STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Living Center of Garrison	609 4th Ave NE Garrison, ND 58540

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13101 Based on record review, review of facility policy, and staff interviews the facility failed to ensure residents remained free from resident-to-resident abuse for 2 of 3 sampled residents (Residents #24 and #51) and 4 supplemental residents (Resident #3, #11, #31, and #36) who received or displayed physical and/or verbal abuse. Failure to identify physical altercations between residents as physical abuse placed residents at risk for possible emotional distress and/or physical injury. This citation is considered past non-compliance based on review of the corrective action the facility implemented following the incidents. Findings include: This surveyor determined a deficient practice existed on 06/08/24. The facility implemented corrective actions and staff education on 07/16/24. Review of the facility policy titled Abuse Prevention Plan occurred on 07/24/24. This policy, dated 2017, stated, Prevention Plan: . Population of neighbors [residents] who reside in facility vary in their ability to ambulate. Neighbors may have diagnoses of dementia or other cognitive impairment. These same neighbors may exhibit behaviors which place them or others at risk. Neighbors who are not able to verbalize needs may be at increased risk for abuse/neglect. 'Abuse': The willful infliction of injury, . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. In includes verbal abuse . physical abuse, and mental abuse . (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult; (2) use of repeated or malicious oral, written, 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 #24's medical record occurred on all days of survey. The record identified diagnoses of psychotic disorder, schizoaffective disorder, major depressive disorder, and Alzheimer's disease. The current care plan stated, I am susceptible to abuse related to cognitive impairment due to Alzheimer's, dementia, and psychosis and physical impairment due to obesity and gout. I have a hx [history] of verbal and physical aggression. Report and investigate suspected abuse cases in accordance with facility policies and procedures . If I become violent or physically aggressive the facility shall implement interventions to minimize risk to self, others within the facility, or visitors and community members as appropriate . (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #24's progress notes identified the following: * 06/13/24 at 10:16 a.m., at 8pm last night, [Resident #24] was at [Resident #3's room], [Resident #24] started kicking him and punch [sic] him like 3-4 times while he was checking the O2 [oxygen] tubing that was tangled at [Resident #24's] wheelchair. [Resident #3] then held her hand and told her to go, by the time CNA [certified nursing assistant] seen her in his room and moved her back to her apartment. no injury noted, nor neighbor reported any pain, although she has known dementia case [sic] and cannot recall what happened last night. neighbor to neighbor incident documentation done . * 06/17/24 at 10:30 a.m., IDT [interdisciplinary team] met to review neighbor to neighbor incident that was documented on 6/13/24. [Resident #3] was trying to help [Resident #24] out by untangling his oxygen tubing from her w/c [wheelchair]. [Resident #24] mistook the other neighbor's actions and was physically aggressive with him. His response was appropriate and did not cause any harm to [Resident #24]. Will educate neighbor to call for staff assistance to remove other neighbors from his room to avoid future conflict. Review of the facility's investigation documents identified the facility notified the POAs for each resident involved and completed 15-minute safety checks for 24 hours for each resident. -Review of Resident #31's medical record occurred on July 23, 2024. Diagnoses included bipolar disorder, current episode manic severe with psychotic features, primary insomnia, and other drug induced secondary parkinsonism. The current care plan stated, I am susceptible to abuse related to my mental health disorders. Report and investigate suspected abuse cases in accordance with facility policies and procedures; I will not commit abuse to other vulnerable adults. If I become violent or physically aggressive the facility shall implement interventions to minimize risk to self, others within the facility, or visitors and community members as appropriate. Review of Resident #31's progress notes identified the following: * 06/08/24 at 3:02 p.m., At 1:30pm, one neighbor reported to CNA that somebody slapped him, this morning the same CNA overheard a conversation of [Resident #31] that she slapped him telling at [sic] story to [another resident] about it. When [Resident #31] confronted about it, then she admitted that this was [sic] happened this morning around 6-6:30 am. She verbalized that [Resident #51] was all over her face following her from nook to chapel and she was annoyed and suddenly slapped him, cannot remember if once or 2 times. She verbalized she just got up and didn't sleep well, then upon realizing what happened, she then started avoiding him. * 06/10/24 at 11:06 a.m.,IDT [interdisciplinary team] to review neighbor to neighbor incident that occurred on 6/8/24 at approximately 6:30am. [Resident #31] did verbalize that she slapped another neighbor as he was following her around and she became irritated. This