STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	**100 ELM AVE, #396 NEW SALEM, ND 58563**

(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 investigation survey regarding a facility reported incident and a complaint was completed on April 14, 2025. During the report investigation the facility was found noncompliant with regulatory requirements. During the complaint investigation the facility was found in compliance 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	F 609		5/9/25

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

Electronically Signed | 05/05/2025

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F 609	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the facility reported incident (FRI) and family and staff interviews, the facility failed to ensure alleged violations involving neglect were reported timely to the State Agency (SA) for 1 of 1 sampled resident (Resident #1). Failure to report an elopement in a timely manner placed all residents at risk for neglect and/or elopement. Findings include: Review of the FRI identified Resident #1 eloped from the facility on 01/27/25. The facility failed to report the elopement to the SA until 04/09/25. The facility could not identify how or when the resident left the building. During an interview on 04/14/25 at 5:00 p.m., Resident #1's family member stated the facility contacted her and stated a member of the community found the resident in the town gym about one block from the facility and returned her to the facility. During an interview on 04/14/25 at 5:30 p.m., two administrative staff members (#1 and #2) stated the elopement actually occurred on 02/01/25, and confirmed the facility failed to report the elopement to the SA in a timely manner.	F 609	1. Nurse on duty promptly initiated code alert for resident #1. Family was notified of event and of measures implemented. 1:1 monitoring with resident #1 was provided as needed during her periods of wandering and exit seeking. The incident for resident #1 was reviewed by the Interim DON and administrator and facility acknowledges that the elopement incident was not reported to the state appropriately in the timely manner per regulations. 2. The facility has determined that potentially all residents may be affected. 3. Policy on Elopements and Wandering Residents was updated to reflect new instructions on the importance of reporting and the process and procedure for same. A nursing meeting was held informing all nursing staff of Survey Tag and updated policy. Any nurses not able to be at the meeting were educated by Interim DON individually and have also signed attendance form. See Signature form, updated policy and nurses meeting notes F609A. 4. The Interim DON or designee will conduct an audit of all residents that have an elopement of any kind weekly for 4 weeks. Incidents will be thoroughly assessed with review of nurses notes too	

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F 609	Continued From page 2	F 609	and reviewed to see if reporting was required. A random audit of 5 residents identified to have an incident will then be completed monthly x 6 months. Findings of this audit will be discussed at the quality assurance meetings.	
F 610 SS=D	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 review of the facility report incident (FRI), record review, and family and staff interview, the facility failed to thoroughly investigate an elopement for 1 of 1 sampled resident (Resident #1). Failure to thoroughly investigate an elopement to determine causative factors may limit the facility's ability to put appropriate interventions in place to prevent further elopement episodes.	F 610	1. Nurse on duty promptly initiated code alert for resident #1. Family was notified of event and of measures implemented. 1:1 monitoring with resident #1 was provided as needed during her periods of wandering and exit seeking. The incident for resident #1 was reviewed by the Interim DON and administrator and facility acknowledges that the elopement incident	5/9/25

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F 610	Continued From page 3 Findings include: Review of the FRI, received by the SA on 04/09/25, indicated Resident #1 eloped from the facility on 01/27/25. Review of Resident #'1's medical record occurred on 04/14/25. A nurses' note dated 02/01/25 at 2:55 p.m., stated the following: * "Res. [resident] confusion regarding leaving elm crest and applying a code alert for her safety. Code alert applied to right ankle." The facility could not identify when the resident left the building but stated the elopement occurred on 02/01/25, not 01/27/25, but the medical record showed to staff charting charting between 1:40 p.m. and 2:44 p.m. (over 1 hour). During an interview on 04/14/25 at 5:00 p.m., Resident #1's family member stated the facility contacted her and told her a member of the community found the resident in the town gym about one block away from the facility and returned her to the facility. The facility failed to thoroughly investigate/determine the causative factors of Resident #1's elopement which placed Resident #1 at risk for elopements and limited the facility's ability to put interventions in place.	F 610	was not appropriately investigated to determine causative factors and that this limited facility's ability to place appropriate interventions. 2. The facility has determined that potentially all residents may be affected. 3. Policy on Elopements and Wandering Residents was updated to reflect new instructions on the process of completing a thorough incident report following an incident, reporting this to the state, and performing a thorough investigation. A nursing meeting was held informing all nursing staff of new information. Any nurses not attending the meeting were educated by Interim DON individually and have also signed attendance form. See Signature form, updated policy and nurses meeting notes F610A. Facility implemented a new elopement risk assessment in it's charting system and this will be completed upon admission and quarterly thereafter to help identify potential wandering residents that may require early intervention. Facility code alert protocol includes code alert checks monthly and door alarms are checked weekly for appropriate response. See forms, F610A. 4. The Interim DON or designee will conduct an audit of all residents with an elopement of any kind weekly for 4 weeks. These residents with elopement incidents will be assessed to ensure any injury is properly investigated and	

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F 610	Continued From page 4	F 610	reported to the appropraite agencies. A random audit of 5 residents with elopement incident will then be completed monthly x 6 months. Findings of this audit will be discussed at the quality assurance meetings.	