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 _____	11/21/2023

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 The Standard Medicare/Medicaid recertification survey started on 11/19/23 and concluded on 11/21/23.	F 000		
F 657 SS=D	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). 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 facility policy, and staff interview, the facility failed to review and	F 657	1.) Resident #23 and #33 had care plan updated 11/21/23 to coincide with	12/12/23

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

Electronically Signed | 12/14/2023

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F 657	Continued From page 1 revise comprehensive care plans to reflect the residents' current status for 3 of 19 sampled residents (Resident #23, #28, and #33). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "RESIDENT CARE PLANNING" occurred on 11/21/23. This policy, dated 12/19/20, stated, ". . . Each resident has a resident care plan (RCP) that is current, individualized, and consistent with the medical regimen. . . . Implementation: Times and actions are stated so that caregivers new to the resident can carry out care with complete continuity. . . ." - Review of Resident #23's medical record occurred on all days of survey and identified the resident experienced a fall which resulted in a fracture on 08/01/23. Resident #23's care plan failed to identify a risk for falls and lacked specific interventions and measurable goals for falls. - Review of Resident #28's medical record occurred on all days of survey. The Minimum Data Sets (MDSs), dated 05/27/23 and 08/26/23, identified weight loss. Resident #28's care plan failed to identify weight loss. During an interview on 11/21/23 at 1:54 p.m., an administrative nurse (#1) agreed the care plans should include falls and weight loss. - Observation on 11/19/23 at 2:59 p.m. showed Resident #33 wore a continuous glucose monitor (CGM). A physician's order, dated 08/27/23,	F 657	resident conditions of fall and continuous blood glucose monitoring. Resident #28 care plan updated 12/12/23 in regard to weight loss. 2.) Items were discussed at monthly Quality Assurance meeting on 11/28/23 with discussion on any other residents that had potential to be affected and required care plan review with updates made accordingly. All staff were in-serviced at all staff meeting 12/5/2023. 3.) Resident status change will be monitored continuously with revisions made to care plans at time of established change. Status changes will be shared with the appropriate personnel as changes occur and will be reviewed with IDT at the monthly QA meetings. 4.) Care plans will be reviewed by the DON or designee and results will be documented on a monitoring log on a weekly basis X 4 weeks, then monthly X4, then quarterly and PRN up to 1 year. Results will be discussed at monthly QA meeting	

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F 657	Continued From page 2 stated "[FreeStyle Libre 2 Sensor] Continuous Blood Gluc [glucose] Sensor . . ." Resident #33's care plan lacked information related to use of a CGM.	F 657		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and facility policy, the facility failed to assure safe and secure storage of narcotic medications for 2 of 2 medication	F 761	1.) 11/24/23 all PRN controlled medications were removed from PRN drawer and placed in double locked	12/13/23

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F 761	Continued From page 3 carts. Failure to store all medications securely may result in unauthorized access to medications and/or medication errors. Findings include: Review of the facility policy titled "Controlled Drugs" occurred on 11/21/23. This policy, dated 03/04/20, stated, ". . . Strict control of narcotics is maintained always. . . . Procedures: . . . All controlled medications are kept under double-lock and in a separate drawer (also known as the narcotic drawer) from other medications. . . ." Observation on 11/20/23 at 2:30 p.m. with two nurses (#2 and #3) showed schedule II-V narcotics/controlled medications ordered as needed (PRN) stored in the bottom drawer of two medication carts with non-controlled medications and not double locked.	F 761	narcotic box. Controlled medications of 60 unit packed medications or more were removed from the narcotic drawer and placed in a locked cupboard in the locked medication storage room. The medications in both the locked medication cart and locked medication room will be counted every shift and verified by oncoming and outgoing nurse every shift for 4 weeks. After 4 weeks the controlled medications stored in the medication cart will continue to be counted every shift and the controlled medications stored in the locked cupboard of the locked medication room will be counted 1 time per day. 2.) Medications of all residents were reviewed 11/24/23 and organized as above 3.) The Controlled Drugs Policy was updated and the nursing staff was in-serviced 11/24/23-12/13/23. 4.) The completion of the Narcotic Dispensing Record will be reviewed by the DON or designee 5 times weekly X 1 week, then weekly X 4 weeks, then monthly and PRN X 1 year with findings discussed at monthly QA meeting.	