running down the hall and called the nurse a [dirty whore]. . . ." * 12/24/17 at 3:40 p.m., "Resident very upset with chair alarm. Is hollering to remove and insists on sitting then standing with alarm sounding constantly . . . alarm removed . . . physician called stating resident will be sent to mental health services for psych [psychological] intervention. There is to be a 24 hour period where resident is totally compliant or alternative measures will be taken to modify behaviors. . . ." * 05/23/18, " . . . Resident kicked another resident in the back of wheelchair. Resident continues to cuss saying [(explicative) you, you (explicative) whore] and putting his middle finger up. . . ." The care plan identified, " . . . staff to monitor my behaviors for situations that may trigger physical aggression. . . . I have a history of physical aggression, uncontrolled behaviors and agitation . . . I had a physically aggressive incident with a resident . . . I have been observed shaking my fists at a resident. . . ." The care plan failed to define Resident #1's	F 740	will then be assessed quarterly as their MDS comes due and as needed to determine if behavioral health services are indicated. New admissions to DCNH will be assessed for behavioral health care needs and if needed, services will be set up. The DCNH Policy on Behavior Log/Physical Aggression has been revised to be more precise, a Behavior Health Services Policy will be implemented. Staff will be in serviced on the policies, on Behavioral Health Services Care and Treatment Basics of Mental Disorders (presentation by Compliance Store) on or by 07-19-18. 4.) A quality monitor to review the resident assessments for completion will be done by Social Services/Designee weekly x 3 months and monthly for a total of 1 year. This will begin 07-19-18. This information will be presented at the scheduled quality assurance meeting for review, revisions to the procedure will be made as needed. 5.) 07-20-18	

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physical and emotional behavioral triggers, identify specific interventions addressing his behaviors, and lacked revisions to interventions that were not effective.

- Review of Resident #5's medical record occurred on all days of survey. The record showed Resident had a history of alcohol abuse. A quarterly Minimum Data Set (MDS), dated 5/31/18, identified the behavior of wandering.

Review of the interdisciplinary team's progress notes identified the following:
* 05/23/18 at 9:15 p.m., " . . . Client was found laying on his back outside the facilities [sic]door . . . client is under the influence of alcohol . . . client became physical grabbing at staff inappropriately, swinging at staff. . . ."
* 05/23/18 at 10:25 p.m., " . . . Physician was called . . . order received to take client to the emergency room (ER) for detox . . . ambulance arrived client continued to be combative, slurred speech. . . ."
* 05/24/18 at 3:30 p.m., ". . . report that resident was seen on 05/23 at approximately 8:00 p.m. getting into a pick-up . . . police notified . . . resident returned 35-40 minutes later, nurses suspected resident may have had a drink . . . resident and fellow residents passed around a Gatorade bottle which contained alcohol . . . one staff found it and dumped it out . . . shortly after this is when resident was found laying on the ground in front of the facility. . . ."
* 06/06/18 at 8:30 p.m., " Certified nursing assistant (CNA) smelled alcohol on client . . . searched clients room and found an water bottle . . . bottle smelled of alcohol. . . ."
* 06/06/18 at 10:00 p.m., " . . . Client trying to

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F 740	Continued From page 34 leave facility . . . client pushed door until it fell off the track, then client went outside . . . client was slurring his speech . . . CNA found empty whiskey bottle in residents jacket pocket. . . ." * 06/07/18 at 12:00 a.m., ". . . Client in hallway wanting a ride to [bar] . . . speech still slurred. . . ." * 06/09/18 at 11:45 p.m., " . . . Client in room with another resident . . . is yelling and swearing . . . client appears to be intoxicated . . . client got mad when staff tried to remove the other resident [he doesn't have to go anywhere this is my (explicative) hours] staff attempted to take dirty cups out of room. Client said [leave my (explicative) cup] police called . . . before leaving police officer stated client does not belong in a nursing home facility, client needs to be in a locked down facility with his behavior.' . . ." * 6/10/18 at 12:55 a.m., " . . . Client in the hallway asking CNA's [for kisses]. CNA assisted client to his room. Client refused to get into bed with assistance . . . Approximately 5 minutes later client was on the floor next to bed. CNA's heard client yell out. Client hit head on bed side dresser causing a laceration 4 centimeters (cm) x 01. cm and an abrasion to right shoulder 8 cm x 5 cm . . . As CNA was taking garbage out of clients room, she found an empty vodka bottle in bottom garbage. . . ." Resident #5's care plan failed to identify his high-risk behaviors (history of alcohol abuse), and failed to address his current physical and verbal behavioral needs. The care plan also failed to address appropriate interventions to prevent him from eloping from the facility. The facility failed to address Resident #5's	F 740		