is not in [Resident #31's] baseline behavior and due to her current manic state she is having difficulty controlling her impulses. [Resident #31] was seen on rounds on 6/7/24 for her mania and was prescribed Lyrica [medication to treat nerve pain] as she complained to the provider of pain at that time. [Resident #31's] sister/POA [name] has advised IDT that the only way to get [Resident #31] out of this mania state is for her to sleep. All facility policies and procedures were followed including both neighbors being on 15 minute checks and all proper notifications were made. [Resident #31] has not exhibited any further instances of aggression towards staff or other neighbors since the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident #51's medical record occurred on all day of survey. The care plan stated Problem. Behavior: I may show fluctuations in behavior r/t [related to] Korsakoff's syndrome [brain changes due to prolonged alcohol consumption]. I explore my environment frequently. I enjoy moving things around within my environment. At times you may hear me talking to myself. I have been verbally and physically aggressive with staff. I become agitated when unable to locate my 'stuff' or my room. I have been involved in neighbor to neighbor incidents. I have made sexual comments to staff. Approach . If I am following other neighbors around and they don't like it, redirect me to another area. You may trial aromatherapy with me during times of restlessness, agitation, or tearfulness. Resident #51's nursing progress notes identified the following: * 06/08/24 at 2:47 p.m., at 1:30 pm, neighbor reported to CNA that some lady slapped him. Early that morning the CNA overheard a conversation of [Resident #31] that she slapped 'him' telling a story to [another resident] about it. when [Resident #31] were interviewed, she admitted that this happened this morning around 6-6:30 am. She verbalized that room [Resident #51] was all over her face following her from nook to chapel and she was annoyed and suddenly slapped him, cannot remember if once or 2 times. she verbalized she just got up and didn't [sic] sleep well, then upon realizing what happened, she then started avoiding him. this incident was unwitnessed. [Resident #51] was then interviewed and assessed for any injury and said the same thing that some lady slapped him, although he denies pain. no redness on face. * 06/10/24 at 11:11 a.m., IDT met to review neighbor to neighbor incident that occurred on 6/8/2024 at approximately 6:30am. Another neighbor did verbalize that she slapped [Resident #51] as he was following her around and she became irritated. Due to [Resident #51's] cognitive impairment he does follow other people around at times if not redirected. Staff will be educated that if he is following a neighbor around and they do not want him to, staff should redirect [Resident #51] to a different area. All facility policies and procedures were followed including both neighbors being on 15 minute checks and all proper notifications were made. The other neighbor has not exhibited any further instances of aggression towards staff or other neighbors since the incident. [Resident #51] has not exhibited any ill effects from the incident and his mood has been intact since. Will continue with current plan of care. * 06/22/24 at 3:36 p.m. Neighbor [Resident #51] was reported by the homemaker in Sunflower area that he hit neighbor [Resident #36], while the neighbor [Resident #36] is walking down the hallway at 2:25pm he hit him in [sic] the top of the head and cussed him. Neighbor came back to the homemaker and apologized. Aroma therapy given and monitored. After 15min, neighbor was seen in good mood and greeting other neighbors. [Resident #51 power of attorney (POA)] informed thru phone. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* 06/24/24 at 9:45 a.m. IDT met to review neighbor-to-neighbor incident that occurred on 6/22/24 and behavior documented on 6/23/24. The neighbor to neighbor incident was not witnessed but was reported by the other neighbor involved. Although that neighbor also has cognitive impairment, it is within his cognitive ability to reliably report the incident. Staff reactions were appropriate to neighbor to neighbor incident. All notifications were made per facility policy. Nursing appropriately conducted necessary assessments. 15-minute checks were implemented and completed per facility policy as well. [Resident #51] has been showing increased anxiety and aggression in the afternoons. Staff reaction and interaction can exacerbate these symptoms at times. Many of these times it is difficult to determine a trigger. Food, fluids, and aromatherapy have been trialed with some effectiveness. It is also known that he does not sleep for long amounts of time and does not nap during the day. IDT recommends that [Resident #51] be seen by [Psychiatrist's name] on psych rounds on 6/25/24 as previously scheduled. Staff training and education also recommended on how to approach [Resident #51] when he is showing s/s [signs/symptoms] of anxiety and how to de-escalate the situation when he is seeming aggressive. * 07/15/24 at 8:00 p.m. [Recorded as Late Entry on 07/16/2024 12:34 AM] [Resident #51] had gotten upset about something said to him by a male neighbor. He was moved away from that neighbor. A female neighbor [Resident #11] was mad and put her fists up towards [Resident #51's] face. This triggered [Resident #51] to slap her across the left side of her