STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 January 25, 2024. During the complaint investigation, the facility was found noncompliant with regulatory requirements	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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 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:	F 609		2/29/24

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

Electronically Signed | 02/15/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 Based on record review, review of facility policy, and staff interview, the facility failed to report alleged violations involving neglect to the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #1) who eloped from the facility. Failure to report allegations and submit investigation results placed all residents at risk for neglect. Findings include: Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 01/25/24. This policy, dated 11/17/16, stated, ". . . Neglect means failure of the facility, its employees, or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. . . . Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse. When abuse, neglect or exploitation is suspected, the Licensed Nurse should: . . . Contact the State Agency and the local Ombudsman office to report the alleged abuse. . . . In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: a. Ensure that all alleged violations . . . 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 . . . to the Administrator of the facility and to other official [sic] (including the State Survey Agency . . .) in accordance with State law. . . ." Review of Resident #1's medical record occurred on 01/25/24. Nurses' notes identified the following:	F 609	1) Facility submitted initial incident report of elopement on 1/26/2024 to DHHS. Full investigation was completed and submitted to DHHS on 1/30/2024. Education was provided to charge nurse on duty the night of the incident on 2/13/2024. 2) Incident reports were reviewed 2/15/2024 for the month of February to ensure that proper reporting was done for incidents related to resident elopement. 3) Facility Abuse and Neglect Policy and Procedure was reviewed and revised on 2/13/2024. Care conference was held on 2/13/2024 with certified nurse aids to educate on Abuse and Neglect policy. Education was provided on the importance of timely reporting of incidents and suspected abuse/neglect. Common and uncommon reportable resident incidents were discussed. Nurse meeting scheduled 2/15/2024. Agenda will include review of Abuse and Neglect Policy and Procedure, reportable incidents and who to report them to, and discussion of common and uncommon reportable scenarios. 4) Director of Resident Services, or designee, will review facility incidents weekly for a minimum of twelve months until compliance has been achieved and sustained, to ensure that all reportable incidents have been reported to DHHS on a timely basis. The results of these audits will be reported to the QA committee on a quarterly basis for a minimum of twelve months.	

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F 609	Continued From page 2 *01/23/24 at 2:32 a.m., ". . . CNA [certified nurse aide] was doing rounds at 12:05 [a.m.] and resident was not in his room. While searching rooms down the hallway CNA heard banging on a window outside door number 8. He was sitting in a patio chair outside the first apt [apartment]. CNA helped him back inside. He stated he was going out for gas and got locked out. He had fallen outside and was very cold. He was brought to his room and changed into warm, dry clothes and covered with warm blankets. He sustained an abrasion to the top of his left forehead and to the outer side of his left hand and both knees were red. As he was warming up his hand and fingers continued to be very cold and all his fingertips on both hands had darkened. Call placed to ER [emergency room] and informed ER nurse and aware that resident was coming to the ER. Ambulance here and picked up resident at 1:30 am and was transferred to [medical facility]. . . ." *01/23/24 at 6:53 a.m., ". . . Call received from [medical facility], resident is being transferred to [burn center]. . . ." *01/23/24 at 4:02 p.m., ". . . Did call [burn center] . . . and received update that [Resident #1] will be there for at least 2 more days trying to get circulation improved to fingers. . . ." The record lacked evidence the facility reported the above incident to the SSA as possible neglect. During an interview on the morning of 01/25/24, an administrative staff member (#1) confirmed the facility did not report the above incident to the SSA.	F 609		