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	355080	A. BUILDING _____ B. WING _____	C 06/21/2018

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F 740	Continued From page 35	F 740		

behaviors and demonstrate a commitment to his safety when they failed to::
* Acknowledge Resident #5's high-risk behaviors of alcohol abuse.
* Obtain the necessary services to address Resident #5's behavioral health care needs.
* Develop individualized interventions related to Resident #5's diagnosed conditions.
* Review and revise interventions that were not effective for Resident #5, and
* Educate staff regarding possible strategies for avoiding such behavior in the future.

- Review of Resident #6's medical record review occurred on all days of survey. Diagnoses included; dementia, severe nicotine dependence, behaviors, and anxiety related to insomnia.

A review of the interdisciplinary team's progress notes showed the following:
* 04/15/18 at 9:00 p.m., "I'm feeling anxious and suicidal. . . ."
* 04/23/18 at 3:15 a.m., ". . . "anxious, can't sleep, . . . out of his room several times, worried about a cig [cigarette]. . . ."
* 04/23/18 at 8:00 a.m., " . . . I need a taxi. I can't stay here . . . resident had left the facility and proceeded to walk towards the street . . . redirected inside. . . ."
* 04/23/18 12: 40 p.m., " resident left facility at 11:50 a.m. . . . nurse followed the resident into a grocery story . . . nurse walked around town with resident to make sure he would not get hurt . . . resident walked into a bar and bought cigarettes . . . two police officers then assisted resident back to nursing home. . . ."
* 04/23/18 1:30 p.m., "resident attempted to leave facility again. . . ."

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F 740	Continued From page 36 * 04/23/18 at 3:45 p.m., "Police notified [facility] staff that resident was at the [bar]. . . ." * 04/23/18 at 4:00 p.m., "Resident once again left facility. Police notified us [facility staff] of the elopement. . . ." The most recent care plan identified the following: * 04/10/18, ". . . Impaired decision making related to my dementia . . . I have a guardian to assist with my decision making . . . elopement . . . wear wanderguard. . . ." Resident #6's care plan failed to identify his/her sleep difficulties, severe nicotine dependence, and "feeling suicidal". The care plan also failed to identify appropriate interventions and techniques for staff to implement when attempting to manage these behaviors. The facility failed to address Resident #6's behaviors and a commitment to his safety when they failed to:: * Acknowledge Resident #6's behaviors related to insomnia and severe nicotine dependence. * Obtain the necessary services to address Resident #6's behavioral health care needs. * Develop individualized interventions related to Resident #6's diagnosed conditions, * Review and revise interventions that were not effective for Resident #6, and * Educate staff regarding possible strategies for avoiding such behavior in the future. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included TBI and history of alcohol abuse. The admission MDS, dated 04/09/18, identified moderate cognitive deficits, independence with	F 740		

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F 740	Continued From page 37	F 740		

locomotion on/off the unit, and wandering; significantly intruding on the privacy/activities of others.

The interdisciplinary team's progress notes identified the following:
* 05/23/18 at 9:15 p.m., ". . . Client's words were slurred . . . Client seemed very intoxicated unsteady gait when trying to walk . . ."
* 06/09/18 at 4:25 p.m., "Resident . . . [with] alcohol on breath. Had been found drinking at [local bar/cafe]" . . . at 11:45 p.m., "Client in another clients room . . . very intoxicated, yelling, making noise, swearing, being very disruptive to other clients . . . Client and other client continue to yell and swear . . . Police called . . ."
* 06/10/18 at 10:20 a.m., "Resident came out of room and started digging through the housekeeping cart . . . stating, 'Where the [explicative] is my jug?' . . . Resident started hollering at nurse saying 'You better watch yourself.' . . . Resident pushed cart towards nurse, causing water to spill on floor . . . Resident continued to holler" . . . at 10:30 a.m., "Resident would walk by nurses' station and hold his fists up at charge nurse. Charge nurse had locked herself in nurses' station due to resident verbally threatening, stating to nurse, 'You better watch it.'" . . . at 10:35 a.m., "Resident was standing by his door and started slamming door . . . Resident was hollering loudly, stating, 'I'll fight you, where's my jug?'" . . . at 10:50 a.m., ". . . Officers had to use extreme force with tazing approx [approximately] 3 times . . ."
* 06/11/18 at 9:30 a.m., ". . . Resident is currently pacing hallways going outside without permission and has a scowl on his face. Staff is frightened to communicate [with] resident as unknown how he

