

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355080		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/02/2024	
NAME OF PROVIDER OR SUPPLIER DUNSEITH COM NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 15 1ST ST NE DUNSEITH, ND 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
F 000	INITIAL COMMENTS			F 000			
F 567 SS=C	The Standard Medicare/Medicaid recertification survey started on 04/29/24 and concluded 05/02/24. Protection/Management of Personal Funds CFR(s): 483.10(f)(10)(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of \$100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any			F 567			6/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/23/2024

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.

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F 567	Continued From page 1 of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on review of resident trust account information and staff interview, the facility failed to deposit residents' funds in an interest-bearing account for 2 of 2 resident fund accounts reviewed (Resident #12 and #17). Failure to maintain resident funds in an interest-bearing account does not allow residents to earn interest and receive credit for the interest earned. This practice has the potential to affect all residents who have funds in an account. Findings include: Review of a quarterly statement from the pooled account showed a non-interest-bearing account. During an interview on 05/01/24 at 3:45 p.m., two business office employees (#5 and #6) stated they keep petty cash available for residents on the weekends. The staff members also stated they keep money for each resident in a pooled checking account at the bank. A staff member (#6) showed individual account sheets for Resident's #12 and #17, and stated the money is in a non-interest checking account.	F 567	1.This facility failed to deposit residents' funds in an interest-bearing account for 2 of 2 resident fund accounts reviewed (Resident #12 and #17). Failure to maintain resident funds in an interest-bearing account does not allow residents to earn interest and receive credit for the interest earned. This practice has the potential to affect all residents who have funds in an account. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Resident (#12) and (#17) with interest-bearing account change by Administrator on 05/17/2024. Assistant Director of Nursing (ADON) implemented policy "Resident Personal Funds" and reviewed policy with Business office Manager on 05/22/2024. 4.Administrator will conduct a random audit of seven (7) residents monthly bank statements for four (4) consecutive months until 100% compliance is reached to ensure that all residents have an interest-bearing account. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting		

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F 567	Continued From page 2	F 567			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583	until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. Date: 06/04/2024		6/15/24

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F 583	Continued From page 3 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of facility policy, and resident interview, the facility failed to ensure dignity and provide privacy during personal cares for 2 of 9 sampled residents (Resident #1 and #6) observed during personal cares. Failure to maintain a resident's privacy during cares is a violation of residents' rights and may decrease their quality of life. Findings include: Review of the facility policy titled "Promoting/Maintaining Resident Dignity" occurred on 05/02/24. This policy, dated 09/19/23, stated, "It is the policy of the Dunseith Community Nursing Home (DNCH) to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life . . . Compliance Guidelines . . . Maintain resident privacy and knock before entering resident's rooms. . . ." Observations during resident cares showed the following: * 04/29/24 at 3:33 p.m., during an interview with Resident #6 and the room door closed, a certified nurse aide (CNA) (#8) entered the resident's room without knocking or announcing him/herself. When asked if staff enter his/her room without announcing/knocking on a frequent basis, Resident #6 stated, "They [staff] do that a lot. Everybody just walks into my room."	F 583	1.This facility failed to ensure dignity and provide privacy during personal care for 2 of 9 sampled residents (Resident #1 and #6) observed during personal care. Failure to maintain a resident's privacy during care is a violation of residents' rights and may decrease their quality of life. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.CNA (#8) and (#3) verbally re-educated after exit interview by Director of Nursing (DON) on maintaining resident privacy by knocking on door, announcing him/herself and waiting for acknowledgement before he/she enters resident's room. Director of Nursing (DON) revised the policy Promoting/Maintaining Residents Dignity on 05/22/2024 to give clear, step by step instructions on what staff is required to do before entering a residents room. Inservice education with all licensed staff addressing Dunseith Community Nursing Home policy Promoting/Maintaining Residents Dignity. To be complete on 05/24/2024. The Social Work Designee will talk with residents about resident rights during the resident council meeting on 05/22/2024. 4.DON/ADON/IP educator will conduct a random audit of two (2)nursing department staff (Nurse, CNA, CMA II)		

