STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

(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 11/18/24 and concluded 11/21/24. Based on the results of the recertification survey an extended survey was also completed on 11/26/24.	F 000		
F 600 SS=J	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 review of the facility reported incident (FRI) and investigation reports, record review, review of facility policy, and staff and resident interviews, the facility failed to provide an environment free of verbal abuse for 1 of 1 sampled resident (Resident #19) with an allegation of abuse. Failure to identify abuse and ensure residents are free from verbal abuse and abusive gestured language, which includes disparaging and derogatory terms caused fear, anxiety, mental anguish, and psychosocial harm.	F 600	Plan of Correction November 2024 F600 SS=J (Free from Abuse and Neglect) 1. Affected Resident #19: a. Facility Reported Incident (FRI) involving Resident #19 was reviewed and investigated by state agency. Findings include facility failure to recognize abuse, failed to assess the resident physically	12/11/24

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

Electronically Signed | 12/10/2024

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 600	Continued From page 1 During the on-site recertification survey and FRI investigation, the team consulted with the State Survey Agency (SSA) on 11/21/24 at 8:44 a.m. and determined an immediate jeopardy (IJ) situation existed on 10/21/24. The facility failed to recognize the abuse, failed to assess the resident physically and mentally, failed to notify the IDT (Interdisciplinary Team), failed to update the care plan, and failed to notify the resident's provider. * 11/21/24 at 10:10 a.m., the survey team notified the Administrator and Director of Nursing (DON) of the IJ situation, provided the IJ template, and requested a plan for removal of the IJ. * 11/21/24 at 12:45 p.m., the survey team reviewed and accepted the facility's removal plan. The removal plan contained the following: * CNA (#AA)'s file was updated to include "do not rehire." * All staff were retrained on immediate re-education on definitions of abuse and how to identify abuse. * Remaining facility staff were re-educated prior to the start of their next shift. * The facility's regional registered nurse re-education administrative staff members (#1 and #2) on definitions of abuse and how to identify abuse. * Remaining administrative staff to be educated by administrative staff members (#1 and #2). * An automated notification was sent to all staff regarding the mandatory re-education prior to start of next shift. * An education packet will be put in the employee newsletter for reference.	F 600	and mentally, failed to notify the IDT (Interdisciplinary Team), failed to update the care plan, and failed to notify the resident□s provider. Resident #19 was offered 1:1 support by Administrative Staff #1. b. Registered Nurse completed physical assessment indicating no new findings. Trauma Informed Care Screen completed with Resident #19 twice since incident occurred indicating that resident prefers to be left alone when upset or bothered by something. PHQ 2-9 assessment completed indicating minimal depressive symptoms will be completed quarterly. Psychiatric Services and Talk Therapy offered and Resident #19 declined, plan of care updated accordingly based on the observation findings and refusal of services. Medical Provider updated on incident with no new orders received. Offer support to resident with changes noted to mood and behavior as resident allows. IDT and Leadership Teams updated on incident. 2. Potential Affected Residents: a. All residents have the ability to be affected by the above deficient practice. Resident questionnaire completed asking the following; "do you feel safe in this environment, if you do not feel safe or have a safety concerns do you know how to report this, and do you have any concerns with any particular staff	

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F 600	Continued From page 2 * On 11/21/24 at 12:32 p.m., the survey team verified the implementation of the removal plan as of 11/21/24 and the IJ removal. The deficient practice remained at an G scope and severity following the removal of the immediate jeopardy. Findings include: Review of the facility policy titled "Abuse Prevention Plan" occurred on 11/20/24. This policy dated 2017, stated, ". . . 'Abuse': The willful infliction of . . . intimidation . . . resulting in . . . mental anguish. . . . It includes verbal abuse . . . and mental abuse . . . use of . . . malicious oral . . . or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening . . ." Review of Resident #19's medical record occurred on 11/20/24. A care conference progress note, dated 10/09/24 at 4:10 p.m., stated, "Resident is cognitively intact per BIMS [Brief Interview for Mental Status] score of 15, resident is his own decision maker. The care plan, revised 08/01/24, stated, ". . . I am a vulnerable adult and need assistance to remain safe within the community. My vulnerabilities include needing assistance with my ADLS (activities of daily living), transfers, use of wheelchair, vision impairment, behaviors towards staff, and difficulty communicating due to unclear speech at times. . . ." * Review of the investigation report occurred on 11/20/24. The report dated 10/28/24, stated,	F 600	members? If concerns identified from questionnaire a Trauman Informed Care Screen to be completed with care plan updated accordingly. 3. Measures/Systemic Changes: a. 11/21/24 at 10:30am CNA #AA file updated to include do not rehire status. At 10:35am immediate re- training abuse definitions and identifications to all staff currently in the building. Training provided by Administrative Staff Members #1 and #2. Documents provided to staff include Abuse/Neglect and reporting policy and definitions of abuse/neglect. Remaining facility staff will be educated prior to the start of their next shift on topics listed above. Education packet created and provided to staff members and signatures obtained. Facility Administrative Staff were educated by Administrative Staff #1 and #2 using education packet method with signature obtained. 11:30am Ever-Bridge notification sent to all staff to notify of needed education prior to start of next shift. Education packet will also be put in the employee newsletter for reference. Administrative Staff #1 and #2 educated by Regional Nurse from Benedictine on the following topics; abuse definitions and identifications, reporting requirements, and memo from State of North Dakota Health and Human Services dated 4/28/23. Update IDT meeting format updated to include discussion on	

