STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Crest Manor	100 Elm Ave, #396 New Salem, ND 58563

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 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. 37620 Based on review of the facility reported incident (FRI) and family and staff interviews, the facility failed to ensure alleged violations involving neglect were reported timely to the State Agency (SA) for 1 of 1 sampled resident (Resident #1). Failure to report an elopement in a timely manner placed all residents at risk for neglect and/or elopement. Findings include: Review of the FRI identified Resident #1 eloped from the facility on 01/27/25. The facility failed to report the elopement to the SA until 04/09/25. The facility could not identify how or when the resident left the building. During an interview on 04/14/25 at 5:00 p.m., Resident #1's family member stated the facility contacted her and stated a member of the community found the resident in the town gym about one block from the facility and returned her to the facility. During an interview on 04/14/25 at 5:30 p.m., two administrative staff members (#1 and #2) stated the elopement actually occurred on 02/01/25, and confirmed the facility failed to report the elopement to the SA in a timely manner.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37620 Based on review of the facility report incident (FRI), record review, and family and staff interview, the facility failed to thoroughly investigate an elopement for 1 of 1 sampled resident (Resident #1). Failure to thoroughly investigate an elopement to determine causative factors may limit the facility's ability to put appropriate interventions in place to prevent further elopement episodes. Findings include: Review of the FRI, received by the SA on 04/09/25, indicated Resident #1 eloped from the facility on 01/27/25. Review of Resident #'1's medical record occurred on 04/14/25. A nurses' note dated 02/01/25 at 2:55 p.m., stated the following: * Res. [resident] confusion regarding leaving elm crest and applying a code alert for her safety. Code alert applied to right ankle. The facility could not identify when the resident left the building but stated the elopement occurred on 02/01/25, not 01/27/25, but the medical record showed to staff charting charting between 1:40 p.m. and 2:44 p.m. (over 1 hour). During an interview on 04/14/25 at 5:00 p.m., Resident #1's family member stated the facility contacted her and told her a member of the community found the resident in the town gym about one block away from the facility and returned her to the facility. The facility failed to thoroughly investigate/determine the causative factors of Resident #1's elopement which placed Resident #1 at risk for elopements and limited the facility's ability to put interventions in place.