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F 583	Continued From page 4 The CNA (#8) failed to knock, announce him/herself, and wait for acknowledgment before he/she entered Resident #6's room. * 04/30/24 at 12:55 p.m., two CNAs (#4 and #7) provided cares for Resident #1 while in bed. A CNA (#3) knocked on the resident's room door and entered at the same time during the cares. The CNA (#3) failed to announce him/herself and wait for acknowledgment before he/she entered Resident #1's room. 2. Based on observation and review of a professional reference, the facility failed to promote privacy and confidentiality of the electronic medication administration records (eMAR) on 1 of 1 treatment carts observed. Failure to promote resident privacy and lock computer screens may result in unauthorized viewing of resident records by other residents, visitors, or unlicensed staff. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 234, stated, ". . . ensure the privacy and confidentiality of client information stored in computers. . . . Do not leave client information displayed on the monitor where others may see it. . . ." Observations on 04/29/24, between 4:17 p.m. and 4:50 p.m., showed a staff nurse (#2) left the treatment cart unattended with residents' eMARs	F 583	weekly for four (4) consecutive weeks, then monthly to ensure that staff is providing dignity and providing privacy during personal cares (knocking and waiting for resident to answer before entering room) until compliance has been meet 100% for two (2) consecutive months. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. 5.Date: 1.This facility failed to promote privacy and confidentiality of the electronic medication administration records (eMAR) on 1 of 1 treatment carts observed. Failure to promote resident privacy and lock computer screens may result in unauthorized viewing of resident records by other residents, visitors, or unlicensed staff. Observations on 04/29/24, between 4:17 p.m. and 4:50 p.m., showed a staff nurse (#2) left the treatment cart unattended with residents' eMARs visible on four separate occasions. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Nurse (#2) verbally re-educated after exit interview by Director of Nursing (DON) on locking laptop screen before leaving it unattended to promote privacy		

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F 583	Continued From page 5 visible on four separate occasions. The facility failed to promote privacy and confidentiality of residents' eMARs when unattended by staff.	F 583	and confidentiality of residents personal information. Director of Nursing (DON) implemented policy Safeguarding of Resident Identifiable Information policy is more detailed Computer screens/laptops showing clinical record information need to be locked before being left unattended when readily observable or accessible by other residents or visitors. Inservice education with all licensed staff addressing policy to be complete on 05/24/2024. 4.DON/ADON/IP educator will conduct a random audit on of two (2) nursing department staff (Nurse, CNA, CMA II) weekly for four (4) consecutive weeks, then monthly to ensure that staff is promoting privacy and confidentiality of eMAR until compliance has been meet 100% for two (2) consecutive months. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. 05/23/2024		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584			6/15/24

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F 584	Continued From page 6 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of facility housekeeping logs, and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 1 of 15 sampled residents			F 584	1.This facility failed to ensure a safe, clean, comfortable, and homelike environment for 1 of 15 sampled residents (Resident #1) observed during survey. Failure to maintain a clean,		

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F 584	Continued From page 7 (Resident #1) observed during survey. Failure to maintain a clean, comfortable, and sanitary environment does not provide a homelike living area for residents and fails to promote quality of life. Findings include: Review of the facility policy titled "Routine Cleaning and Disinfection" occurred on 05/02/24. This policy, dated 12/30/23, stated, "It is the policy of the Dunseith Community Nursing Home (DNCH) to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. . . . Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in . . . resident rooms . . . Horizontal surfaces with infrequent hand contact (window sills and hard surface flooring) in routine resident-care areas should be cleaned: a. On a regular basis b. When soiling and spills occur . . . Cleaning of walls, blinds, and curtains will be conducted when visibly soiled. . . ." Observations on 04/29/24 and 04/30/24 in Resident #1's room and bathroom showed the following: * A strong urine odor in the bathroom. The bathroom floor sticky with rust colored substance around the base of the toilet and floor. * A square foam wheelchair cushion located on the floor between two nightstands with visible sticky substance on the cushion and built-up dried debris on the floor around the cushion. * The wall beside the resident's bed with dried food/drink spills in several areas.	F 584	comfortable, and sanitary environment does not provide a homelike living area for residents and fails to promote quality of life. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Resident (#1) interviewed/educated by Director of Nursing (DON) in regard to residents refusals to allow housekeeping/nursing staff to routinely clean/disinfect and remove items that may be considered unsanitary to others. Resident (#1) verbalized understanding and agreed to allow housekeeping to clean/disinfect and remove unsanitary items from his room 1x a week on bath days. Maintenance Director updated Environmental Services Daily Cleaning Checklist to include resident refusals/with reason and charge nurse notification for documentation purposes on 05/22/2024. Inservice education with all staff addressing update to check list for housekeeping and nursing documentation of resident refusals to be completed on 05/24/2024. 4.DON/ADON/IP will conduct a random audit of one (1) housekeeping/maintenance staff weekly for four (4) consecutive weeks, then monthly to ensure that housekeeping/maintenance staff is maintaining a clean, comfortable, and sanitary environment until compliance has been meet 100% for two (2) consecutive months. The plan of correction will be		

