STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	107 12TH ST S , COOPERSTOWN, North Dakota, 58425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 08/04/25 and concluded 08/06/25.	F0000		08/27/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F0641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The MDS Coordinator will review Resident #4's medical record and annual MDS dated 07/08/2025. The MDS Coordinator will mark "transcription error" and code H0100A, indwelling catheter to reflect the medical record and re-submit the MDS to the State Department. The MDS Coordinator will review Resident #33's medical record and the significant change MDS dated 07/18/2025. The MDS Coordinator will mark "transcription error" and code K03000 as code 1, no significant weight loss and resubmit the MDS to the State Department. The MDS Coordinator will review Resident #26's medical record and the quarterly MDS dated 07/08/2025. The MDS Coordinator will code PEG tube with water flushes and resubmit the MDS to the State Department. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. A 100% audit of the most recently completed Minimum Data Set assessments for all residents who currently have a Foley Catheter, Significant Change, or PEG tube will be completed in order to ensure that there were no coding errors. Any coding errors that are identified during this audit will be corrected immediately. This audit will be conducted by the Minimum Data Set nurse and will be completed no later than 09/09/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient	09/09/2025

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 reverse for further 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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F0641 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 13 sampled residents (Resident #4, #26, and #33). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan, and the care provided to the residents. Findings include: SECTION H: BOWEL AND BLADDER The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2024, pages H-1 and H-2, stated, ". . . H0100: Appliances . . . Coding Instructions Check next to each appliance that was used at any time in the past 7 days . . . H0100A, indwelling catheter . . ." Observations on all days of survey showed Resident #4 with a foley catheter. Review of Resident #4's medical record occurred on all days of survey. The annual MDS, dated 07/08/25, identified facility staff failed to code H0100A, indwelling catheter. SECTION K: SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI User's Manual, revised October 2024, page K-4 stated, ". . . K0300: Weight Loss. Loss of 5% or more in the last month or loss of 10% or more in last 6 months. “0”, [for] No or unknown. . . . “2”, [for] Yes, [and] not on physician-prescribed weight-loss regimen . . ." Page K-10 stated, ". . . Nutritional Approaches . . . Check all the following nutritional approaches that apply. . . . B. feeding tube (e.g., nasogastric or abdominal (PEG) [percutaneous endoscopic gastrostomy]) . . ." -Review of Resident #33's medical record occurred on all days of survey. The significant change MDS, dated 07/18/25, showed staff coded K0300 as Code 2, yes, not on physician-prescribed weight-loss. The medical record lacked documentation Resident #33 lost weight.	F0641	Continued from page 1 practice will not recur: The facility will accurately reflect resident assessment on the MDS. The facility will ensure that section H (bowel and bladder) and section K (nutrition) will be accurately coded on the MDS. The process failure occurred for section H and one area of section K due to staff pushing the wrong button on the computer and a technical issue with the computer which has been resolved. On 08/06/2025 the MDS Coordinator was re-educated on Section K of the MDS assessment related to nutrition, PEG tubes, and proper coding for this section. On 8/7/2025 the MDS Coordinator was re-educated on Section H of the MDS assessment related to indwelling catheters. How the corrective action(s) will be monitored to ensure the practice will not recur: The nursing management team including the Quality Assurance Nurse and Director of Nursing will review the whole MDS Assessment for every MDS Assessment completed by the MDS coordinator to ensure accuracy each week for twelve (12) consecutive weeks to ensure the plan of correction is effective and remains in compliance with the regulatory requirements. The Quality Assurance Nurse and Director of Nursing will then perform a random audit on the whole MDS Assessment monthly for three (3) months and then as determined by the Quality Assurance Committee. Results of audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 09/09/2025	

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F0641 SS = D	Continued from page 2 -Review of Resident #26's medical record occurred on all days of survey. A physician order, dated 04/09/2025, stated, ". . . Enteral Feeding: Peg - Tube . . . " The quarterly MDS, dated 07/08/25, failed to identify a PEG tube. During an interview on 08/05/25 at 2:18 p.m., an administrative staff member (#2) confirmed the facility failed to code the MDSs accurately.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #2) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed mental illness may result in the delivery of care and services that are inconsistent with the resident's needs. Findings include: The North Dakota PASARR Provider Manual, revised December 2020, page 13, stated, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact [the contracted agency] to update the Level I screen for	F0644	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Social Worker in coordination with the Director of Nursing will complete a PASARR Level II screening on resident #2. The Social Worker and the Director of Nursing will implement any new interventions for resident's mental health diagnosis of psychotic disorder with delusions and will update the resident's care plan to address any new needs identified by the PASARR assessment. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all resident's with mental health diagnosis will be completed to ensure PASARR assessments were completed. Any errors that are identified during this audit will be corrected immediately. This audit will be conducted by the Social Worker and Director of Nursing and will be completed no later than 09/09/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility will ensure that PASARR assessments are completed on all new admits as well as any resident with a new psychiatric diagnosis or intellectual disability. The facility will implement a PASARR policy to include specific, mandatory steps for cross-referencing all diagnoses with PASARR requirements at intake and upon any significant change in a resident's condition.	09/09/2025

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F0644 SS = D	Continued from page 3 determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC [mental illness, intellectual disability, and conditions related to intellectual disability referred to in regulatory language as related conditions or RC] was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ."Review of Resident #2's medical record occurred on all days of survey and identified a PASARR completed on 08/03/23. A provider progress note, dated 02/12/24, stated, ". . . Psychotic disorder with delusions . . . The patient endorses a history of fixed false thoughts with disruptive behavior, not insightful when redirected by staff or reoriented by staff . . . Her psychotropic medications will be adjusted today. . . . Discussed new diagnosis . . . psychotic disorder with delusions . . . increase quetiapine [an antipsychotic medication] . . . for psychosis . . ." The record lacked evidence facility staff completed a PASARR related to the new diagnosis of psychotic disorder with delusions. During an interview on 08/06/25 at 3:00 p.m., an administrative nurse (#1) confirmed the facility failed to complete a change in status Level 1 screen for Resident #2.	F0644	Continued from page 3 On 08/06/2025 the Social worker was educated and the Director of Nursing was re-educated on PASARR assessments including identifying diagnoses that trigger a PASARR Level II review, the process for coordinating assessments with the state mental health/ID authority, required documentation and reporting procedures. Both the Social Worker and Director of Nursing were given a copy of CMS form 20090 (Preadmission Screening and Resident Review Critical Element Pathway). How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing will perform a monthly audit on all new admissions and significant change assessments for three (3) consecutive months to ensure the new PASARR policy is being followed correctly in coordination with the regulatory requirements. The Director of Nursing will then perform a random audit on PASARR assessments completed monthly for three (3) months and then as determined by the Quality Assurance Committee. Results of audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. A master log will be created and maintained to track the PASARR status of all residents with MD or ID. The log will be reviewed weekly by the interdisciplinary team. Corrective action completion date: 09/09/2025	