STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355101	A. BUILDING _____ B. WING _____	C 12/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAKOTA ALPHA	1303 27TH STREET NW MANDAN, ND 58554

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F 583 SS=G	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on information received from the	F 583	1. The Director of Nursing and	12/26/19

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

Electronically Signed | 12/17/2019

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F 583	Continued From page 1 complainant, observation, record review, resident interview, and staff interview, the facility failed to provide care for 1 of 1 sampled resident (Resident #1) in a manner/environment that maintained, enhanced, and respected the resident's privacy. Failure to ensure the resident's personal dignity resulted in embarrassment, psychosocial harm, and a decreased quality of life. Findings include: Information provided by the complainant indicated facility staff "strip searched" Resident #1 in the nurses' station on November 26, 2019. Review of the document titled " Dakota Alpha Compliment, Concern or Grievance Form" occurred 12/04/19. This document, dated 11/26/19 stated, ". . .Resident Involved: [Resident #1] . . . Two staff nurses [#1 and #2] initiated the search in the health station in a private area of the health station. . . . The staff nurse [#2] agree [sic] to the search and proceeded with having Resident #1 remove her shirt and take her pants and underwear down to her knees. . . ." During an interview on 12/04/19 at 1:50 p.m., a staff nurse (#1) reported she instructed another staff nurse (#2) to perform a "strip search" of Resident #1 in the health station on November 26, 2019. During an interview on 12/04/19 at 2:23 p.m., Resident #1 reported two staff nurses (#1 and #2) performed a search in the health station after instructing her to remove her top and pull down her pants and underpants. Resident #1	F 583	Administrator and Social Worker educated staff on search protocol and privacy during the 12/19/2019 all staff meeting. 2. The facility has determined that any resident has the potential to be affected. 3. Action Taken: The personal search protocol for resident 1 was updated on 12/19/19 to a no personal search protocol. During all staff meeting staff were educated on the no personal search protocol for resident 1. Updated personal search protocol for resident 1 on 12/19/19 was sent to nursing staff message through Point Click Care. Resident 1 personal search protocol was removed from care plan and also put in the communication book in the nurse’s station. 4. The Director of Nursing, Administrator, Social Worker or Occupational Therapist will conduct random observations of staff providing privacy random weekly audits for 6 weeks, random audits bi weekly for 2 months, and random monthly audits for 4 months to ensure staff are promoting privacy. Findings of this audit will be discussed at the QAPI Committee. The audits will be reviewed at the quarterly QAPI meeting.	

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F 583	Continued From page 2 confirmed she stood exposed while the nurses (#1 and #2) performed the search. During an interview on the morning of 12/04/19, an administrative nurse (#3) reported a staff nurse (#2) performed the search of Resident #1 in the health station on November 26, 2019 after another staff nurse (#1) instructed her to do so. The administrative nurse (#3) showed this writer exactly where the search took place in the health station. Observation showed wall to wall windows on one side of the health station with frosted glass half way up the window. The search took place in the back room of the health station. From outside the health station, this surveyor could view the back room over the frosted glass. The administrative nurse (#3) confirmed the back room had no door and the windows had no curtains to provide privacy. The facility staff failed to provide Resident #1 with privacy when they performed the search.	F 583		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		12/26/19

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F 600	Continued From page 3 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on information received from the complainant, review of facility policy, record review, resident interview, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #1) remained free from mental abuse. Failure to protect Resident #1 from a humiliating body search resulted in intimidation, shame, agitation, and loss of dignity. Findings include: Information provided by the complainant indicated facility staff "strip searched" Resident #1 in the nurses' station on 11/26/19. Review of the facility policy titled "ABUSE PROHIBITION POLICY" occurred 12/04/19. This undated policy stated, "Abuse is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. . . . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse . . . . Willful means the individual deliberately, not that that [sic] the individual must have intended to, inflict injury or harm. . . . Mental abuse includes but is not limited to: humiliation, harassment, or threats of punishment or deprivation. . . ." Review of the facility document titled "[Resident #1] - Search Protocol" occurred 12/04/19. This	F 600	1. The Director of Nursing and Administrator and Social Worker educated staff on the updated personal search protocol for resident 1. The personal search protocol for resident 1has been removed entirely and educated staff on abuse, neglect, and exploitation during the 12/19/2019 all staff meeting. 2. The facility has determined that any resident has the potential to be affected. 3. Action Taken: On 12/19/19 during all staff meeting education was provided on abuse, neglect, and exploitation. All staff watched a video, received an abuse, prevention test and a test on resident rights and also received identify abuse cards. 4. The Director of Nursing, Administrator, Social Worker or Occupational Therapist will conduct random observations of staff to ensure proper protocol is being followed regarding abuse, neglect and exploitation random weekly audits for 6 weeks, random bi weekly audits for 2 months, and random monthly audits for 4 months to ensure staff are following proper protocol to prevent abuse, neglect and exploitation. Findings of this audit will be discussed at the QAPI Committee. The audits will be reviewed at the	

