STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	**15 1ST ST NE PO BOX 669, DUNSEITH, North Dakota, 58329**

(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 An unannounced on-site complaint investigation survey was completed on December 23, 2025. During the complaint investigation the facility was found noncompliant with regulatory requirements.	F0000		01/28/0202
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility reported incident s(FRI), review of facility policy, and staff interviews, the facility failed to ensure residents remained free from abuse for 2 of 2 sampled residents (Resident #1 and #6) intimidated and yelled at by staff members (Resident #6) and verbal outbursts/physical behaviors towards other residents (Resident #1). Failure to protect residents from abuse resulted in physical, verbal, and mental abuse, pain and has to potential to affect all residents. Findings include: Review of the facility's policy titled "Abuse, Neglect, and Exploitation" occurred on 12/22/25. This policy,	F0600	1. Nursing staff received formal re-education through in-service training and were provided with the updated Abuse, Neglect, and Exploitation Policy on 12/11/2025, with additional re-education initiated on 01/28/2026 to reinforce compliance expectations. Staff additionally educated on the Dunseith Community Nursing Home Personnel Polices stating "Personal Appearance of Employees dress code guidelines" page 24, under finishing touches, b. fingernails will be kept clean, trimmed, and acceptable length, c. no artificial nails are allowed in residents care areas. Resident #6's care plan was reviewed and updated to reflect individualized interventions and will be implemented consistently by staff. Staff will encourage participation in meals and activities without coercion, allow adequate time for care provision, utilize alternative staff when refusals occur, and offer secondary meal or snack options as appropriate. To ensure resident safety and immediate corrective action, the two staff members involved were suspended, with termination finalized on 12/29/2025. The social services designee conducted follow-up with Resident #6 to validate safety, provide support, and confirm resident well-being. 2. Dunseith Community Nursing Home has determined that all residents have the potential to be affected by the identified deficient practice. 3. The facility's Abuse, Neglect, and Exploitation Policy was comprehensively reviewed, and all relevant staff were re-educated to ensure alignment with federal and state reporting requirements. Staff were also provided the North Dakota Health & Human Services memorandum for Long-Term Care Facilities and Hospital Swing Bed Facilities issued by Bridget Weider, addressing the reporting of allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property. Dunseith Community Nursing Home Policies were also comprehensively reviewed and all	02/09/2026

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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F0600 SS = G	Continued from page 1 revised 07/01/24, stated, ""... Abuse ... the willful infliction of injury ... intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and ... resident to resident altercations. ... 'Mental Abuse' includes, but is not limited to ... humiliation, harassment, threats of punishment or deprivation. ... 'Physical Abuse' includes, but is not limited to hitting, slapping, punching ... 'Verbal Abuse' means the use of oral ... or gestured that willfully includes disparaging and derogatory terms to residents ... regardless of their age, ability to comprehend, or disability. ..." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anxiety, conduct disorder, and depression. Medications included Sertraline daily for depression. The quarterly Minimum Data Set (MDS), dated 10/15/25, identified moderate cognitive impairments and delusions. The current care plan stated, "... Provide quiet, non-hurried environment, free of background noises and distractions. ... Staff will ... redirect resident for any disruptive behaviors. ... Resident needs extensive assistance for toileting, R/T [related to] frequent episodes of incontinence. ... Resident is at risk for falls related to poor safety skills and with the use of a standard walker. ... Staff to assist resident with all cares ... Assist x [times] 1 with personal hygiene, toileting, and dressing ... transfer with assist of 2 with gait belt and FWW [front wheeled walker] ..." The initial FRI report, dated 12/10/25 at 5:43 p.m., stated, "... Several CNAs [certified nurse aides] were involved in an incident with resident [Resident #6] during attempts to get her up for supper. Staff consistently reported that [Resident #6's] bed was wet, she was distressed, yelling, and at times refusing to get up or cooperate. Multiple CNAs ... were in and out of the room. During attempts to move [Resident #6], she ended up naked on the bathroom floor. Conflicting accounts were given about how she got to the floor, though several reported she refused to stand or get herself up. A gait belt was applied directly to her bare skin, and staff lift [sic] her with it at least once. Several CNAs ... were reported to have hollered at [Resident #6], pointing in her face, and insisted that she apologize, [another CNA] entered later, found [Resident #6] crying on the floor, and noted scratches	F0600	Continued from page 1 nursing staff will be re-educated on Personal appearance if employees. #4 DON will conduct an audit on social service director/ designee to have weekly visits with resident #6 and will conduct two random samples monthly for the remainder of the year regarding safety. Audit will be labeled as "DON Progress Note Review & Safety Documentation Audit Form". This audit will be conducted over a consecutive four-week period with different times and day of the week on resident #6. The remaining monthly audits will be random residents and times each month for the remainder of the year or until 100% compliance. DON will review the chart to verify that there was completion of weekly and monthly safety visits. DON will complete the same process for all other monthly samples. DON will provide a written summary of audit results upon completion of the four-week review period and monthly for the random samples for the remainder of the year or until 100% compliance is reached. Infection preventionists will conduct audits for the next four weeks to interview two staff members per week, one nurse, and one CNA, on the knowledge of identifying abuse and properly reporting until 100% compliance is reached. QA results and progress will be discussed/reviewed at monthly meetings. #5 Completion Date: All corrective actions will be fully implemented by: 02/09/2026.	

