STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275079	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wibaux County Nursing Home	712 Wibaux St S Wibaux, MT 59353

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35356 Based on interview and record review, the facility failed to notify a resident's provider and family member of the events surrounding an elopement, so they may have made the necessary medical decisions for the resident following the elopement for 1 resident (#1) of 6 sampled residents. This deficient practice had the potential to affect all residents who require informed care from family and medical providers. Findings include: A review of the facility's policy and procedure titled, Elopement and Wandering Residents, with a revision date of 5/22/24, reflected: - . 6. Procedure post-elopement a. A nurse will perform a physical assessment, document, and report findings to physician. b. Any new physician orders will be implemented and communicated to the family/authorized representative . Review of resident #1's MDS: Section C, dated 7/8/24, reflected resident #1 had a BIMS of 4, a score considered to be a severe cognitive impairment. During an interview on 8/13/24 at 2:00 p.m., NF1 stated they were aware resident #1 had eloped from the facility, but were not made aware of the details surrounding the 12-hours the resident was absent from the facility. NF1 stated they were not aware the resident had been picked up and brought back to a stranger's cabin overnight before being returned to the facility the following morning. NF1 stated they would have wanted to know that information so they could have planned to have the resident further evaluated for any potential concerns following the elopement. During an interview on 8/14/24 at 10:15 a.m., NF3 stated they were told resident #1 had eloped, but were not given any details about the events surrounding the time the resident was out of the facility. NF3 stated had they been made aware resident #1 was out of the facility overnight and stayed in the cabin of a stranger, they would have ordered an assault kit and further exams for the resident. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 10:35 a.m., staff member N stated the facility had not made them aware of the events which occurred for resident #1 while they were out of the facility. Staff member N stated they would have sent the resident to the emergency room for a sexual assault exam and further sexual transmitted disease screenings. During an interview on 8/14/24 at 9:00 p.m., staff member C stated it was the expectation that the events surrounding an elopement were to be reported to the provider and the family.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35356 Based on observation, interview, and record review, the facility failed to complete a comprehensive physical assessment to ensure the patient's physical and sexual health remained intact after an elopement which had the potential for harm of the resident related to sexual trauma, and to become withdrawn from regular activities for 1 (#1) of 6 sampled residents. Findings include: During an interview on 8/14/24 at 1:30 p.m., staff member E stated the man who came to the facility was a construction guy from the road crew. Staff member E stated the man found resident #1 in his car and thought she was drunk. He told the facility staff he took resident #1 to his RV park cabin to let her sleep it off. The man then realized, in the morning, resident #1 was confused, and was talking about finding her children while pointing to the facility. The man then decided to go ask the facility if they were missing a resident. During an observation and interview on 8/13/24 at 11:05 a.m., resident #1 was sitting at the dining room table, she was not completing any activities or watching television. She was intermittently closing her eyes for long periods of time. Staff member M stated resident #1 had packed her things this morning, as she normally did, but had not made her usual attempt to leave the facility. During an observation and interview on 8/13/24 at 1:00 p.m., resident #1 was sitting at the dining room table. She was not completing activities or watching the television. Staff member N stated the resident seemed more subdued than usual, and she had not been exit seeking per her normal behavior. During an interview on 8/13/24 at 2:20 p.m., NF2 stated they spoke with the individual who found resident #1 in their vehicle. NF2 stated the individual drove the resident around attempting to find where she lived. When they could not find her home, he offered for her to sleep on the couch at his cabin, which was located in the RV park across the street from the facility. NF2 stated the next morning the individual was able to determine the resident was from the facility and notified the facility that the resident was at his cabin. NF2 stated when the staff from the facility picked up the resident from the individual's cabin, she was asleep on the couch with her pajama bottoms on and no underwear. She was covered in a blanket. NF2 stated the resident had returned to the facility and believed the facility would conduct a comprehensive physical assessment to ensure the patient's physical and sexual health remained intact after the elopement occurred. NF2 stated the assessment of the resident was outside his scope of practice, and was not able to determine if the resident could give sexual consent based on her cognition level. During an interview on 8/13/24 at 2:46 p.m., staff member D stated resident #1 returned to the facility, and she completed a basic head-to-toe skin assessment and did not see any visual injuries. Staff member D stated she did not send the resident to the emergency room for a comprehensive physical exam or sexual assault exam, after the resident spent the night in the cabin, with the man she did not know, because she was waiting for guidance from the police department on the next steps to take. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 8:40 a.m., staff member A stated they did not send resident #1 to the emergency room for an additional examination for sexual assault, because they were told by NF2 that they did not feel that a sexual assault had occurred. Staff member A stated they did not follow their post-elopement procedure, and should have had the resident assessed at the emergency department to rule out the potential of sexual assault after staying overnight at the cabin. During an interview on 8/13/24 at 2:00 p.m., NF1 stated resident #1 was not able to give sexual consent. NF1 stated she was upset to find out resident #1 had spent the night at a stranger's cabin, and that there was not a complete physical assessment to rule out sexual assault. Review of resident #1's MDS: Section C, dated 7/8/24, reflected resident #1 had a BIMS of 4, a score considered to be a severe cognitive impairment. During an interview on 8/14/24 at 10:15 a.m., NF3 stated they were told resident #1 had eloped, but were not given any detail about the events surrounding the time the resident was out of the facility. NF3 stated they had been made aware resident #1 was out of the facility overnight and stayed in the cabin of a stranger, they would have ordered an assault kit and further exams for the resident. During an interview on 8/14/24 at 10:35 a.m., staff member N stated they facility had not made them aware of the events which occurred for resident #1 while they were out of the facility. Staff member N stated they would have sent the resident to the emergency room for a sexual assault exam and further sexual transmitted disease screenings. A review of the facility's policy and procedure titled, Elopement and Wandering Residents, with a revision date of 5/22/24, showed: - . 6. Procedure post-elopement a. A nurse will perform a physical assessment, document, and report findings to physician. b. Any new physician orders will be implemented and communicated to the family/authorized representative .