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F 600	Continued From page 4 protocol, dated 07/20/18, stated, "For the sake of consistency, please use the follow [sic] guidelines if [searching] [Resident #1] before or after she has left the facility for an outing, appointment, etc. This applies to any time she leaves the facility, with staff or non-staff. . . . Ask her if she has anything she isn't allowed to have, or anything she obtained without permission. Ask her to empty all of her pockets and show you the inside of her socks. Please search her purse [if she's been approved to take it with], camera bag, etc. or basically any other object that items could be in. If an item is visibly bulging from her clothing, ask her to remove it. If she refuses, it will be assumed she has something she shouldn't, and it will be marked on her Behavior Checklist. . . ." Review of Resident #1's careplan (used at the time of the incident on 11/26/19) occurred on 12/04/19 and stated, ". . . I have decreased social appropriateness. . . . Anytime I have left the facility, staff will accompany me to the Health Station to be searched by nursing staff according to protocol. Date initiated: 03/14/19. Revision on: 03/14/19 . . ." Review of the document titled "Dakota Alpha Compliment, Concern or Grievance Form" occurred on 12/04/19. This document, dated 11/26/19, stated, ". . .Resident Involved: [Resident #1] . . . At 1:30 pm [Resident #1] was asked to step into the health station by [certified nursing assitant #7] [CNA] with [staff nurse #1 and #2] to do [sic] search before [Resident #1] was leaving on an outing. Search protocol for [Resident #1] is to ask her if she has anything she isn't allowed to have, or anything she	F 600	quarterly QAPI meeting	

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F 600	Continued From page 5	F 600		

obtained without permission, ask her to empty her pockets and show the inside of her socks, search her purse, camera bag, etc or basically any other object that items could be in. If an item is visibly building [sic] from her clothing, ask her to remove it. [Staff nurse #1 and #2] initiated the search in the health station in a private area of the health station. [Staff nurse #2] agreed to do the search. [Staff nurse #1] had been previously been [sic] informed by the previous DON [director of nursing], almost a year ago when she lasted [sic] worked, that a strip search would need to be done. [Staff nurse #1] instructed another [staff nurse #2] to do a strip search to include, checking pockets, clothing, skin folds which included bending over to check buttocks area, and any bags. [Staff nurse #2] agree [sic] to the search and proceeded with having [Resident #1] remove her shirt and take her pants and underwear down to her knees. [Staff nurse #1] stepped around to the other area of the health station and sat beside [administrative nurse #3], while the [staff nurse #2] continued the search. [Resident #1] asked [staff nurse #2] why was this search being done and [staff nurse #2] stated that this was what she was instructed to do. . . ."

During an interview on 12/04/19 at 2:23 p.m., Resident #1 reported the following:
* She had to be checked out at the health station before leaving with activity staff to go shopping. Two nurses took her into a small room in the back of the health station and told her to take her shirt off. A nurse (#2) un-snapped her bra and "started feeling me inside my bra" and she "thought that was inappropriate."
* The nurse told her to pull her pants and underpants down and to bend over. The resident

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F 600	Continued From page 6	F 600		

stated that after it happened, "I was in such a tizzy, it took me about 20 minutes to calm down."
* She stated she "could not sleep that night" and was "just beside myself."
* She spoke to the social worker and the administrator after it happened. "I was in such a tizzy, I couldn't even talk, it really bothered me, I couldn't even sleep that night."
She stated "I felt so terrible when she had me bend down without my pants on."
* She stated she is "uneasy talking about it" and "it seemed unnecessary [to remove clothing]."
* She stated the two nurses (#1 and #2) "make me feel uneasy" and she does not feel comfortable around them.

During an interview on 12/04/19 at 11:20 a.m., a social work staff member (#5) reported she spoke with Resident #1 after staff searched her. The staff member (#5) stated Resident #1 "generally isn't one to show a lot of emotion" and "she questioned why the nurse did that."

