STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	**1 E MAIN ST , CARRINGTON, North Dakota, 58421**

(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
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding facility reported incidents was completed on 04/30/26. During the investigation, the facility was found noncompliant with regulatory requirements.	F0000		05/21/2026
F0600 SS = E	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 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the facility reported incident (FRI) investigations, observations, review of facility policy, and resident and staff interviews, the facility failed to ensure residents remained free from abuse for 5 of 5 sampled residents (Resident #2, #3, #4, #5, #6) who were subjected to verbal and physical abuse by Resident #1. Failure to protect residents from verbal and physical abuse may result in injury, fear, anxiety, mental anguish, emotional distress and resulted in retaliatory abuse to Resident #1. Findings include: Review of the facility policy titled "Resident to	F0600	1. Immediate Corrective Action for Affected Residents. Residents identified as affected by the resident-to-resident altercation were immediately separated from resident #1 to ensure resident safety. A nursing assessment was completed on all affected residents, including evaluation for injuries, pain, and emotional distress as indicated. No injuries were identified. Resident #1 was immediately removed from the situation and placed under increased staff supervision and behavioral monitoring. The resident's care plan was reviewed and updated to include individualized interventions related to behavioral symptoms and sundowning behaviors. 2. Identification of Other Residents at Risk The facility identified residents with cognitive impairment, wandering behaviors, intrusive behaviors, behavioral symptoms, or history of resident-to-resident interactions as having the potential be affect by this practice. 3. Systemic Changes Implemented The facility continues to work with the resident #1's family regarding psychiatric services and behavioral management support. Referrals were placed to local Memory Care units to assist in managing the residents' increasing behavioral symptoms. Additional staff supervision and individualized behavioral interventions were implemented during high-risk time periods, including evening hours associated with sundowning behaviors. Medication changes were completed by the physician to assist in reducing behavioral symptoms, and the resident continues to be monitored by the attending physician. Education was provided to nursing staff on 5/19/26 and 5/20/26 regarding recognition,	05/28/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0600 SS = E	Continued from page 1 Resident Altercation" occurred on 04/30/26. This policy, dated 04/20/26, stated, " . . . Resident to Resident Altercations can include: Verbally aggressive behaviors 1. Screaming 2. Cursing . . . Physically aggressive behaviors 1. Hitting 2. Kicking, grabbing . . . 4. Pushing/shoving . . . Touching or rummaging through other resident's property h. wandering into other resident's room/space . . ." Review of the facility policy titled "Resident Abuse and Neglect" occurred on 04/30/26. This policy, dated 07/01/11, stated, "Residents have the right to be free from verbal . . . physical and mental abuse . . ." Review of Resident #1's medical record occurred on 04/30/26. Diagnoses included dementia, restlessness and agitation. The care plan stated, ". . . Alteration in mood and behaviors related to . . . restless and agitation, and dementia with psychotic disturbances. Current indicators . . . History of entering other rooms, rummaging, verbal and physical behaviors. The quarterly Minimum Data Set (MDS), dated 04/12/26, indicated severely impaired cognition. -Incident between Resident #1 and #3 Review of the FRI investigation, dated 04/09/26, stated, ". . . [Resident #3] was sitting in common area/TV [television] in a recliner. [Resident #1] was by one of the other recliners in the TV area and [Resident #3] told him to leave the cords alone. [Resident #3] then got up and went to [Resident #1]. [Resident #1] started to mess with [Resident #3's] bag that was sitting on his recliner, and [Resident #3] proceeded to hit [Resident #1] on the left side of the head. [Resident #1] then hit [Resident #3] on the left side of the arm. . . ." Observation on 04/30/26 at 11:16 a.m. showed Resident #1 seated in a recliner in the front lobby area. When asked how he was, Resident #1 stated, "Comfortable right now." When asked if he remembered being any physical altercations with other residents, he stated, "No, I wouldn't hit anyone." During an interview on 4/30/26 at 8:51 a.m. when asked about the above incident, Resident #3 stated, "I did not get hurt. [Resident #1] has dementia so bad." Review of Resident #3's medical record occurred on	F0600	Continued from page 1 prevention, de-escalation, supervision, and management of resident-to-resident altercations and behavioral symptoms in long-term care. Education was provided on 5/21/26 to agency staff, non-direct care personnel, and those unable to attend the nursing staff meetings The facility policy regarding Resident-to-Resident Altercations was reviewed and updated. The revised policy was distributed on 5/25/56 to all current staff and agency personnel working within the facility. This policy will also be incorporated into the onboarding educational materials for all new hires. 4. Quality Assurance and Monitoring The Director of Nursing or designee will conduct audits of five residents exhibiting behavioral symptoms to ensure interventions, supervision, and care plan approaches are implemented appropriately. Audits will include review of behavioral documentation, care plan interventions, supervision and monitoring practices, escalation or trigger identification, and follow-up after behavioral incidents. Audits will be conducted weekly for four weeks, monthly for three months, and quarterly thereafter as indicated. Results of audits and monitoring activities will be reviewed through the facility QAPI process to identify trends, determine effectiveness of interventions, and ensure sustained compliance. Additional education and interventions will be implemented if concerns are identified.	05/28/2026