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F 740	Continued From page 38 will react . . ." The most recent care plan identified the following: * 04/03/18, ". . . TBI [and] memory loss [and] impulsive behavior [with] no concerns for his own safety . . . Staff to try to redirect [Resident #8], be non-judgmental, keep environment calm, frequent reminders as [Resident #8] has limited memory." The care plan failed to address Resident #8's history of alcohol abuse/recent incarceration and subsequent behaviors (hollering/yelling, swearing, threatening others, pumping his fist, pushing items towards others, slamming doors, pacing), and lacked revisions to interventions that were not effective. The facility failed to address Resident #8's behaviors and demonstrate a commitment to his safety when they failed to: * Acknowledge Resident #8's high-risk behaviors upon admission (history of alcohol abuse and recent incarceration), * Obtain the necessary services to address Resident #8's behavioral health care needs, * Develop individualized interventions related to Resident #8's diagnosed conditions, * Review and revise interventions that were not effective for Resident #8, and * Educate staff regarding possible strategies for avoiding such behavior in the future.	F 740		
F 841 SS=E	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director.	F 841		7/20/18

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F 841	Continued From page 39 §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility's medical director failed to implement resident care policies and coordinate medical care for 1 of 1 sampled resident (Resident #5) and 3 discharged residents (Resident #6, #7, and #8) who eloped from the facility. Failure to acknowledge the high-risk behaviors of the residents upon admission, identify each resident's risk of elopement, and identify the facility's capacity to care for residents with dementia and/or related disorders, a history of substance abuse, and/or problematic behaviors, resulted in Resident #5, #6, #7, and #8 being placed in avoidable dangerous situations after they eloped from the facility. Findings include: Review of facility policy titled "Elopements and Wandering Residents" occurred on 06/15/18. This policy, revised 01/17/18, stated, ". . . The facility shall establish and utilize a systematic 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 risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary . . . Residents will be assessed for risk of elopement	F 841	1.) Resident # 6,7,and 8 have been discharged from facility. Resident #5 was acknowledged for high risk behaviors. Care plan was revised and updated. Resident #5 received mental health services on February 8th, 2018. Recommendations and Mental Health Notes have been placed in Residents File. Resident #5 was then referred by mental health services at IHS for a neuro-psychological consult. Appointment is scheduled October 2nd, 2018 at St Alexius, Bismarck ND with Dr. Brooks. 2.) All residents have the potential to be affected by this deficient practice. 3.) The DCNH Policy on Behavior Log/Physical Aggression has been revised to be more precise, a Behavior Health Services Policy will be implemented. IDT team, physician/medical director, and nursing staff will be in serviced on the policies on Behavioral Health Services Care and Treatment Basics of Mental Disorders (presentation by Compliance Store) on or by 07-19-18.The DON/Charge Nurse/Social Service director will notify the physician immediately with all incidents. The physician will adjust plan of care if needed, and further referrals for high risk behaviors will be followed	

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F 841	Continued From page 40 and unsafe wandering upon admission and throughout their stay . . . Procedure for Locating Missing Residents . . . The Charge Nurse will notify the . . . residents provider . . ." During an interview on 06/21/18 at 12:10 p.m., an administrative nurse (#4) reported the medical director of the facility was also Resident #5, #6, #7, and #8's attending physician. - Review of Resident #5's medical record occurred on all days of the survey. Diagnoses included a history of alcohol abuse. An admission elopement risk assessment, dated 02/20/17, identified, ". . . Client zero elopement risk. . . ." The assessment was updated on 05/08/17 and identified, "Client now has elopement bracelet . . . client only able to sign out with certain family members due to alcohol abuse. . . ." Facility staff held a care conference on 05/31/18 at 11:20 a.m. Notes from the conference identified, ". . . to discuss recent elopements . . . discussed concerns and interventions to put in place to prevent elopement. Care plan reviewed/revised as needed. . . ." Review of Resident #5's physician's orders identified; * 05/23/18, " . . . send client to Indian Health Services (IHS) to emergency room (ER) to detox. . . ." * 06/10/18 at 1:00 a.m., ". . . Perform room and body searches once a shift until 06/11/18 for alcohol. . . ."	F 841	through by social service director/designee. 4.) A Quality monitor will be implemented by DON/Designee to assure all incidents are reported to the physician. The quality monitor will assure plan of care was adjusted if needed and followed through by the physician/medical director, Social Service Director/Designee, and DON/Charge Nurse. The quality monitor will be evaluated and monitored on all incidents 3x weekly for 3 months, than 3x biweekly for 3 months, than 1x weekly for 1 month, than 1x monthly for 5 months for a total of 1 year. The monitor will start 07/20/18. Results of the QA will be reviewed at the Quality Assurance Meeting and revised as needed. 5.) 07/20/2018	

