STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	C 10/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	**609 4TH AVE NE GARRISON, ND 58540**

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F 000	INITIAL COMMENTS For the complaint survey, conducted on 10/03/17, the sample included 7 residents for review.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		10/31/17

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

Electronically Signed | 10/18/2017

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F 157	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility procedure, and staff interview, the facility failed to promptly notify the resident's representative of a resident to resident incident for 2 of 7 sampled residents (Resident #1 and #2) residing in the special care unit. Failure to promptly notify the resident's representative limited their ability to make informed decisions regarding the residents' care. Findings include: Review of the facility procedure titled "Change in Neighbor Status" occurred on 10/03/17. This policy, revised January 2011, stated, ". . . 2. BLCG's [Benedictine Living Center of Garrison] care partners will notify family members unless the neighbor states otherwise. . . ." - Review of Resident #1's medical record occurred on 10/03/17. Diagnoses included	F 157	F157 All events have been audited from June 1 to current, one neighbor guardian was found to not have been notified of a fall on 9/29/2017 guardian was notified on 10/12/2017. All neighbors are potentially at risk for this and charts have been reviewed for the need to update MD and notification of family or family representative. The facility policy titled Change in Neighbor Status has been reviewed and is deemed appropriate. Staff education provided on 10/18/2017 Education was provided for all licensed nursing personnel on how, when and documentation regarding MD and family or family representative notifications.	

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F 157	Continued From page 2 dementia. Progress notes showed the following: *08/27/17 at 4:36 a.m.: "Resident was noted sleeping in the same bed with another female resident. According to staff, they were both naked. A behavior tracking sheet was filled [sic]." *08/27/17 at 12:34 p.m.: "Neighbor was noted by staff to be in his room while another female neighbor was lying in his bed at 0630 [6:30 a.m.]. When staff went in room neighbor was naked from waste [sic] down approaching other neighbor in a sexual way. Staff approached him to escort him out of his room, he did cooperate, female neighbor did eventually come out of his room and went into her own room." *08/29/17 at 4:20 p.m.: "IDT [interdisciplinary team] reviewed incident from 8/27/17 involving [Resident #1] and another neighbor being in bed together and fondling each other. Staff attempted to separate and redirect both neighbors when discovered together. Female neighbor was becoming upset and combative, so staff continued to monitor intermittently and re-approach in an effort to separate the two neighbors. At no time did either neighbor appear to be in distress. Upon re-approach, staff were able to remove [Resident #1] from his room and eventually remove the female neighbor from his room also. Both neighbors were on 15 mins [minute] checks during and after. IDT agrees that staff handled the situation appropriately." *08/30/17 at 10:10 a.m.: "[Resident #1's] wife was notified of situation on 8/27/17 including time line of events. . . ." Facility staff failed to notify Resident #1's family representative until three days after the incident	F 157	They were also educated on other possible reasons to notify family. DON or designee will ensure and monitor compliance. Audits will be conducted 5 x week for 4 weeks; than 3x week for 4 weeks, than weekly x 3 months. Audits will consist of looking at all events and progress notes of all neighbors. Analysis of the observations and facility's compliance will be presented to our Quality Assurance Team beginning 10/31/2017, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 157	Continued From page 3 occurred. - Review of Resident #2's medical record occurred on 10/03/17. Diagnoses included dementia with behaviors and Alzheimer's disease. Progress notes showed the following: *08/27/17 at 4:40 a.m.: "Resident was noted sleeping in the same bed with another male resident. According to staff, they were both naked. A behavior tracking sheet was filled [sic]." *08/29/17 at 4:55 p.m.: "IDT reviewed incident from 8/27/17 involving [Resident #2] and another neighbor being in bed together and fondling each other. [Resident #2] was in the male neighbor's bed. Staff attempted to separate and redirect both neighbors when discovered together. [Resident #2] was becoming upset and combative, so staff continued to monitor intermittently and re-approach in an effort to separate the two neighbors. At no time did either neighbor appear to be in distress. Upon re-approach, staff were able to remove the male neighbor from his room and eventually remove [Resident #2] from his room. Both neighbors were on 15 mins checks during and after. IDT agrees that staff handled the situation appropriately. Message was left for [Resident #2's] son to advise of situation." Facility staff failed to notify Resident #2's family representative until two days after the incident occurred. An interview with administrative staff members (#2 and #3) occurred on 10/03/17 at 12:30 p.m. The staff members stated they did not	F 157		