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F0600 SS = E	Continued from page 2 04/30/26. The care plan stated, ". . . Alteration in mood and behaviors related to: depression, anxiety, mental disorder, mild cognitive disorder . . . History (sic) verbal and physical behaviors involving others . . ." The annual MDS, dated 04/08/26, indicated intact cognition. -Incident between Resident #1 and #4 Review of the FRI investigation, dated 04/19/26, stated, ". . . [Resident #1] followed [Resident #4] into the TV area. [Resident #1] was seen hitting [Resident #4] on the left side of the face. . . . On 4/20/26 [Resident #4] reported to [social service designee] that [Resident #1] came up and hit him and asked [Resident #4] if he had his wallet. [Resident #4] then stated to [Resident #1] 'I don't have your [explicit] wallet' and then [Resident #1] hit him. . . . Upon reviewing video footage of the altercation, it showed [Resident #4] ambulating with his walker past the nurse's station and turning into the TV area with [Resident #1] ambulating behind him. . . . [Resident #1] was seen standing right behind [Resident #4] and it appeared he made a comment to [Resident #4]. [Resident #4] was seen swatting at [Resident #1] and then [Resident #1] hit [Resident #4] on the left chin area. . . ." Resident #1's progress note, dated 04/19/26 at 9:35 p.m., stated, ". . . Resident physically assaulted another resident at 2004 [8:04 p.m.]. [Resident #4] was returning to a seat in the common area and [Resident #1] tried to engage him in conversation. When [Resident #4] did not respond to [Resident #1], he suddenly punched [Resident #4] on the left cheek. Writer had heard the raised pitch and arrived just as he was striking the other resident. Writer intervened and [Resident #1] was informed that such behavior was unacceptable. . . ." Review of Resident #4's medical record occurred on 04/30/26. The quarterly MDS, dated 03/03/26, indicated moderately impaired cognition. During an interview on 4/30/26 at 11:50 a.m. when asked if he remembered the altercation with Resident #1, Resident #4 stated, "Yes, but I don't know why he would do that. I was just sitting here; I didn't do anything." -Incident between Resident #1 and #2 Review of the FRI investigation, dated 04/26/26, stated, ". . . Staff report that on 4/26/26 at around	F0600		05/28/2026