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F 584	Continued From page 8 * A second wheelchair cushion with dried drink/food spills on it propped against the wall on top of the square cushion. * A layer of dust on a shelf located on the wall above the head of the resident's bed. * Approximately 10 paper straw wrappers located behind the wheelchair cushion along the wall. * Two empty uncovered water bottles on the floor between the resident's bed and the wall. * The room floor unclean and dirty. Review of the housekeeping logs and Resident #1's medical record lacked evidence the resident refused housekeeping services. During an interview on 04/30/24 at 1:32 p.m., when asked about the wheelchair cushions on the floor in Resident #1's room, two CNAs (#4 and #7) stated the Resident (#1) did not like the cushions from physical therapy, so he threw them on the floor. The CNAs stated the cushions should have been returned to physical therapy. The CNA (#7) attempted to remove the square cushion from the floor, the cushion adhered to the floor with a dried sticky substance and difficult to remove. Loose debris and a sticky dried substance remained in the area where the cushions were removed and under the nightstands. When asked about the overall cleanliness of Resident #1's room, both CNAs agreed the room needed attention.	F 584	reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. 05/23/2024		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641			6/15/24

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F 641	Continued From page 9 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 15 sampled residents (Resident #21 and #27). 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: The Long-Term Care Facility RAI User's Manual, revised October 2023, page K5 stated, ". . . K0300: Weight Loss (cont.) . . . Coding Instructions . . . Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. . . ." Page K-11 stated, "K0520: Nutritional Approaches (cont.) . . . Coding Instructions Check all that apply . . . K0510D, therapeutic diet (e.g., low salt, diabetic, low cholesterol). . . . THERAPEUTIC DIET . . . a diet intervention prescribed by a physician . . ." - Review of Resident #21's medical record occurred on all days of survey. A physician's	F 641	1.The facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 15 sampled residents (Resident #21 and #27). 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. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Resident (#21) Annual MDS 07/24/2023 will be modified to correct code K0510D, therapeutic diet and resubmitted on 05/23/2024. Resident (#27) admission MDS 02/01/2024 will be modified to correct code of unknown and resubmitted on 05/23/2024. MDS Coordinator will review section K on every MDS with the dietary manager and make revisions as needed to reflect and ensure that the dietary information current, correct and code is accurate prior to submission. 4.DON/ADON/IP educator will conduct a random audit of one (1) resident assessment weekly for four (4) consecutive weeks, then monthly to assure that the resident receives an accurate assessment, reflective of the		

