STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on observation, record review, and resident and staff interview, the facility failed to ensure residents received adequate supervision and/or monitoring to prevent elopements and/or extended personal outings from the facility for 1 of 1 sampled resident (Resident #44). Failure to provide adequate supervision and monitoring may result in avoidable accidents an/or injury. Findings include: Observations on 03/02/20 showed the following: * At 1:50 p.m. - Resident #44 walking outside across the street from the facility. * At 4:55 p.m. - Resident #44 at the nurses' station signing the Resident Sign Out Sheet for return to the facility carrying a grocery bag. Review of Resident #44's medical record occurred on all days of the survey. The current care plan stated, . At risk for elopement due to mental illness . Use verbal and if necessary physical cues for redirection to persuade (sic) exit-seeking behaviors . Use diversional activities when exit-seeking behavior is occurrig (sic) . Seek referral for a mental health evaluation from primary care physician as needed . Offer reassurance when distressed over placement . Refer to social services as needed . Elopement assessment at time of admission and then at least quarterly . Allow resident to call close family/friend for reassurance when exit-seeking behaviors occurring . Involve resident in activities of their liking . May appear to look as if he is a visitor . See outing restriction guidelines (discontinued 03/05/20) . (Resident name) likes to go out walking to the store, park or (local motel) . When signing (Resident name) out, please remind him of the time frame . Staff signing him out needs to be aware of the time and alert staff if he has not returned to go look for him . The outing restriction guidelines, updated 09/26/19, stated, . You may go out any day of the week for 1 hour and 30 minutes at a time between the hours of 10 am - 3 pm. Please let your nurse . know you are leaving . These guidelines discussed between the resident's guardian and social work and signed by Resident #44. Review of Elopement Risk Assessment, dated 02/11/20, indicated Resident #44 was not considered at risk for elopement. The Resident Sign Out Sheet and progress notes identified the following: * 02/22/20 at 1:11 p.m. - The sign-out sheet showed the resident signed out to go for a walk and returned to facility at 6:15 p.m. (5 hours out of facility, documentation lacked follow-up after 1.5 hours) * 02/22/20 at 7:04 p.m. - Resident left the facility at 1310 (1:10 p.m.) today for a walk. (Nurse name) was at desk when he left. He also told her that he is going for a walk. Resident did not return to facility until 1815 (6:15 p.m.). His phone was left in his room during this time. * 02/29/20 at 1:48 p.m. - The sign-out sheet showed the resident signed out to go for a walk to the grocery store and failed to sign return time. * 02/29/20 at 7:01 p.m. - Resident in front of facility visiting in new friend's vehicle at 1815 (6:15 p.m.). Resident had signed out of facility at approximately 1345 (1:45 p.m., 4.5 hours out of facility) and had not returned. This nurse and (nurse name), RN/RCC (Registered Nurse/Resident Care Coordinator) asked (resident name) to come in to the building. (Resident name) was reminded of his outing guidelines put in place by . his brother/guardian, and that staff were concerned when he did not return within the required time frame. (Resident name) apologetic and understanding that staff want to ensure he is safe and that guidelines are in place to help assist staff in that . * 02/29/20 at 7:24 p.m. - (Resident name) did have a functional cell phone in his jacket pocket. He has 2 old phones in his room. Resident was praised for having his phone with him. * 03/02/20 at 1:50 p.m. - The sign-out log showed the resident signed out to go for a walk to the grocery store and returned to the facility at 4:53 p.m. (3 hours out of the facility) * 03/02/20 at 5:03 p.m. - (Social Worker) made another call to . resident's guardian and brother. Informed him of resident's outtings (sic) that have exceeded 1.5 hours away . * 03/02/2020 at 7:49 p.m. - Late entry for 3/2/20 at 1454 (2:54 p.m.): (Resident name) returned to GAM (Golden Acres Manor) after haven (sic) been called by the Social worker . because he did not return to the facility when expected. (Social worker name) stated that she had talked to (Resident name) brother on the phone and he said that (Resident name) is not to go out of the facility again until he talks to him . During an interview on 03/03/20 at 5:25 p.m., Resident #44 stated he was out longer than allowed (greater than 1.5 hours) and staff had not been out to find him. During an interview on 03/05/20 at 10:00 a.m., an administrative staff member (#1) stated Resident #44 is not exit seeking or an elopement risk and confirmed staff did not go looking for the resident after 1.5 hours. If the resident had not returned for evening meal, staff would go looking for the resident. The facility failed to: * Modify/update interventions on care plan * Accurately complete sign-out sheet * Provide adequate supervision when out of the facility (between 10 a.m. - 3 p.m.) * Search for Resident #44 after being out of facility longer than 1.5 hours
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications for 1 of 1 sampled resident (Resident #45) who received an as needed (PRN) [MEDICAL CONDITION] medication. Failure to include documentation regarding the clinical justification/specific circumstances for continued use of the PRN [MEDICAL CONDITION] medication beyond 14 days and failure to establish a specific start and stop date may result in the resident receiving a medication for an excessive duration and/or experiencing adverse side effects related to its use. Findings include: Review of the facility policy titled Use of [MEDICAL CONDITION] Drugs occurred on 03/05/20. This policy, dated 11/28/17, stated . PRN orders for [MEDICAL CONDITION] drugs are limited to 14 days, except as provided if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. He or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. Review of Resident #45's medical record occurred on all days of survey. A physician's order for [MEDICATION NAME] (antianxiety medication), dated 07/22/19, stated, Give 0.5 mg (milligrams) - 1 mg by mouth/Per Rectum/Sublingual every 4 hours PRN Restlessness or Anxiety. Review of Resident #45's Medication Administration Record [REDACTED]. Review of the form titled [MEDICAL CONDITION] PRN Medication Review, dated 02/12/20, stated, . [DIAGNOSES REDACTED]. Rationale for continued use: Discontinuation of the listed medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's functions, well-being, safety and quality of life . Continued use is in accordance with current standards of practice for previously stated [DIAGNOSES REDACTED]. Duration of above Order . Until seen on next rounds . During an interview on 03/05/20 at

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

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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 10:00 a.m., an administrative nurse (#1) stated Resident #45 had not received any PRN [MEDICATION NAME] since the physician ordered it in July. The facility failed to obtain an order to extend or discontinue the [MEDICATION NAME] beyond the original 14 days, including the rational/specific circumstances for its extended use and a specific start and stop date established by the prescriber.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, review of facility policy, and staff interview, the facility failed to provide safe and secure storage of medications for 1 of 3 medication carts (Grove unit) during observation of medication pass. Failure to store all medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled Controlled Substances occurred on 03/05/20. This policy, revised January 2020, stated . The medication cart . must remain locked at all times except when being accessed to dispense medications for residents. Observation on the morning of 03/02/20 showed a staff nurse (#3) left the medication cart to deliver medications to residents down the hallway. The medication cart remained unlocked, unattended, and not within the nurse's view. During an interview on the morning of 03/05/20, an administrative nurse (#1) confirmed she expected the medication cart to be locked at all times when not being accessed to dispense medications.