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F0600 SS = E	Continued from page 3 1645 [4:45 p.m.] they witnessed [Resident #2] and [Resident #1] wrestling around on a reclining chair while another resident was sleeping on it. . . . CNA [certified nurse aide] reports being called to the front to assist the nurse with [Resident #1] and [Resident #2]. She states that she helped the nurse separate the individuals but did not know what led to the altercation and did not know what was said prior. . . . . LPN [licensed practical nurse] reports that she was alerted by another resident that [Resident #1] and [Resident #2] were fighting. Upon entering the TV area, she saw both residents engaged in physical contact with each other and laying on their sides in a recliner on top of another resident. She states that her and [a CNA] were able to get the residents apart and separate them. [The LPN] completed an assessment and found that [Resident #2] had a small light red spot noted on the center of her head with no lump present. She also had a light red mark to her upper inner arm which she was unsure was due to the altercation or from the nurse attempting to assist resident from the recliner. Both areas resolved after time. . . . Review of video footage . . . of the incident between [Resident #2] and [Resident #1] at around 1652 [4:52 p.m.] showed as follows: [Resident #1] was standing in front of the TV in the lounge area fidgeting with the control box. . . . [Resident #1] was sitting in the recliner. . . . After about 5 minutes [Resident #1] walked over to [Resident #2] and grabbed her by the arm which appeared as if he was trying to guide her away from the TV. [Resident #2] then turned around and hit [Resident #1] in the left arm. [Resident #1] then hit [Resident #2] back in the right arm. Both residents grabbed each other and had their arms around one another and then fell onto a reclining chair which was occupied by [Resident #7] who was reclined back in the chair. Staff immediately intervened and separated the residents. . . ." Review of Resident #2's medical record occurred on 04/30/26. The quarterly MDS, dated 03/21/26, indicated severely impaired cognition. -Incident between Resident #1 and #5 Review of Resident #1's progress notes, dated 04/24/26 at 3:54 p.m. stated, ". . . Activity director was walking residents down to the dinner tables and [Resident #1] kicked [Resident #5] who was walking in front (sic) him and he chuckled. Activities director corrected [Resident #1] and said that was not very nice and that we don't kick people. The [Resident #5] then turned around that he kicked and told him not to (sic) that again. . . ."	F0600		05/28/2026

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F0600 SS = E	Continued from page 4 During an interview on 4/30/26 at 11:20 a.m. when asked about the incident when [Resident #1] kicked [Resident #5,] an administrative staff member (#2) stated, "I think [Resident #1] thought it was a joke and [Resident #5] did not take it that way." Review of Resident #5's medical record occurred on 04/30/26. The quarterly MDS, dated 02/28/26, indicated severely impaired cognition. During an interview on 4/30/26 at 11:30 a.m. when asked if she remembered when Resident #1 kicked her, Resident #5 stated," Yes, when I was standing and talking, she just let me have it. She's not 100 percent though." -Incident between Resident #1 and #6 Review of Resident #1's progress notes, dated 04/20/26 at 2:03 p.m., stated, ". . . Writer heard [Resident #6] yelling from Social Services office 'Get out here. Let it alone. Get out here you [explicit] Piece of slop' writer walked out to the front lobby sitting area to see what was going on. [Resident #1] was lifting up [Resident #6's] cushion in her chair looking for his wallet. writer got in between the two residents. AS [sic] writer was distracting resident, he raised his voice back and called her [Resident #6] a [explicit] bitch. [Resident #6] was still yelling and cursing and was going to take her shoe off to use towards Resident #1. Writer had this resident go for walk and look for his wallet in his room. After that resident and writer walked to prairie and he is sitting in recliner in Prairie dining room watching tv. Resident is calm sitting on prairie. . . ." Review of Resident #6's medical record occurred on 04/30/26. The quarterly MDS, dated 03/04/26, indicated intact cognition. During an interview on 04/30/26 at 11:35 a.m. when asked if she remembered the above incident, Resident #6 stated, "Yes, he said he was looking for his keys or wallet. He's never had any keys or wallet." When asked if Resident #1 hit her she stated, "No, but he wanted to hurt me. He gets me so mad. He hits my friend [Resident #4] for no reason. He hit [Resident #4] on the chin and [Resident #4's] glasses were crooked from it. I really wanted to hit him, but [Social Services Designee] told me that would not be a good idea, I'd probably end up in jail. I'm worried about my friend [Resident #4] though."	F0600		05/28/2026

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F0600 SS = E	Continued from page 5 During an interview on 04/30/26 at 12:00 p.m., when asked what she would do if she witnessed a resident hit another resident, the staff member (#3) stated, "I'd get the RNs (Registered Nurses)." When asked if there was anything else she would do, the staff member stated, "I'd try to get a hold of someone." During an interview on 04/30/26 at 12:15 p.m., an administrative staff member (#1) stated Resident #1 has not been seen by psychiatry since 2024. The facility failed to protect Resident #2, #3, #4, #5, and #6 from Resident #1's abusive behaviors which resulted in retaliatory abuse to Resident #1.	F0600		05/28/2026