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F 641	Continued From page 10 order, dated 04/27/23, stated, ". . . Low potassium diet. . ." An annual MDS, dated 07/24/23, identified the facility failed to code section K0510D as resident receiving a therapeutic diet. During an interview on the afternoon of 05/02/24, a dietary manager (#9) acknowledged Resident #21's low potassium diet since 04/27/23 and the facility failed to accurately code section K0510D on the annual MDS dated 07/24/23. - Review of Resident #27's medical record occurred on all days of survey and included the diagnoses of adult failure to thrive. Review of the resident's weights showed an admission weight of 125 lbs (pounds) on 01/25/24 and a weight of 111.8 lbs on 04/24/24 (a 10% weight loss in three months). The medical record lacked indication/orders the physician prescribed a weight loss regimen. The admission MDS, dated 02/01/24, identified section K0300 coded yes indicating Resident #27 on physician-prescribed weight-loss regimen. During an interview on 05/01/24, a nurse manager (#12) confirmed Resident #27 is not on a physician prescribed weight-loss regimen and the admission MDS was not coded accurately.	F 641	residents status at the time of the assessment until compliance has been meet 100% for two (2) consecutive months. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. 05/23/2024		
F 657 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	F 657			6/15/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2025
FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 11 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. (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 observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans for 3 of 15 sampled residents (Resident #13, #23, and #179). Failure to review and revise the care plan limited staff's ability to communicate needs, ensure continuity of care, and may negatively impact the care provided to residents. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on	F 657	1.This facility failed to review and revise care plans for 3 of 15 sampled residents (Resident #13, #23, and #179). Failure to review and revise the care plan limited staff's ability to communicate needs, ensure continuity of care, and may negatively impact the care provided to residents. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Corrective action after exit interview by		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 12 05/01/24. This policy, dated 10/10/23, stated, "Policy: It is the policy of the Dunseith Community Nursing Home (DCNH) to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights . . . to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. . . . Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs . . . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly assessment. . . ." - Review of Resident #13's medical record occurred on all days of survey. Elopement Assessments completed 10/24/23 and 01/20/24, identified the resident as "At Risk" for elopement. A physician's order, dated 09/13/22, stated, "Wanderguard check TID [three times a day] . . ." Observations on 04/29/24 through 05/01/24 showed a wanderguard on Resident #13's ankle. Resident #13's current care plan lacked a problem, goal, or interventions related to wandering or the use of a wanderguard. - Review of Resident #23's medical record occurred on all days of survey. The nursing progress notes, dated 08/05/23 through 04/29/24, identified the resident wandered around the facility, including into other resident rooms. A provider's note, dated 02/29/24, stated, ". . . Advanced Dementia with history of behavioral issues including aggressive behaviors	F 657	Director of Nursing and Assistant Director of Nursing include, resident (#13) care plan updated to include elopement risk, with a goal, and interventions related to use of wander guard. Resident (#23) care plan updated to include Behavioral symptoms, Cognitive loss/Dementia, with goals and interventions related to wandering into other residents rooms and history of inappropriate behavior. Resident (#179) care plan updated with intervention's related to fall precautions. In-Service education with all licensed nursing staff addressing the Comprehensive Care Plan policy, and education on the importance of an accurate, current care plan, and proper procedure for documentation completed 05/24/2024. 4.DON/IP/ or Designee will conduct a random quality monitoring on one (1) residents care plan weekly for four (4) consecutive weeks, then monthly until compliance has been meet 100% for two (2) consecutive months to ensure that nursing staff is following the policy/procedures related to care planning, updating care plans in a timely manner to ensure continuity of care and positively impact the care provided to the residents by staff. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. Date: 06/04/2024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2025
FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 13 with other residents and sexually inappropriate behaviors. . . ." A provider's note, dated 03/27/24, stated, ". . . Nursing reports . . . decreased inappropriate sexual behaviors . . ." Observations of Resident #23 showed the following: * 04/29/24 at 4:22 p.m., attempted to enter Room #114, another resident's room. * 04/30/24 at 9:28 a.m., attempted to exit the south doors of the building. The doors locked and unable to exit. * 04/30/24 at 1:23 p.m., exited Room #123, another resident's room located in a different hallway. During an interview on 05/01/24 at 10:55 a.m., a certified nurse aide (CNA) (#7) confirmed Resident #23 wanders in and out of other resident rooms. Resident #23's care plan lacked a problem, goal, or interventions related to wandering into resident rooms and a history of sexual behaviors. - Review of Resident #179's medical record occurred on all days of survey. The record identified the resident had a fall resulting in a right elbow fracture prior to admission. A provider order, dated 04/24/24, stated, "Max fall precautions for resident, due to fall risk. . . ." Observations on all days of survey showed Resident #179 with a cast and sling to the right arm and a chair alarm attached to the resident's wheelchair. Resident #179's care plan lacked interventions	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 14 related to fall precautions.	F 657			
F 658 SS=D	During an interview on 05/02/24 at 8:35 a.m., an administrative nurse (#1) stated a resident's care plan should indicate "what they [staff] are supposed to be doing [for resident specific fall precautions]." Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 2 sampled residents (Resident #21) reviewed with orders for specific parameters for weight and blood pressure. Failure to notify the physician of weight gain/loss and low systolic blood pressures as ordered placed the resident at risk for delayed treatment and adverse health events. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, "Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ."	F 658	1.This facility failed to follow professional standards of practice for 1 of 2 sampled residents (Resident #21) reviewed with orders for specific parameters for weight and blood pressure. Failure to notify the physician of weight gain/loss and low systolic blood pressure as ordered placed the resident at risk for delayed treatment and adverse health events. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Director of Nursing (DON) implemented the policy Provision of Physician ordered Services 05/22/2024 to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. Inservice education with all licensed staff on implemented policy and		6/15/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	Continued From page 15 Review of Resident #21's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (progressive breathlessness and cough), chronic bronchitis (inflammation of air passages), hypertension (high blood pressure), renal failure (kidney failure-unable to filter wastes from the body), and anemia (deficiency of red blood cells in the blood). A physician's order, dated 05/25/23, stated, "Call MD [medical doctor] if systolic blood pressure [the top number of a blood pressure reading] is < [less than] 100 [mmHg (millimeters of mercury)]." A physician's order, dated 03/27/24, stated, "Call MD if 4 lb [pounds] weightgain [sic] or decrease fromcurrent [sic] weight." Review of Resident #21's blood pressure results from 05/25/23 through 05/01/24 showed 12 occurrences of the systolic blood pressure below 100 mmHg and four occurrences of the systolic blood pressure below 90 mmHg. Review of Resident #21's weights from 03/27/24 through 04/24/24 showed the following: * 04/17/24: 219.6 lbs (loss of 8 lbs from the prior weight on 04/10/24). * 04/24/2024: 226 lbs (gain of 6.4 lbs from the prior weight on 04/17/24). The record showed the facility failed to notify the physician of the changes in Resident #21's systolic blood pressure readings and weights. During an interview on the afternoon of 05/02/24, an administrative nurse (#1) confirmed the staff failed to notify the provider of the changes in	F 658	notifying the physician when resident is above/below specific parameters as ordered on 05/24/2024 4.DON/ADON/IP educator will conduct quality monitoring on nursing orders and notifying physician when specific parameters are ordered to ensure nursing staff are following professional standards of practice weekly for four (4) consecutive weeks, then monthly until compliance has been meet 100% for two (2) consecutive months. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. 05/23/2024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	Continued From page 16			F 658			
F 690	Resident #21's blood pressures and weights.			F 690			
SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)						6/15/24
	§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.						

