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	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

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46477 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. 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. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	* An education packet will be put in the employee newsletter for reference. * 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, 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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, 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.