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F 157	Continued From page 4 immediately notify the residents' family members of the incident because they wanted to complete their investigation prior to the notification.	F 157		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention.	F 226		10/31/17

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F 226	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to perform a thorough investigation of a resident to resident incident in the special care (dementia) unit for 1 of 1 incident reviewed (08/27/17 incident). Failure to perform a thorough investigation limited staffs' ability to assess, develop, and implement interventions for the residents' behaviors. Findings include: Review of the facility policy "Abuse Prevention Plan for Nursing Homes" occurred on 10/03/17. The policy, dated 06/01/17, stated ". . . 'Neglect': Failure to supply a vulnerable adult with care or services, including . . . supervision, that is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult. . . . All accidents and incidents as well as allegations of abuse, neglect . . . will be investigated . . ." Review of the facility policy "Neighbor to Neighbor Incidents" occurred on 10/03/17. The policy, dated 04/24/17, stated, ". . . AFTER EVERY NEIGHBOR TO NEIGHBOR INCIDENT . . . - Complete page 1 - Behavior Incident Form - at time of incident. - then document starting on page 2 for 15 minute checks - Continue 15 minute checks for 24 hours." Page 1 of the Behavior Incident Form included	F 226	F226 Neighbor #1 and neighbor # 2 care plans have been reviewed and deemed appropriate. All residents are potentially at risk and all reports have been reviewed. The facility policy titled “behavior incident” has been reviewed and updated. New “initial investigation guide” has been implemented by SSD on 10/06/2017 to assist with proper, timely investigations of allegation of abuse, neglect, misappropriation etc. Staff education was provided on the revised policy on 10/18/2017 to ensure understanding of the policy “behavior incident” and where to locate this policy. They were also educated on the new “initial investigation guide”. SSD or designee will ensure and monitor compliance. Audits will be conducted 5x week for 4 weeks, than 3 x week for 4 weeks, than weekly for 3 months. Audits will consist of all reports on “behavior incident” form. Analysis of the observations and facility’s compliance will be presented to our Quality Assurance Team beginning 10/31/2017, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 226	Continued From page 6 the following: * Time of the incident, who was involved, and a description of the incident * Environment at the time of the incident * Events leading up to the incident * Possible triggers * Interventions attempted and their effectiveness Pages 2-6 for the form included a log for 15 minute checks for the next 24 hours. - Review of Resident #1's medical record occurred on 10/03/17. Diagnoses included dementia. Progress notes showed the following: *08/27/17 at 4:36 a.m.: "Resident was noted sleeping in the same bed with another female resident [Resident #2]. According to staff, they were both naked. A behavior tracking sheet was filled [sic]." *08/27/17 at 12:34 p.m.: "Neighbor was noted by staff to be in his room while another female neighbor [Resident #2] was lying in his bed at 0630 [6:30 a.m.]. When staff went in room neighbor was naked from waste [sic] down approaching other neighbor in a sexual way. Staff approached him to escort him out of his room, he did cooperate, female neighbor did eventually come out of his room and went into her own room." *08/29/17 at 4:20 p.m.: "ID [interdisciplinary team] reviewed incident from 8/27/17 involving [Resident #1] and another neighbor being in bed together and fondling each other. Staff attempted to separate and redirect both neighbors when discovered together. Female neighbor was becoming upset and combative, so staff continued to monitor intermittently and re-approach in an effort to separate the two neighbors. At no time did either neighbor appear	F 226		

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F 226	Continued From page 7	F 226		

to be in distress. Upon re-approach, staff were able to remove [Resident #1] from his room and eventually remove the female neighbor from his room also. Both neighbors were on 15 min's [minute] checks during and after. ID agrees that staff handled the situation appropriately."
*08/30/17 at 10:10 a.m.: "[Resident #1's] wife was notified of situation on 8/27/17 including time line of events. . . ."