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 690	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of a professional reference, and staff interview, the facility failed to provide appropriate treatment and services for 1 of 8 sampled residents (Resident #18) who required staff assistance with toileting. Failure to provide assistance with toileting may result in a loss of dignity and placed residents at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries. Findings include: Review of the facility policy titled "Helping a Resident with Toileting Needs" occurred on 05/01/24. This policy, revised 02/19/24, stated, ". . . Assist resident with toileting or incontinence care every two hours or as needed. . ." Kozier & Erb's "Fundamentals of Nursing: Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, ". . . any accumulation of secretions or excretions is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. . . ." Page 1221 stated, "Managing Urinary Incontinence . . . Habit training, also referred to as timed or prompted voiding and scheduled toileting, attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry . . ." Review of Resident #18's medical record occurred on all days of survey. The care plan	F 690	1.This facility failed to provide appropriate treatment and services for 1 of 8 sampled residents (Resident #18) who required staff assistance with toileting. Failure to provide assistance with toileting may result in a loss of dignity and placed residents at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.CNA (#3) and (#4) verbally re-educated after exit interview by Assistant Director of Nursing (ADON) on importance of assisting with toileting every 2-3 hours and as needed and consequences of failing to toilet residents every 2-3 hours or as needed may result in loss of dignity, poor grooming/hygiene, and decreased self-esteem, skin breakdown, falls/or injuries and increase in UTI's. Assistant Director of Nursing (ADON) revised the policy Helping a resident with Toileting Needs and Incontinence on 05/22/2024. Inservice education with all licensed staff addressing the revised policies to be completed on 05/24/2024. 4.DON/ADON/IP educator will conduct a quality monitoring on nursing department weekly for four (4) consecutive weeks, then monthly until compliance has been meet 100% for two (2) consecutive months to ensure staff are following the		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 690	Continued From page 18 stated, ". . . Resident is incontinent of bladder . . . Staff will assist X2 [two staff members] with resident for toileting every 2-3 hours . . . and as needed for incontinent episodes." Observation on 04/29/24 at 2:40 p.m. showed Resident #13 in a wheelchair. The front edges of the resident's shirt and front of pants were wet with a strong odor. Observation on 04/30/24 at 10:21 a.m. showed two certified nurse aides (CNAs) (#3) and (#4) utilized a mechanical lift to assist Resident #13 to the toilet. The resident's pants and wheelchair seat saturated through with urine. Review of Resident #13's toileting record, dated April 1, 2024 through April 30, 2024, identified 20 occasions where staff failed to assist the resident with toileting every two - three hours as care planned. The record showed gaps of approximately 7 to 16 hours between staff assistance with toileting. During an interview on 04/30/24 at 10:30 a.m., the CNAs (#3) and (#4) confirmed Resident #13 should be toileted every two to three hours.	F 690	policy/procedure on toileting/incontinence. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. 05/23/2024		
F 744 SS=G	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 744	1.This facility failed to provide		6/15/24