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The interdisciplinary team's progress notes identified Resident #5 eloped from the facility, obtained alcohol, fell and required hospitalization on 05/22/18, and fell again in his room, hitting his head resulting in a laceration and abrasion due to alcohol consumption.

Facility staff completed "Incident Reports/Post Elopement Forms" following each of Resident #5's elopements. Each report showed Resident #5's physician received notification of his elopements and falls.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included behaviors related to advanced dementia and nicotine dependence.

An Elopement risk assessment, dated 03/12/18, stated, ". . . is probably too [sic] weak to elope. Will monitor frequently. . . ."

Review of Resident #6's physician orders, dated, 04/26/18, stated, ". . . dementia, severe nicotine dependence . . . recent severe behavioral problems, not sleeping uncontrolled anxiety, agitation, demanding to smoke continuously. . . ."

The interdisciplinary team's progress notes identified Resident #6 eloped from the facility and/or found himself in avoidable dangerous situations on April 23, 2018.

Facility staff completed an "Incident Reports/Post Elopement Forms" following Resident #6's elopement on 04/23/18. The report showed Resident #6's physician received notification of his elopement.

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F 841	Continued From page 42 - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included stroke with expressive aphasia (communication deficit) and dementia. The admission Minimum Data Set (MDS), dated 04/25/18, identified severe cognitive deficits and independence with locomotion on/off the unit. An admission nursing assessment, dated 04/19/18, identified, ". . . Family report that resident was living at retirement home [and] would elope numerous times . . ." A social service progress note, dated 04/29/18, identified, ". . . He has had a long history of wandering, which necessitated Nursing Home placement. . . . [Resident #7] has delusions. Misconceptions and beliefs that are firmly held contrary to reality. He has been returned to his previous address several times by the police in the middle of winter and still thinks he can walk outdoors by himself. . . ." A physician's progress note, dated 05/24/18, identified, ". . . He has a history of severe dementia . . . was outside in the winter without proper clothing, decision was made to have him . . . placed in the nursing home . . . He eloped from the facility in spite of having a wander guard, likes to walk a lot, staff doing their best to try to keep an eye on him, keep him from leaving the facility. . . ." The interdisciplinary team's progress notes identified Resident #7 eloped from the facility and/or found himself in avoidable dangerous situations on May 1, 2, 5, 8, 25, 29, and 30, 2018.	F 841		

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F 841	Continued From page 43 Facility staff completed "Incident Reports/Post Elopement Forms" following five of Resident #7's elopements. Each report showed Resident #7's physician received notification of his elopements. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included traumatic brain injury (TBI) and history of alcohol abuse. The admission MDS, dated 04/09/18, identified moderate cognitive deficits, independence with locomotion on/off the unit, and wandering; significantly intruding on the privacy/activities of others. A social service progress note, dated 04/03/18, identified, ". . . He has been incarcerated as well as homelessness with a history of legal charges including trespassing, theft, disorderly conduct, open container . . ." A physician's progress note, dated 04/03/18, identified, ". . . He has guardian and no etoh [alcohol] intake since incarceration. NH [nursing home] placement to ensure safety and continued abstinence . . ." During an interview on 06/15/18 at 10:00 a.m., when asked questions pertaining to the elopements, an administrative nurse (#1) reported Resident #8's physician directed staff to "let [Resident #8] leave [the facility], because of his aggression. He was a large guy. Staff [were] afraid of him, afraid [they'd] get hit." The interdisciplinary team's progress notes identified Resident #8 eloped from the facility and/or found himself in avoidable dangerous	F 841		