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F0600 SS = G	Continued from page 2 on [Resident #6's] left arm. No staff could provide a clear explanation for the scratches. [The last CNA to enter the room] refused to leave [Resident #6] on the floor and ultimately calmed, cleaned, dressed, and brought her to supper. Charge Nurse . . . reported she was only told that [Resident #6] had a behavior and that the gait belt was used. She was not informed about [sic] yelling, the resident being on the floor naked, the number of staff involved, or any injuries. Overall, staff consistently note yelling towards the resident, difficulty during transfer, [Resident #6's] distress and that the full details were not reported to the charge nurse at the time. . . ." The final FRI investigation, received from the facility on 12/12/25, stated CNA (#5 and #6) removed and suspended. A Behavior/Mood Event report, dated 12/04/25 5:28 p.m., stated, ". . . resident was yelling and refusing to get up and changed before supper. Three aides were needed in order to get her to cooperate. Gait belt was needed in order to get her toileted . . . Client did apologize to staff after . . . No further concerns at this time. . . . [No] injuries noted. . . ." During an interview on 12/21/25 at 2:10 p.m., when asked about the incident on 12/04/25, a CNA (#3) reported hearing Resident #6 "screaming from across the hall." When she entered Resident #6's room, she saw her "naked on the bathroom floor." She indicated Resident #6 was "crying and looked scared," while CNA (#6) "was in her face, screaming 'Get up. Get up and apologize. Apologize right now.'" The CNA (#3) also reported seeing "three large, fresh scratches" on the resident's upper arm and noticed CNA (#6) was not wearing gloves and had "really long nails." Two of the CNAs (#5 and #6) denied scratching her, blaming the injury on her gait belt. The CNA (#6) told the others to "Leave her. She can get up on her own. We need to feed the others." The CNA (#3) stayed with the resident, helped her get dressed, and assisted her to the dining room. During this time, Resident #6 alleged CNA (#5) threatened to withhold her snack, because she "wasn't listening to them." The CNA (#3) admitted she reported her observations/concerns to the Director of Nursing a few days after the incident. During an interview on 12/22/25 at 10:47 a.m., when asked about the incident on 12/04/25, a CNA (#4)	F0600		

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F0600 SS = G	Continued from page 3 described Resident #6's clothing and bedding as soiled with urine and indicated the resident was able to walk "pretty good" with a walker. The CNA (#4) revealed she and another CNA (#5) assisted Resident #6 into the bathroom without utilizing a gait belt, assisted her to sit on the toilet, and removed her soiled clothing. The CNA (#4) stated, "When we tried to put on her new clothes, she was uncooperative. I was trying to get her to stand up, so I offered her peanuts." The CNA (#5) told the resident she "couldn't have any peanuts, cereal, or pop, because she wasn't cooperating." She then told CNA (#4) to find CNA (#6) to assist them. The CNA (#4) reported Resident #6 continued to resist cares and began screaming. She described CNA (#6) as "pretty frustrated" and "talking loudly," loud enough for CNA (#3) to "hear the commotion in the hall and enter the room." The CNA (#4) was unable to explain how the resident ended up on the floor. Then CNA (#3) pointed out fresh scratches on Resident #6's arm. The CNA (#4) confirmed, "They weren't there before." She indicated the CNA (#6) "wasn't wearing any gloves" and "had acrylic nails." The CNA (#4) stated, "I've never seen [Resident #6] like that before." During an interview on 12/22/25 at 4:10 p.m., when asked about the incident on 12/04/25, an administrative nurse (#1) stated staff told her the resident "sat herself on the floor." The administrative nurse (#1) did not observe the scratches to Resident #6's arm as staff failed to report the incident in a timely manner. The administrative nurse (#1) stated it is not acceptable for staff to holler at or threaten a resident or get in a resident's personal space or place a gait belt around bare skin. The administrative nurse (#1) expected staff to redirect residents who have behaviors, allow them a few minutes to calm down and reapproach, and/or have another staff member work the resident. The facility failed to protect Resident #6 from mental, verbal, and physical abuse and failed to report the abuse in a timely manner. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia with agitation. The Admission Minimum Data Set (MDS), dated 10/15/25, identified behaviors directed towards others that significantly disrupts care or living environment. The current care plan stated, ". . . [Resident #1] at risk for agitation related to dementia . . . Staff will redirect resident when he becomes agitated."	F0600		