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F 744	Continued From page 19 resident council minutes, resident interview, and staff interview, the facility failed to provide appropriate dementia care and services for 1 of 1 sampled resident (Resident #23) with wandering behaviors and a history of inappropriate sexual behaviors. Failure to adequately assess for necessary care and services and implement effective behavior management interventions resulted in a decreased level of psychosocial well-being for Resident #23 and had a negative impact on other residents. Findings include: Review of Resident #23's medical record occurred on all days of survey. Diagnoses included dementia, agitation, and insomnia. A provider visit note, dated 02/29/24, stated, ". . . Advanced dementia with history of behavioral issues including aggressive behaviors with other residents and sexually inappropriate behaviors. . ." Resident #23's current medication orders included: * Seroquel (an antipsychotic) 100 milligrams (mg) at bedtime, start date 08/07/23. * Seroquel 50 mg once a day at 3:00 p.m., start date 10/26/23. * Trazodone (an antidepressant) 50 mg at bedtime, start date 11/30/23. * Melatonin (treats insomnia) 5 mg at bedtime, start date 08/02/23. Resident #23's current care plan included the following: "Problem start date 08/09/23 . . . Behavioral Symptoms: Resident is at risk for elopement related to Hx [history] of elopement	F 744	appropriate dementia care and services for 1 of 1 sampled resident (Resident #23) with wandering behaviors and a history of inappropriate sexual behaviors. Failure to adequately assess necessary care and services and implement effective behavior management interventions resulted in a decreased level of psychosocial well-being for Resident (#23) and had a negative impact on other residents. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.IDT will review and ensure resident (#23) and all other residents with dementia have a person-centered care plan that address the resident (s) specific condition, risks, needs, preferences and interventions. Behaviors should be identified and approaches for modification of physical environment will include pictures on door (s) with simple signs (e.g. red stop sign) to help resident(s) with stopping before entering another residents room and redirection that includes measurable objectives, and the need for close supervision to prevent resident(s)from wandering into the rooms of other residents, to protect residents in similar situations to be completed by 05/23/2024. Inservice education with all licensed staff addressing policy Dementia Care. To be complete on 05/24/2024. 4.DON/IP educator will conduct a quality monitoring on care plans of two (2) residents with dementia weekly for four		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 744	Continued From page 20 and diagnosis of Dementia as evidenced by exit-seeking behavior. . . . Problem start date 12/03/23. . . . Resident is at risk for harming others R/T [related to] diagnosis of severe dementia with agitation as evidenced by having a few incidents of hitting staff members and verbally threatening them. . . . Problem start date 08/09/23 . . . Cognitive Loss / Dementia: Resident's cognition is impaired related to diagnosis of Dementia as evidenced by limited ability to make decisions and short/long-term memory deficits. . . ." Review of Resident #23's nursing progress notes showed the following: * 08/06/23 at 2:15 a.m., "resident took apart call light and walked into another residents room and continued to argue with the other resident. resident than [sic] told staff [sic] quit touching him or he was going to poke out an eye. . . ." * 08/07/23 at 5:52 a.m., "resident turned off bed alarm and went into another resident room. other resident reported that he was tickling his feet and then proceeded to sit in the other residents recliner. other resident yelled for nurse. . . . went got [sic] the wheelchair and resident hit writer and kicked at writer. writer went got [sic] other staff to see if he would cooperate with them. resident hit and kicked at staff. other resident stated get him of my room. . . ." * 08/13/23 at 7:37 p.m., ". . . Resident has been wondering [sic] into other resident rooms. . . ." * 08/17/23 at 9:25 p.m., "Resident was beginning to wander into other resident's rooms and was trying to disrobe in front of other residents and staff. . . . resident also argued with staff as they were redirecting them out of other resident's rooms and was telling staff they were 'out of their	F 744	(4) consecutive weeks, then monthly to ensure staff are following the policy/procedure related to care planning and assessment in regard to dementia care, then monthly until compliance has been meet 100% for two (2) consecutive months. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. 06/04/2024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2025
FORM APPROVED
OMB NO. 0938-0391