- Review of Resident #2's medical record occurred on 10/03/17. Diagnoses included dementia with behaviors and Alzheimer's disease. Progress notes showed the following:
*08/27/17 at 4:40 a.m.: "Resident was noted sleeping in the same bed with another male resident [Resident #1]. According to staff, they were both naked. A behavior tracking sheet was filled [sic]."
*08/29/17 at 4:55 p.m.: "ID reviewed incident from 8/27/17 involving [Resident #2] and another neighbor being in bed together and fondling each other. [Resident #2] was in the male neighbor's bed. Staff attempted to separate and redirect both neighbors when discovered together. [Resident #2] was becoming upset and combative, so staff continued to monitor intermittently and re-approach in an effort to separate the two neighbors. At no time did either neighbor appear to be in distress. Upon re-approach, staff were able to remove the male neighbor from his room and eventually remove [Resident #2] from his room. Both neighbors were on 15 min's checks during and after. ID agrees that staff handled the situation appropriately. Message was left for [Resident #2's] son to advise of situation."

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A Behavior Tracking Sheet (not part of the medical record and kept in the social services office), dated 08/27/17 at 1:30 a.m., stated, "I informed charge nurse [Resident #1] laying [sic] bed with [Resident #2] & [and] touching him and he also removed his underpants several times. . . . were in bed together . . . I told the Gentleman to please not be removing underpants . . . I tried [sic] removing [Resident #2]. . . ."

The "Investigation of Incident" dated 09/01/17, stated, ". . . Both neighbors were in [Resident #1's] bed. [Resident #2] had refused to allow her pajamas to be put on earlier that night, so she was still wearing pants and a shirt. She additionally had a brief on. [Resident #1] had a shirt and pajama pants on and was also wearing a brief. . . . [Resident #1's] pants and brief had been pulled down to mid-thigh. . . ."

The investigation showed the following:
* Staff failed to complete the Behavior Incident Form for the "neighbor to neighbor incident," as per facility policy
* Staff performed 15 minute checks from 1:45 a.m. to 6:15 a.m. on 08/27/17 (4 hours and 30 minutes - not 24 hours as stated in the policy)
* Staff failed to interview the Certified Nursing Assistant (CNA) on duty on 08/27/17 until 09/01/17 (5 days after the incident)
* Staff failed to update Resident #1 and #2's care plans until 09/01/17 (5 days after the incident)
* The facility failed to educate staff regarding interventions for Resident #1 and #2 until 09/01/17 (5 days after the incident)

The facility's failure to promptly interview the CNA on duty on 08/27/17 to obtain information as

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F 226	Continued From page 9 soon as possible after the incident, immediately assess, develop, and implement revisions to the residents' care plans and educate staff regarding those revisions placed Resident #1 and #2, and other residents residing on the special care unit, at risk of a resident to resident incident.	F 226		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F 514		10/31/17

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F 514	Continued From page 10 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a complete and readily accessible medical record for 5 of 7 sampled residents (Resident #1, #2, #5, #6, and #7). Failure to have a complete, accurate, and readily accessible medical record limited staff's ability to track residents' behaviors. Findings include: An interview with a social services staff member (#1) occurred on the morning of 10/03/17. The staff member stated direct care staff fill out Behavior Tracking Sheets when they observe a behavior. The staff member (#1) stated the direct care staff are to give the Behavior Tracking Sheets to the charge nurse, who then documents the incident in the medical record. She stated the Behavior Tracking Sheets do not become part of the medical record, but are stored in her office. Review of Resident #1's and #2's medical record occurred on 10/03/17 and identified the following inconsistencies: * Resident #1's progress note, dated 08/27/17 at 4:36 a.m., stated, "Resident was noted sleeping in the same bed with another female resident. According to staff, they were both naked. A behavior tracking sheet was filled [sic]." Resident #2's progress note, dated 08/27/17 at	F 514	F514 Neighbor # 1, 2, 5, 6, 7 charts were reviewed and accurate and complete information has been added to their charts regarding exhibited behaviors. All behavior tracking reports from June 1 to current have been verified that complete and accurate information was placed in all appropriate medical records. Education was provided on 10/18/2017 regarding accurate and complete information placed in medical records and the updated "behavior tracking sheet" DON or designee will ensure and monitor compliance. Audits will be conducted 5x week for 4 weeks, than 3 x week for 4 weeks, than weekly x 3 months. Audits will consist of all behavior tracking forms and events. Analysis of the observations and facility's compliance will be presented to our Quality Assurance Team beginning 10/31/2017, who will recommend changes and on-going monitoring/auditing after analysis.	