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F 841	Continued From page 44 situations on April 5, 2018, May 23 and 30, 2018 and June 9, 10, 11, and 12, 2018. Facility staff completed "Incident Reports/Post Elopement Forms" following three of Resident #8's eight elopements. Each report showed Resident #8's physician received notification of his elopements. The interdisciplinary team progress notes also identified Resident #8's physician received notification he eloped on one other occasion. Failure of the medical director to coordinate Resident #5, #6, #7, and #8's medical care, by acknowledging their high-risk behaviors, risk of elopement, and the facility's capacity to care for residents with dementia and/or related disorders, a history of substance abuse, and/or problematic behaviors, placed them in avoidable dangerous situations after they eloped from the facility. Refer to F607 and F689.	F 841		
F 843 SS=D	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by	F 843		7/23/18

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F 843	Continued From page 45 another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to have a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. Failure to ensure an agreement was in place may result in negative outcomes for those residents who require transfers for timely admission to the hospital and/or the exchange of information required for care/treatment. Findings include: During an interview on 06/21/18 at 12:10 p.m., when asked questions pertaining to the facility's written transfer agreements, an administrative nursing staff member (#4) stated, "I don't think [the facility] has a contract with either hospital. I don't think one exists." No evidence of a contract	F 843	1.) The facility will have transfer agreement in effect with a hospital sufficiently close to the facility to make a transfer feasible. 2.) All residents have the potential to be affected by this deficient practice. 3.) The DON/Administrator will initiate a transfer agreement with Presentation Medical Center in Rolla, ND and the Dunseith Community Nursing Home, Dunseith ND for all non-native residents. All Native residents who have Tribal affiliation will be transfer to Indian Health Services, Belcourt, ND or residents preference of hospital. Transfer agreement will be completed on or before 07/23/18 4. N/A	

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F 843	Continued From page 46 was provided to the survey team prior to the team exiting the facility.	F 843	5. 07/23/18	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, record review, and staff interview, the facility failed to maintain a Quality Assurance (QA) process, which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practices to ensure compliance with federal requirements. Findings include: Review of the North Dakota Department of Health, Division of Health Facilities Provider Files identified the facility failed to maintain compliance in the following areas previously cited: * F610 (previously F225) - Investigate, prevent, correct alleged violations of neglect * F967 (previously F520) - QAPI/QAA improvement activities Review of sampled and discharged residents' (Resident #5, #6, #7, and #8's) medical records identified the facility failed to identify each resident's risk for elopement, implement, monitor,	F 867	1.) The QA Committee will meet on 07-17-18 to discuss all deficiencies and to revise the facility's QAPI Program to assure that DCNH has QA Processes in place to identify and address quality issues that effect our residents safety. 2.) All residents have the potential to be affected by this deficient practice. 3.) In-service education will be conducted for staff on 07-19-18 to review the QAPI Program and the Processes. The IDT will continue to review quality issues for individual residents, such as falls, elopements, behavioral issues and safety concerns Monday to Friday at the management staff meeting. Interventions to promote that residents safety will be implemented or modified at that time if needed. Quality issues will be reviewed at the monthly Safety Meeting (falls, medication errors, resident incidents, staff incidents, near misses, elopements and any other safety concerns) and at the bi-monthly Empowerment Meeting (falls r/t medication use, resident behaviors and	7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

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F 867	Continued From page 47 and modify individualized resident-centered interventions when necessary, and demonstrate a commitment to the residents' overall safety, resulting in Resident #5, #6, #7, and #8 being placed in avoidable dangerous situations after they eloped from the facility. During an interview on the morning of 06/21/18, an administrative staff member (#5) reported the facility's managerial staff attended an inservice on QA in April, 2018. The staff member (#5) also reported facility staff had identified and are currently addressing quality issues pertaining to fire safety, food temperatures, proper documentation, and smoking safety. The facility failed to develop and implement appropriate plans of action to correct the deficient practices which allowed Resident #5, #6, #7 and #8 to repeatedly elope from the facility. Refer to F610 and F689.	F 867	other behavioral health issues). The IDT will evaluate if the QA Processes in place are identifying and addressing quality issues in a timely and efficient manner and revise the process if needed during these meetings or at anytime that it is indicated. 4.) The QA Committee will meet bi-monthly to discuss the QAPI Program related to all deficiencies, in addition to the items on the scheduled agenda. The committee will review QA processes that are in place to assure that they are identifying and addressing safety issues that affect our residents. The DON/Designee will do a quality monitor weekly x 3 months and monthly x 9 months for a total of one year to review if quality issues that effect our residents are being addressed. This monitor will start 07-16-18. The data will be reviewed at the scheduled QA Meeting and the plan revised if indicated. 5.) 07-20-18	