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F 744	Continued From page 21 damn minds.' . . ." * 08/30/23 at 8:45 p.m., "Behavior: Staff notified Nurse that resident had wandered into room 117 and used the toilet while resident in this room was present and was watching them. Staff then redirected resident out of [sic] room as staff was [sic] going to perform HS [bedtime] cares on resident in room 117. After a few minutes, resident then wandered into [sic] room and attempted to watch staff perform cares on resident in room 117. Staff then asked resident repeatedly to leave the room. Resident became upset with staff and stated they 'just wanted to watch.' Staff asked resident to leave again, and resident did finally leave room. . . ." * 10/18/23 at 9:04 a.m., "Last evening, Resident had become combative with staff and had grabbed the breast of a staff member. . . ." * 12/07/23 at 7:48 a.m., "Resident up all night, using the bathroom or wanting to walk the hallways. Resident also had been sexually inappropriate with staff last evening and also during the night. . . ." * 02/11/24 at 6:04 p.m., "Behavior: Resident started to swing his arms at another resident thinking she [the other resident] was in his room. Resident orientated to his own room . . ." * 04/20/24 at 9:39 p.m., "Resident became aggressive with an aide when asked to leave another resident room. The resident room he was in was upset he was in there. Resident hit [sic] CNA [certified nurse aide] 2 times when she asked to leave. . . ." Observations of Resident #23 showed the following: * 04/29/24 at 4:22 p.m., attempted to enter Room #114, a room of another resident.	F 744			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 744	Continued From page 22 * 04/30/24 at 9:28 a.m., attempted to exit the south doors of the building. The doors locked and unable to exit. * 04/30/24 at 1:23 p.m., exited Room #123, a room of another resident located in a different hallway. During a resident interview on all days of survey, Resident #6 reported Resident #23 wanders into his/her room and "Sometimes I find him laying in my bed." The resident stated he/she asked for a lock on their room door "or some safety thing." "I don't feel safe with him here. He walks into my room all the time." "He lays on my bed all sprawled out. He even said 'come lay with me' and 'starts playing with himself. I told him to get the [explicit] out of my room. I mean he's a real nice guy. I'm afraid of him now." During an interview on 05/01/24 at 10:55 a.m., when asked about Resident #23's behaviors, a CNA (#7) confirmed the resident wanders into other resident rooms and can be difficult to redirect "If he is laying in a bed and is asleep." The CNA (#7) confirmed Resident #23's behaviors affect other residents, including Resident #6. Review of the Resident Council Minutes, dated 12/28/23, identified Resident #6 attended the meeting and "brought up another resident who wanders. . . ." During an interview on 05/01/24 at 11:00 a.m. with a social service member (#13), when asked if she was aware of Resident #6's concerns of Resident #23 entering his/her room and/or laying in his/her bed, the staff member (#13) stated,	F 744			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 744	Continued From page 23 "Only once in Resident Council." When asked about corrective actions implemented, the staff (#13) stated, "We put a picture of him [Resident #23] on his door so he can locate his room more easily" and further stated, "[Resident #6] said it got better." When asked if she was aware Resident #23 displayed sexual behaviors towards residents, the staff member (#13) stated she was not aware. The facility failed to assess and monitor patterns/trends of Resident #23's behaviors, develop an effective behavior management program, implement a person-centered care plan to include interventions to address the resident's wandering into other resident rooms and sexual behaviors. The facility failed to modify the physical environment within the facility to ensure the dignity, privacy, and safety of Resident #6 and other residents. This failure resulted in Resident #23's inability to achieve the highest level of functioning and infringed upon the rights of other residents affected by the behaviors to achieve their highest level of physical, mental, and psychosocial well-being.	F 744			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812			6/15/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 24 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure food is stored in accordance with professional standards for food service sanitation in 1 of 1 kitchen (main kitchen). Failure to ensure food is safe from contamination from ice/condensation, dirt, and rust has the potential to result in a foodborne illness or adverse effects for patients, visitors, and staff. Findings include: Review of the policy titled, "Sanitation Inspection" occurred on 05/02/24. This policy, dated 03/01/24 stated, "Policy: It is the policy of the Dunseith Community Nursing Home (DCNH), as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. Policy Explanation and Compliance Guidelines: . . . 4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators/coolers, freezers . . . daily. b. Weekly: The dietary manager shall	F 812	1.This facility failed to ensure food is stored in accordance with professional standards for food service sanitation in 1 of 1 kitchen (main kitchen). Failure to ensure food is safe from contamination from ice/condensation, dirt, and rust has the potential to result in a foodborne illness or adverse effects for patients, visitors, and staff. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Dietary staff member (#10) re-educated after exit interview by Director of Nursing (DON) and Dietary Manager on maintaining sanitation of rusty storage racks, build-up black debris on the grate the fan on the ceiling, and ice build-up in walk-in freezer. The walk-in freezer will be serviced by the electrician within the next two weeks. Food storage racks will be ordered by 06/05/2024 and will be removed and replaced by 06/13/2024. Food storage racks will be sanitized weekly, and all foods present with ice		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 25 inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulations. . . ." The 2022 Food and Drug Administration (FDA) Food Code, Annex 3 page 100 states, ". . . Preventing contamination from the premises . . . 3-305.11 Food Storage. 3-305.12 Food Storage, Prohibited Areas. Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate . . . can be sources of microbial contamination for stored food. . . . (page155) Chapter 4 Equipment . . . 4-101.11 Characteristics . . . equipment is subject to deterioration because of its nature, i.e., intended use over an extended period of time. . . . Surfaces that are unable to be routinely cleaned and sanitized because of the materials used could harbor foodborne pathogens. Deterioration of the surfaces of equipment such as pitting may inhibit adequate cleaning of the surfaces of equipment . . . Inability to effectively wash, rinse and sanitize the surfaces of food equipment may lead to the buildup of pathogenic organisms transmissible through food." Observation of the kitchen on 04/29/24 at 12:30 p.m. showed the following: - Walk-in Cooler: Food storage racks with several rusty areas and rough surfaces. When asked about cleaning the racks, a dietary staff member (#10) stated "they are hard to get clean." Observation also showed a build-up of black debris on the grate of the fan on the ceiling. - Walk-in Freezer: Large amount of ice build-up on a pipe, on the back north wall, back east wall, and on the ceiling. Observation showed ice build-up in an open box of sherbet cups, on	F 812	build-up will be removed immediately. Director of Nursing (DON) and Dietary Manager revised the policy Sanitation Inspection on 05/22/2024. In-service education with all kitchen staff addressing Dunseith Community Nursing Home policy Sanitation Inspection to be completed on 05/24/2024. 4.The Dietary Manager will conduct a quality monitor on kitchen staff to ensure staff are following policy/procedure on sanitation and food service regulations. Quality monitoring will be once weekly for four (4) consecutive weeks, then monthly until compliance has been met for 100% for two (2) consecutive months. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. 05/23/2024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 26 packages of coffee, and ice build-up on the ceiling above a bag of garlic toast and other boxes of food. Observation of the kitchen on 05/02/24 at 10:00 a.m. showed the same conditions as observed above, except the open box of sherbet had been removed.			F 812			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:			F 880			6/15/24