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F 600	Continued From page 3 "Investigation indicated that allegation of abuse was unsubstantiated although through the investigation process it appears likely a verbal altercation did occur between [Resident #19] and alleged staff member [CNA #AA]." "The resident [Resident #11] across the hall verified hearing yelling between the two. . ." During an interview on 11/20/24 at 1:59 p.m., Resident #19 indicated a CNA put him to bed. After being put to bed CNA (#AA) came into his room, leaned over his bed, and said, "If you don't stop talking about me, I'm going to put a pillow over your head and kill you." When asked if he was scared, Resident #19 said "Yes, wouldn't you be?" During an interview on 11/20/24 at 2:06 p.m., Resident #11 stated one night in October he/she heard yelling between Resident #19 and CNA (#AA). He/she could not make out what was being said, but recalled it was around 11:00 p.m. During a phone interview on 11/20/24 at 2:55 p.m., a CNA (#5) could not recall the day she conversed with CNA (#AA), but did recall CNA (#AA) stating, "he would put a pillow over his [referring to Resident #19] head." She did not take CNA (#AA) seriously and failed to report the statement to management. During a phone interview on 11/20/24 at 3:28 p.m., a CNA (#3) recalled a conversation she had with Resident #19. She stated Resident #19 told her that she should have stayed another 15 minutes the night before because "[expletive] went down." Resident #19 said CNA (#AA) had come in his room, leaned over his bed, and said,	F 600	Facility Reported Incidents and any ongoing investigations. Quality Council will be updated per policy of Facility Reported Incidents and any ongoing investigations. New staff members to be educated on Abuse/Neglect definitions, policy, and reporting requirements prior to start of first shift. 4. Monitoring: a. The Director of Nursing and/or designee will complete weekly audits for one month for five randomly selected interview able residents and three non-interview able residents and five randomly selected staff. Then complete audits on two interview able residents, two non-interview able and two staff every two weeks for three months and as needed thereafter based on compliance as determined through quality council review. The audits for interview able residents will ensure no safety concerns are present, if a concern arises how to report concern, and if residents feel safe in environment. The audits for non-interview able residents will consist of a non-verbal assessment of soft signs of abuse. The audits for staff will ensure awareness of abuse/neglect definitions, when to report, and how to report. The audits will be reviewed by the Director of Nursing and/or designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be	

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F 600	Continued From page 4 "If you don't stop talking [expletive] about me, I'm going to put this pillow over your face and kill you." The CNA (#3) also recalled having a conversation with Resident #11 and he/she told her about the yelling that occurred the night before between Resident #19 and CNA (#AA). During a phone interview on 11/20/24 at 3:46 p.m., a CNA (#AA) denied the allegations against him. He stated, "It never happened, and I did not go in his room. No one told me that I couldn't go in his room. I worked with him one more time after that. He was a little better, I did go in another time, when he was sleeping, to empty his urinal." During an interview on 11/20/24 at 5:00 p.m., two administrative staff member (#1 and #2) indicated they spoke with the consulting social worker and the consultant determined the facility had come to the right decision. Administrative staff member (#2) stated, "We highly suggested CNA (#AA) should resign or that he would be terminated." Administrative staff member (#1) confirmed CNA (#AA) resigned from his position and confirmed they marked "this employee is eligible for rehire" on his employment information record. After the IJ was called, CNA (#AA)'s employment record was changed to "do not rehire."	F 600	determined through analysis and review of results. The Director of Nursing will follow up on further training and process improvements as needed. b. A facility wide audit on all current in-house interview able residents (BIMS 8-15) was completed to ensure no further safety concerns are present at this time Non- interview able residents (BIMS 0-7) to be assessed based on changes to mood and behavior, concerns noted to physical assessment identifying any apparent signs of abuse, and review of soft signs of abuse. The audit identified no further safety concerns. c. Trauma Informed Care Screen will be reviewed quarterly, annually and recompleted if there are any changes in mood that could indicate signs of trauma. 5. Completion Date: a. 12/11/2024	