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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. 48261 Based on observations, interviews, and record review, the facility failed to secure the memory unit and monitor a cognitively impaired resident with a known history of elopement attempts, which resulted in the resident leaving the building unsupervised overnight, putting the resident at risk for serious injury or death, for 1 (#1) of 6 sampled residents. Findings include: Review of a Facility Reported Incident, sent to the State Survey Agency for resident #1, dated 8/4/24, reflected, . review of facility cameras, resident went out the memory lane dining room door and alarm did not sound when resident went out at 1924 (7:24 p.m.). Resident then went out the fence gate which did not alarm.8/5/24 facility staff started search for resident again and resident was found across the road at the RV park inside someone's cabin sleeping on the couch. During an interview on 8/13/24 at 12:30 p.m., staff member M stated the dining room door alarms, in the memory unit, had been broken for approximately two weeks before resident #1 eloped on 8/4/24. During an observation and interview on 8/13/24 at 12:44 p.m., resident #1 was sitting in the dining room, by the exit door, eating her lunch. Staff member M stated resident #1 had her belongings all packed up and had a history of getting out of the windows of other residents' rooms. Staff member M stated resident #1 was now on 15-minute checks, since the elopement on 8/4/24. During an interview on 8/13/24 at 12:55 p.m., with staff members C, D, and E, staff member D stated . A guy found her (#1) in his car, and he took her to his camper. Staff member E stated the broken door in the memory unit was reported to staff member E on 7/17/24. Staff member E stated a magnetic child lock window alarm was placed on the door on 7/19/24. Staff member C stated, We realize now we should have put 24/7 supervision on the door at that time. During an interview on 8/13/24 at 2:06 p.m., staff member O stated the (facility) gates must not have been activated. The alarm was very loud, and he did not hear the alarm the night resident #1 eloped. Staff member O stated he had found the gate not alarmed on many occasions. Staff member O stated the gate alarm required a specific set of steps to activate the alarm, and many staff were not trained to set the alarm. During an interview on 8/13/24 at 2:20 p.m., NF2 stated they spoke with the individual who found resident #1 in their vehicle. NF2 stated the individual drove the resident around attempting to find where she lived. When they could not find her home, he offered for her to sleep on the couch at his cabin, which was located in the RV park across the street from the facility. NF2 stated the next morning the individual was able to determine the resident was from the facility and notified the facility that the resident was at his cabin. NF2 stated when the staff from the facility picked up the resident from the individual's cabin, she was asleep on the couch with her pajama bottoms on and no underwear. She was covered in a blanket. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/24 at 3:05 p.m., staff member I stated she found resident #1 had eloped at 10:00 p.m., on 8/4/24 during her walking rounds and immediately began a full search and notifications to management and police. Staff member I stated resident #1 had not been found as of the end of her shift on 8/5/24 at 6:00 a.m. During an interview on 8/14/24 at 8:49 a.m., staff member B stated she was made aware of resident #1's elopement on the morning of 8/5/24. Staff member B stated she knew the (facility) door was broken. Staff member B stated, We were in the wrong. Staff member B stated, Standard protocol is 24/7 door coverage when an alarmed door is broken in the memory unit. During an observation and interview on 8/14/24 at 11:19 a.m., staff member F stated the temporary alarm we put on the memory unit door was a childproof lock with magnets that alarm if the connection is broken. Staff member F stated the alarm was put on the door with double stick tape. Staff member F stated in his opinion the alarm fell off the door because of the cool temperatures overnight altering the stickiness of the tape. Staff member F demonstrated the gate alarm, and the process required the following steps: 1. Use the key, found in the open memory unit dining room cabinet, to turn off the alarm. 2. Turn the key back to the on position. 3. Wait 10-20 seconds for alarm to beep three times. 4. Turn the key back to the neutral position to remove the key. During an interview on 8/14/24 at 1:30 p.m., staff member E stated, Someone must have turned it (the door alarm) off at some point. I'm not sure who shut it off. Review of the facility's camera footage dated 8/4/24 - 8/5/24, reflected resident #1 exited the facility through the dining room door at 7:24 p.m., carrying a pair of shoes. Two other residents were present in the dining room. No staff were present at the time of the elopement. No alarms were heard on the video from the childproof magnet lock or the gate alarms. The childproof lock popped off the door and fell to the ground at 11:11 p.m. At 7:13 a.m., a man arrived at the facility. Resident #1 returned to the facility with staff at 7:30 a.m. on 8/5/24. Review of resident #1's MDS: Section C, dated 7/8/24, reflected resident #1 had a BIMS of 4, a score considered to be a severe cognitive impairment. Review of resident #1's Care Plan, dated 8/7/24, reflected resident #1 was at risk of elopement from the facility. The care plan reflected resident #1 had a history of exit seeking since admission on 4/4/24. The care plan reflected resident #1 had exited the memory care unit on 4/17/24 and had eloped through a window at the facility on 5/23/24. Review of the facility's policy, Elopements and Wandering Residents, revised 5/22/24, reflected: 1. [The Facility Name] is equipped with door locks/alarms to help avoid elopements.