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4:40 a.m., stated, "Resident was noted sleeping in the same bed with another male resident. According to staff, they were both naked. A behavior tracking sheet was filled [sic]."

The "Investigation of Incident" dated 09/01/17, stated, ". . . Both neighbors were in [Resident #1's] bed. [Resident #2] had refused to allow her pajamas to be put on earlier that night, so she was still wearing pants and a shirt. She additionally had a brief on. [Resident #1] had a shirt and pajama pants on and was also wearing a brief. . . . [Resident #1's] pants and brief had been pulled down to mid-thigh. . . ."

On 09/01/17 the facility educated staff on Resident #1's wife's request to keep him and Resident #2 separated.

The progress notes in Resident #1 and #2's medical records failed to contain accurate information on the 08/27/17 incident.

* Resident #2's "Behavior Tracking Sheet," dated 09/05/17, stated, ". . . Neighbor initiated contact with [Resident #1]. She followed him up & down the halls & to his room. She was redirected to her room. . . ." Resident #1's medical record lacked evidence of the 09/05/17 incident.

* Resident #2's progress note dated 09/13/17 at 2:28 p.m. stated, "Neighbor was noted to be napping in [Resident #1's] recliner this afternoon. He [Resident #1] was sitting on the bed. Initially neighbor [Resident #2] refused to get up and neighbor didn't want to leave the room either. Re-approached and staff were able to get neighbor to come out of the room and out to the

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F 514	Continued From page 12	F 514		

dining room but she was not happy about it. . . ." Resident #1's medical record lacked evidence of the 09/13/17 incident.

* Resident #1's "Behavior Tracking Sheet," dated 09/15/17 at 9:00 a.m., stated, ". . . Neighbor was asking another female to come have breakfast with him. She politely told him no. He proceeded to go into her room, grab her by the hand & walk her to the dining room. After breakfast he grabbed her by the hand & said lets go to bed. I redirected with every contact he made & he would go right back. After I took female neighbor to her room, I redirected him back to the dining room, where he again attempted to get a different female neighbor to go to his room with him. . . ." A progress note, dated 09/15/17 at 3:27 p.m., of the incident failed to identify the time the incident occurred. The "Behavior Tracking Sheet" and the progress note failed to identify the female resident.

* Resident #1's "Behavior Tracking Sheet," dated 09/15/17 at 3:00 p.m., stated, ". . . Neighbor approached another female neighbor & grabbed her hand & was attempting to get her to go to the car with him. The female neighbor politely refused & he left her alone. He went back to this female about ten minutes later & was attempting to get her to go to his room with him. I redirected him & the other female neighbor. I sat them at different tables for supper & he moved to the table she was sitting at. . . ." The "Behavior Tracking Sheet" failed to identify the female resident. Resident #1's medical record lacked evidence of the 09/15/17 incident.