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F0600 SS = G	Continued from page 4 The FRI, dated 12/11/25, stated, ". . . DON [director of nursing] heard hollering, she went to hallway to find [Resident #1] and [Resident #2] close to each other with their wheelchairs. Both residents were moving arms to get away from each other. [Resident #1] had [Resident #2]'s right arm and was holding it. DON and CNA [certified nurse aide] were able to separate residents, and [Resident #1] let [Resident #2] arm released [sic]. During the separation, [Resident #1] hit [Resident #2] on the right side of his face with his right fist closed. DON and CNA immediately separated residents. Vital signs take [sic] on both residents. Not sure how it initially started." The FRI, dated 12/22/25, stated, ". . . Resident [#1] was involved in resident-to-resident altercation. Resident [#1] was sitting in the activity room with a few other residents watching television and socializing. During this time, nurse was alerted by loud shouting in the activity room among the residents. CNA and nurse went to assess concerns, staff was [sic] informed by residents present in the activity room [Resident #3] was hit in her mouth by resident's [Resident #1] closed fist. [Resident #3] confirms this occurred. She reports her mouth is sore. Vital signs taken, skin and mouth assessed, there is no indication of broken skin or bruise at this time." During an interview on 12/22/25 at 1:30 p.m., administrative staff members (#1 and #2) reported "[Residents #1, #2 and #3] did not have any injuries following the incidents, care plans for all resident's involved were reviewed and updated, [Resident #1] is closely monitored by all staff, and staff education was completed." The facility failed to protect Resident #2 and #3 from verbal and physical abuse.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the	F0609	1. Nursing staff received formal re-education through in-service training and were provided the updated Abuse, Neglect, and Exploitation Policy on 12/11/2025, with additional re-education initiated on 01/30/2026 to reinforce compliance expectations regarding mandatory reporting requirements. The policy provides comprehensive education on reporting protocols and required timeframes for reporting. Staff were also provided the North Dakota Department of Health & Human Services memorandum for Long-Term Care Facilities and Hospital Swing Bed Facilities, which addresses the reporting of allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident	01/30/2026

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F0609 SS = D	Continued from page 5 allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the facility reported incident (FRI), and staff interview, the facility failed to report an incident of abuse to the administrator and the State Survey Agency (SSA) within the required time frames for 1 of 1 sampled resident (Resident #6) who experienced mental, verbal, and physical abuse from staff. Failure to ensure incidents of abuse are reported immediately, but not later than 2 hours after the allegation is made, may result in continued abuse, fear, anxiety, and psychosocial harm. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anxiety and conduct disorder. The Minimum Data Set (MDS), dated 10/15/25, identified moderate cognitive impairments and delusions. A "Behavior/Mood Event" report, dated 12/04/25 at 5:28 pm., stated, ". . . resident was yelling and refusing to get up and changed before supper. Three aides were needed in order to get her to cooperate. Gait belt was needed in order to get her toileted . . ." Review of the initial FRI, received by the SSA on 12/10/25, stated the following, "Date of allegation: 12/04/2025 . . . Several CNAs [certified nurse aides] were involved in an incident with resident [Resident #6] during attempts to get her up for supper. Staff consistently reported that [Resident #6's] bed was wet, she was distressed, yelling, and at times refusing to	F0609	Continued from page 5 property. 2. Dunseith Community Nursing Home has determined that all residents have the potential to be affected by the identified deficient practice. 3. The current Abuse, Neglect, and Exploitation Policy has been reviewed and reinforced with all staff. All staff members were provided the North Dakota Department of Health & Human Services memorandum regarding the reporting of allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property. 4. The Director of Nursing, Social Services, and/or designee will conduct audits of the next four (4) incident reports utilizing the Incident Reporting and Immediate Staff Response & Protection Audit Tool. Quality Assurance monitoring will continue until 100% compliance is achieved for three consecutive audit cycles. Progress and outcomes of the Plan of Correction will be reviewed and trended through the Quality Assurance and Performance Improvement (QAPI) Committee until sustained substantial compliance is demonstrated. 5. Completion date: All corrective actions will be fully implemented by 1/30/2026.	