During an interview on 12/04/19 at 12:00 p.m., an administrative nurse (#3) reported she heard Resident #1 "protesting" the search. The administrative nurse (#3) stated Resident #1 repeatedly told staff the search had not happened like this before.

An interview with an activity staff member (#6) occurred on 12/04/19 at 12:15 p.m. The staff member (#6) reported she and another activity staff member (#7) took Resident #1, along with some other residents, shopping on the afternoon of 11/26/19. Prior to leaving, Resident #1 was very upset, so the other activity staff member (#7) told the resident she needed to go talk to the

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F 600	Continued From page 7	F 600		

social worker before they would leave to go shopping. The staff member (#6) stated the resident "kept repeating it [the incident] over and over" and was told she needed to talk about it with the social worker or the administrator.

An interview with another activity staff member (#7) occurred on 12/04/19 at 12:40 p.m. The staff member (#7) reported Resident #1 was upset prior to leaving to go shopping and told her "they strip searched me." The activity staff member stated Resident #1 was "too upset to shop" and was very agitated, so she told the resident to go talk to the social worker. The staff member (#7) reported Resident #1 seemed relieved after talking to the social worker and the administrator.

During an interview on 12/04/19 at 1:51 p.m., a staff nurse (#1) stated a staff member told her she needed to search Resident #1 before the resident could leave to go shopping. She reported she had a newly hired nurse (#2) with her, and she told the nurse what to do. The staff nurse (#1) stated when she worked at the facility previously, a nurse told her they needed to do a "strip search" of Resident #1, so that is what she told the nurse (#2) to do. She reported they took the resident to the back room of the nurses station, and she watched while the other nurse (#2) looked under the resident's bra. The nurse (#1) stated she then left the back room and sat down at the computer at the nurses station while the other nurse (#2) continued her search.

An interview with a medication aide (#8) occurred on 12/04/19 at 1:00 p.m. The staff member (#8) reported he/she is the one who does most of the searches on Resident #1 and has never been

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F 600	Continued From page 8 told to do a strip search. The medication aide (#8) stated he/she has the resident raise her arms up and she checks her pockets and bag. An interview with a charge nurse (#9) occurred on 12/04/19 at 1:41 p.m. The charge nurse (#9) reported he/she occasionally performs searches on Resident #1 and has never heard that staff should do a strip search of the resident.	F 600		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §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- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure staff received training on abuse, neglect, and exploitation policies for 1 of 1 nurse (#1). Failure to ensure staff receive training may result in staff being unaware of facility policies and put residents at risk for abuse, neglect, and exploitation.	F 943	1. The Director of Nursing and Administrator and Social Worker educated staff that the personal search protocol for resident 1 has been removed and educated all staff on abuse, neglect and exploitation during the 12/19/2019 all staff meeting. Orientation packets have been updated.	12/26/19

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F 943	Continued From page 9 Findings include: During an interview on 12/04/19 at 1:50 p.m., a nurse (#1) reported he/she received no training when he/she started in November 2019 at Dakota Alpha. During an interview on the afternoon of 12/04/19, two administrative staff (#3 and #4) confirmed the facility had no record of any training for the nurse (#1). The facility failed to provide documentation of training related to abuse, neglect, and exploitation for the nurse (#1).	F 943	2. The facility has determined that any resident has the potential to be affected. 3. Action Taken: The updated orientation and checklist will include abuse, neglect, and exploitation for all staff including travel. Director of Nursing reviewed the orientation checklist and competency checklist with travel staff on 12/6/19. Director of Nursing and Administrator are completing an orientation and checklist protocol for all staff including that have not worked at Dakota Alpha for 3 or more months. If staff including travel staff, have not worked at Dakota Alpha for 3 or more months it will be required that staff including travel staff will go through the orientation and competency checklist before they will be allowed to provide direct care. All staff meeting on 12/19/19 staff were educated on the protocol for staff regarding competency and orientation and all staff education on abuse, neglect and exploitation. A training record for abuse, neglect and exploitation for all staff including travel will be maintained by the director of nursing or the administrator. 4. The Director of Nursing or designee will conduct random audits of travel and new staff to verify that they have been through orientation and competency checklists before they provide cares. The audits will be done random weekly audits for 6 weeks, random bi weekly audits for 2 months, and random monthly audits for 4	

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F 943	Continued From page 10	F 943	months to ensure staff are completing orientation and competency checklists. Findings of this audit will be discussed at the QAPI Committee. The audits will be reviewed at the quarterly QAPI meeting.	