* Resident #1's "Behavior Tracking Sheet," dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	C 10/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	**609 4TH AVE NE GARRISON, ND 58540**

(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 514	Continued From page 13 09/23/17 at 1:30 p.m., stated, ". . . [Resident #2] was sitting & watching TV. [Resident #1] walkes [sic] directly to her & put his hand on hers, we redirected imedintly [sic], not 2 min [minutes] later he was back over to her & sat in the chair. We redirected to his room . . . he came back out of his room saying 'I was just talking to that little devil' 'where did she go?' . . . [Resident #1] was sitting across the room . . . still trying to talk to her. 1:44 [p.m.] walked back to [Resident #2] & began talking again. Redirected again back to room. . . ." Resident #2's medical record lacked evidence of the 09/23/17 incident. * Resident #1's "Behavior Tracking Sheet," dated 09/23/17 at 2:25 p.m., stated, ". . . 2:25 [p.m.] [Resident #1] walked up to [Resident #2] calling her [Resident #1's wife's name] we redirect him to a chair. 2:26 [p.m.] still continued to try and talk across the room to her. Was then redirected with another conversation. 2:27 [p.m.] He got up from his chair and walked across room to her. 2:45 [p.m.] He walked over to [Resident #2] and was redirected. @ [at] 2:50 [p.m.] walked up to [Resident #5] and kissed her calling her [Resident #1's wife's name] was then redirected. 2:52 [p.m.] walked back over to [Resident #5] and tried to hold her hand. Was redirected. 2:54 [p.m.] got up from the chair and went over to [Resident #2] was the [sic] redirected to the couch. 2:55 [p.m.] was back up walking toward [Resident #2] but then was redirected to the table. 3:20 [p.m.] walked up to [Resident #2] and sat down and started conversation was redirected. 3:27 [p.m.] got up, walked over to [Resident #2] and said 'Lets go home.' . . ." Resident #2 and #5's medical record lacked evidence of the 09/23/17 incident.	F 514		

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	355064	A. BUILDING _____ B. WING _____	C 10/03/2017

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F 514	Continued From page 14 * Resident #1's "Behavior Tracking Sheet," dated 09/27/17 at 12:00 p.m., stated, ". . . [Resident #1] had finished eating his lunch & walked over to [Resident #6] & was asking her to go lay in bed with him. [Resident #6] replied, 'no [Resident #1], I'm not coming with you.' He said 'oh, come on [Resident #1's wife's name], lets go lay down.' I redirected him & told him that's not [Resident #1's wife], that is [Resident #6]. He said 'oh okay' and walked away from her. He then approached [Resident #2] & started rubbing her back and said 'come on sweetie it's time for us to go' [Resident #2] ignored him. I went and redirected him again that that was not [Resident #1's wife] that her name is [Resident #2]. I assisted him to a different table, where he sat down. He got up and said 'alright [Resident #2], let's go to bed now' and grabbed her hand I redirected him and said '[Resident #1], let me show you to your room so you can lie down.' . . . [Resident #1] then went & sat down in the dining room beside [Resident #7]. He grabbed her hand & kissed it. I redirected [Resident #1] again & told him '[Resident #1], that is not [Resident #1's wife]. This is [Resident #7].' He looks at [Resident #7] & says, 'Well [Resident #7], you are very beautiful. Can I show you to my room.' I redirected [Resident #7] to sit back down & sit with me at the table & told [Resident #1] he was welcome to go to his own room if he'd like. He came & sat down at the table where [Resident #7] and I were sitting. He grabbed her hand again and I asked him to please let her be. He has grabbed her hand again multiple times, and everytime I redirect him. . . ." Resident #2, #6, and #7's medical record lacked evidence of the 09/27/17 incident.	F 514		

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F 514	Continued From page 15 * Resident #1's "Behavior Tracking Sheet," dated 09/27/17 at 2:00 p.m., stated, ". . . [Resident #1] grabbed [Resident #7's] hand, stood up and started pulling on her. He said 'okay hunny, I can't wait anymore lets go.' I redirected [Resident #1] away from her & he went right back over. He pulled on her arm again, and again I redirected him away. I sat him at a table by himself and gave him a snack. . . ." Resident #7's medical record lacked evidence of the 09/27/17 incident. Failure to ensure a complete and accurate medical record reduces staffs' knowledge of all behaviors exhibited by Resident #1, #2, #5, #6, and #7 and limits their ability to develop and implement effective interventions for the behaviors.	F 514		