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F0609 SS = D	Continued from page 6 get up or cooperate. Multiple CNAs [names of CNAs] were in and out of the room. During attempts to move [Resident #6], she ended up naked on the bathroom floor. Conflicting accounts were given about how she got to the floor, though several reported she refused to stand or get herself up. A gait belt was applied directly to her bare skin, and staff lifted her with it at least once. Several CNAs mainly [two CNA's names] reported to have hollered at [Resident #6], pointing in her face, and insisted that she apologize. [CNA name] entered later, found [Resident #6] crying on the floor, and noted scratches on [Resident #6's] left arm. No staff could provide a clear explanation for the scratches. [CNA name] refused to leave [Resident #6] on the floor and ultimately calmed, cleaned, dressed, and brought her to supper. Charge Nurse [name] reported she was only told that [Resident #6] had a behavior and that a gait belt was used. She was not informed about yelling, the resident being on the floor naked, the number of staff involved, or any injuries. Overall, staff consistently note yelling toward the resident, difficulty during the transfer, [Resident #6's] distress, and that the full details were not reported to the charge nurse at the time. During an interview on 12/22/25 at 4:10 p.m. an administrative nurse (#1) stated facility staff failed to report the incident in a timely manner and it not acceptable for staff to holler at or threaten residents.	F0609		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F0657	F0657 Care plan Timing and Revision 1.The Director of Nursing has updated and reviewed the Comprehensive Care Plan Policy. Nursing staff have been educated on the policy. Care plan meetings are conducted quarterly, annually, and as needed by the interdisciplinary team in accordance with regulatory requirements to ensure resident-centered care planning and timely updates to reflect changes in resident condition. Resident #1's pain management on 1/24/2026 and notified MD regarding update on daily medication administration and to further evaluate resident #1's pain management. MD ordered schedule pain medication to coincide with AM & HS cares. On 12/02/2026 resident had an increase in Seroquel to 100mg PO BID and 150mg at bedtime. On 12/17/2025 residents were re-evaluated by MD and new orders to increase Seroquel to 100mg PO BID and 200mg at bedtime and care plan updated. 2. Dunseith Community Nursing Home has determined that all residents have the potential to be affected by the identified deficient practice.	02/09/2026

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F0657 SS = D	Continued from page 7 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to review and revise care plans to reflect the resident's current status for 1 of 7 sampled residents (Resident #1). Failure to update/revise care plans limited the staff's ability to communicate residents needs and ensure continuity of care. Findings Include: - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included chronic pain and dementia with agitation. The Admission Minimum Data Set (MDS), dated 10/15/25, identified behaviors directed towards others that significantly disrupt care or living environment. Review of Resident #1's progress notes from 10/09/25 to 12/21/25 identified the following: * 21 occasions of pain and/or requested pain medication. * Two occasions of verbal and/or physical aggression with other residents. * 23 occasions of verbal and/or physical aggression with staff. Resident #1's current care plan lacked problems, goals, and interventions addressing pain and verbal/physical aggression towards others. During an interview on 12/22/25 at 1:30 p.m., two	F0657	Continued from page 7 3. Inservice education provided on 01/30/2026 regarding current Comprehensive care plan policy has been updated and reviewed and reinforced with nursing staff. Update to policy consists of Staff shall implement interventions as written and document outcomes, The comprehensive care plan will include measurable objectives and timeframes to meet the resident’s needs as identified in the resident’s comprehensive assessment. 4. The administrator will conduct a random monthly audit for one resident for two consecutive quarters and then one resident for the remaining two quarters, or until 100% compliance is reached. The plan of correction will be reviewed/ monitored at the monthly QA meeting until consistent substantial compliance has been met. 5. Completion Date: All corrective actions will be fully implemented 02/09/2026.	

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F0657 SS = D	Continued from page 8 administrative staff members (#1 and #2) confirmed Resident #1's care plan required updates/revisions.	F0657		