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 27 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			F 880			

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F 880	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 5 of 15 sampled residents (#1, #9, #15, #18, and #22) observed during medication administration and resident cares. Failure to follow infection control standards related to hand hygiene and glove use has the potential to transmit infections to residents, staff, and visitors. Findings include: Review of the facility policy titled "Personal Protective Equipment" occurred on 05/02/24. This policy, dated 02/19/23, stated, ". . . Gloves . . . Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene. . . Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another . . . The outside of gloves are contaminated. . . . Do not reuse gloves. . . ." - Observation on 04/29/24 at 4:17 p.m. showed a nurse (#2) performed hand hygiene, donned gloves, entered Resident #22's room, and performed a blood sugar check. Without removing her gloves, the nurse exited Resident #22's room, disinfected the accucheck machine (used to check blood sugar levels), placed the supplies back into the medication cart, and typed on the computer. The nurse (#2) failed to remove her gloves and perform hand hygiene prior to exiting Resident #22's room. - Observation on 04/29/24 at 4:29 p.m. showed a	F 880	1.This facility failed to follow standards of infection control for 5 of 15 sampled residents (#1, #9, #15, #18, and #22) observed during medication administration and resident cares. Failure to follow infection control standards related to hand hygiene and glove use has the potential to transmit infections to residents, staff, and visitors. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Nurse (#2) and Nurse (#11) verbally re-educated after exit interview by Director of Nursing on proper hand hygiene procedures, personal protective equipment policy, infection control principle for cleaning and disinfection reusable single-resident items. In-service education with all licensed staff addressing Hand Hygiene policy, personal protective equipment policy, indications/considerations for PPE use (gloves, gowns, face protection, respiratory protection) and sequence of donning/removing PPE. Inservice/Education to be completed on 05/24/2024. 4.IP educator will conduct a random audit of two (2) nursing department staff (Nurse, CNA, CMA II) weekly for four (4) consecutive weeks, then monthly to ensure that staff is following infection control policy/procedures until compliance has been meet 100% for two (2)		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 29 nurse (#2) performed hand hygiene, donned gloves, entered Resident #15's room, and performed a blood sugar check. Without removing her gloves, the nurse exited Resident #15's room, disinfected the accucheck machine, placed the supplies back into the medication cart, and typed on the computer. With the same gloves on, the nurse (#2) gathered supplies for Resident #15's insulin administration from the medication cart, entered the resident's room, and administered the insulin. The nurse exited Resident #15's room, placed the insulin supplies back into the medication cart, and typed on the computer. The nurse (#2) failed to remove her gloves and perform hand hygiene prior to exiting Resident #15's room and in between the blood sugar check and insulin administration. - Observation on 04/29/24 at 4:43 p.m. showed a nurse (#2) performed hand hygiene, donned gloves, entered Resident #9's room, and performed a blood sugar check. Without removing her gloves, the nurse exited Resident #9's room, disinfected the accucheck machine, placed the supplies back into the medication cart, and typed on the computer. The nurse (#2) failed to remove her gloves and perform hand hygiene prior to exiting Resident #9's room. - Observation on 04/29/24 at 4:50 p.m. showed a nurse (#2) performed hand hygiene, donned gloves, entered Resident #18's room, and administered insulin. The nurse exited Resident #18's room, placed the insulin supplies back into the medication cart, and typed on the computer. The nurse (#2) failed to remove her gloves and perform hand hygiene prior to exiting Resident #18's room.	F 880	consecutive months. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. The above monitoring will be implemented on 05/24/2024. 05/23/2024		

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F 880	Continued From page 30 - Review of Resident #1's medical record occurred on all days of survey. The record identified diagnoses of chronic ulcers to both upper back of legs and sacral/coccyx areas and a history of Methicillin-resistant Staphylococcus aureus (MRSA) and Vancomycin-resistant enterococci (VRE) infections (infections resistant to many antibiotics). The record also identified the resident on enhanced barrier precautions (EBP). Observation on 04/30/24 at 1:55 p.m. showed a nurse (#11) put on a gown, donned gloves, donned a second pair of gloves over the first pair of gloves (double gloved) and applied a pain-relieving cream to the resident's upper back. The nurse doffed the soiled outer pair of gloves, donned a clean second pair of gloves, and cleansed the resident's wounds. The nurse doffed the soiled outer pair of gloves, donned a clean pair of second gloves, applied the wound medications, and dressed the wounds. The nurse then removed both pairs of gloves and completed hand hygiene. The nurse (#11) failed to remove gloves and perform hand hygiene before and after the wound cleansed and the medications applied. During an interview on the afternoon of 04/30/24, and administrative nurse (#12) confirmed double gloving is not the practice of the facility.			F 880			