face. Neighbors were again moved away from each other. CNA was able to redirect [Resident #51] to another area. [Resident #51's POA] was notified of the event. Told her that we would be doing 15-minute checks on him for the next 24 hours. She is worried that we are changing his meds to fast. Explained that we work with [Psychiatrist's name] and he does the actual med changes. She seem [sic] alright with this. * 07/16/24 at 5:55 p.m. IDT met to review neighbor-to-neighbor that occurred on 7/15/24. [Resident #51] had gotten upset about something said to him by a male neighbor. He was moved away from that neighbor. CNA was able to redirect [Resident #51] to another area. [Resident #51's POA] was notified of the event. Told her that we would be doing 15-minute checks on him for the next 24 hours. She is worried that we are changing his meds to fast. Explained that we work with [Psychiatrist's name] and he does the actual med changes. She seem alright with this. All community policies were followed and all notifications made per policy as well. [Resident #51] does not recall the situation and has not displayed any adverse effects from the incident. [Resident #51] has had multiple med changes since admission. Group staff education completed as well as 1:1 [one to one] staff education specific to redirecting and interacting with [Resident #51] throughout the day and during times of agitation. IDT has been unable to determine triggers and/or patterns as to the behaviors. Care conference will be held with [POA] to discuss appropriateness of placement. During an interview, on 07/23/24 at 11:45 a.m. an administrative staff member (#1) identified she provided education to the staff on interventions/tools for Resident #51 to prevent resident and/or staff harm. The facility failed to identify the above incidents as physical abuse. Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented corrective actions. * The IDT met after each incident to problem solve and implement changes * Policies were reviewed to make sure they were followed (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Providers and resident representatives were notified * Group staff education was completed as well as 1 to 1 staff education specific to redirecting and interacting with residents' with behaviors 46259

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46259 Based on record review, review of facility policy, and staff interview the facility failed to report incidents of resident-to-resident abuse to the State Survey Agency (SSA) for 2 of 3 sampled residents (Resident #24 and #51) and 1 supplemental resident (Resident #31). Failure to report resident-to-resident abuse allegations and the results of the facility's investigation to the SSA placed all residents at risk for possible abuse. Findings include: Review of the facility policy titled, Abuse Prevention Plan occurred on 07/24/24. This undated policy stated, . All events will be investigated whether they cause injury or harm or no injury or harm. Events may include, but are not limited to, . resident to resident altercations [a resident to resident altercation is an incident involving a resident who willfully inflicts injury upon another resident. 'Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm], . If the event that caused suspicion involves abuse or results in serious bodily injury, the individual is to report the suspicion to the state immediately, but not later than 2 hours after forming the suspicion. If the event does not involve abuse and does not result in bodily injury, the individual is required to report to the state no later than 24 hours after forming the suspicion. - Review of Resident #24's medical record occurred on all days of survey. Diagnoses included psychotic disorder, schizoaffective disorder, major depressive disorder, and Alzheimer's disease. A progress note dated 06/13/24 at 10:16 a.m., stated, at 8pm last night, neighbor [Resident #24] was at [another resident] room, she started kicking him and punch him like 3-4 times while he was checking the O2 [oxygen] tubing that was tangled at [Resident #24's] wheelchair. [The other resident] then held her hand and told her to go, by the time CNA [certified nurse aide] seen her in his room and moved her back to her apartment. no injury noted, nor [sic] neighbor reported any pain, although she has known dementia [sic] and cannot recall what happened last night. neighbor to neighbor incident documentation done, POA [Power of Attorney] was notified. -Review of Resident #31's medical record occurred on 07/23/24. Diagnoses included bipolar disorder, current episode manic severe with psychotic features, primary insomnia, and other drug induced secondary parkinsonism. A progress note dated 06/08/24 at 3:02 p.m., stated, At 1:30pm, one neighbor reported to CNA that somebody slapped him, this morning the same CNA overheard a conversation of [Resident #31] that she slapped him telling at story to [another resident] about it. When [Resident #31] confronted about it, then she admitted that this [sic] happened this morning around 6-6:30 am. She verbalized that [Resident #51] was all over her face following her from nook to chapel and she was annoyed and suddenly slapped him, cannot remember if once or 2 times. She verbalized she just got up and didn't sleep well, then upon realizing what happened, she then started avoiding him. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review of Resident #51's medical record occurred on all days of survey. The MDS, dated [DATE], showed Resident #51 unable to complete the BIMS interview. The care plan stated Problem. Behavior: I may show fluctuations in behavior r/t [related to] Korsakoff's syndrome [brain changes due to prolonged alcohol consumption] . Resident #51's progress notes showed the following: * 06/22/24 at 3:36 p.m. Neighbor was reported by the homemaker in Sunflower area that he hit [another resident], while the [Resident #51] is walking down the hallway at 2:25pm he hit him in [sic] the top of the head and cussed him. * 07/15/24 at 8:00 p.m. [Recorded as Late Entry on 07/16/2024 12:34 AM] [Resident #51] had gotten upset about something said to him by a male neighbor. He was moved away from that neighbor. A female neighbor was mad and put her fists up towards [Resident #51's] face. This triggered [Resident #51] to slap her across the left side of her face. Neighbors were again moved away from each other. CNA was able to redirect [Resident #51] to another area. The facility lacked evidence the above incidents were reported to the administrator and the SSA. During an interview on 07/23/24 at 11:45 a.m., an administrative staff member (#1) confirmed the resident-to-resident incidents had not been reported to the SSA. 13101

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40489 Based on observation, record review, review of manufacturer's instructions for use, and staff interview the facility failed to ensure staff followed standards of practice for 3 of 4 residents (Resident #6, #23, and #40) observed during administration of rapid acting insulin. Failure to administer rapid acting insulin within the time specified by the manufacturer may result in a hypoglycemic (low blood sugar) reaction. Findings include: Prescribing information for Humalog insulin (a raid acting insulin), found at https://www.humalog.com, occurred on 07/24/24 and stated, Administer HUMALOG . within 15 minutes before a meal or immediately after a meal. Important safety information for NovoLog (a rapid acting insulin), found at novolog.com, occurred on 07/24/24 and stated, Novolog starts acting fast. Eat a meal within 5 to 10 minutes after taking it. - Review of Resident #6's medical record occurred on all days of survey. Current physician's order included, Novolog insulin; 20 units with meals three times a day. Observations on 07/22/24 showed the following: * 3:38 p.m., a nurse (#2) prepared and administered 20 units of Novolog insulin to Resident #6. *4:50 p.m., Resident #6 received the evening meal. (One hour and 12 minutes after receiving a rapid acting insulin) - Review of Resident #23's medical record occurred on all days of survey. Current physician's order included, Humalog insulin; give 8 units three times a day and sliding scale insulin based on the resident's blood glucose level. Observations on 07/22/24 showed the following: * 4:04 p.m., a nurse (#2) prepared and administered 20 units of Humalog insulin to Resident #23. *4:33 p.m., Resident #23 received the evening meal. (29 minutes after receiving a rapid acting insulin) - Review of Resident #40's medical record occurred on 07/24/24. Current physician's order included, Novolog insulin; 2 units and sliding scale insulin based on the resident's blood glucose level. Observations on 07/23/24 showed the following: * 8:43 a.m., a nurse (#3) prepared and administered 2 units of Novolog insulin to Resident #40. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 9:11 a.m., Resident #40 received the morning meal. (28 minutes after receiving a rapid acting insulin) The facility failed to follow prescribing instructions for fast-acting insulin related to timing and meals for Resident #6, #23, and #40. During an interview on 07/24/24 at 10:40 a.m., an administrative nurse (#5) confirmed she expected staff to follow the manufacture's guidelines for administering rapid acting insulin

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40489 Based on observation, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 4 residents (Resident #20 and Resident #40) observed during medication administration. Four medication errors occurred during staff administration of 32 medications, resulting in a 12.5 percent error rate. Failure to properly prepare medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the prescribing information for NovoLog insulin, found at www.novo-pi.com/novolog.pdf, occurred on 07/24/24, and stated, Instructions for use . C. Pull off the big outer needle cap . E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to zero. - Observation of medication administration on 07/23/24 at 8:43 a.m. showed a nurse (#3) prepared a Lantus (long-acting) insulin pen and a Novolog (rapid-acting) insulin pen for Resident #40. The nurse attached a needle and with the cap on, dialed each pen to two units to prime the insulin pen. The nurse (#3) failed to remove the cap prior to priming the insulin pen. - Observation of medication administration on 07/23/24 at 9:00 a.m. showed a nurse (#4) prepared a Lantus (long-acting) insulin pen and a Novolog (rapid-acting) insulin pen for Resident #20. The nurse attached a needle, removed the cap, dialed each pen to two units, and held each pen pointed down to prime the insulin pen. The nurse (#4) failed to prime the insulin pen with the needle pointing upward. During an interview on 07/24/24 at 10:40 a.m., an administrative nurse (#5) stated she expects staff to prime the insulin pens with the cap off and with the needle pointing upwards.