STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 The standard Medicare/Medicaid recertification survey survey started on 05/27/25 and concluded on 05/29/25.	F 000		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and family and staff interviews, the facility failed to provide the resident's representative a copy of quarterly financial statements for 1 of 1 sampled resident (Resident #19) reviewed for personal fund accounts. Failure to provide quarterly statements to the individual designated by the resident to make financial decisions on their behalf prevented the representative from verifying transactions and fund balances. Findings include: Review of facility policy titled "Resident Personal Funds" occurred on 05/29/25. This policy, dated May 2024, stated, ". . . The individual financial	F 568	1. The Business Office manager immediately re-educated Business Office Assistant on 5/29/2025. Re-educated on Accounting and Records of Personal Funds Policy. Business Office Manager observed Business Office Assistant completing Last quarterly Statement, Business Office Manager Observed Assistant mailing out statements to Legal Representatives and hand delivering Quarterly Statement to Resident (19) and all other residents. The Business office mailed the last quarterly statement to all legal representative. Resident (19) and all other residents received a hand delivered copy of last quarterly statement on	6/18/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 568	Continued From page 1 record must be available to the resident through quarterly statements . . ." During an interview on 05/27/25 at 6:00 p.m., Resident #19's financial power of attorney (POA) stated she had not received any quarterly financial statements. During an interview on 05/29/25 at 8:50 a.m., a business office staff member (#6) confirmed staff failed to send quarterly statements to Resident #19's financial POA.	F 568	6/18/2025. 2. Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3. Inservice education provided to office staff on appropriate Residents Personal Funds / Accounting and Records Policy. Monthly Personal Funds Statements will be saved to Residents personal records and on a quarterly basis Quarterly Personal Funds Statement will be hand delivered to Residents and Mailed to Legal Representatives. A copy of the statements will be saved in each Resident file as verification. Review of facility policy of Residents Personal Funds / Accounting and Records Policy completed by Business Office Manager on 6/18/2025. 4. Business Office Manager will conduct a random quarterly audit for Six (6) residents for two (2) consecutive quarters. QA's will not have the same residents and will continue until 100% compliance is reached. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. 5. Completion Date: All corrective actions will be fully implemented by 6/18/2025.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		6/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 658	Continued From page 2 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 observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed professional standards of practice for 4 of 4 supplemental residents (Resident #8, #9, #10, and #17) observed during insulin preparation and 1 of 1 supplemental resident (Resident #10) reviewed for insulin use. Failure to properly prime an insulin pen and follow physician's orders regarding out-of-range blood sugar levels, may result in residents receiving an inaccurate dose of insulin and/or possible adverse events. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 05/28/25. This policy, dated 07/14/23, stated, ". . . screw the pen needle onto the insulin pen. Twist open and remove outer cover from the pen needle. . . . With the needle pointing up, push the plunger, and watch to see that at least a drop of insulin appears on the tip of the needle. . . ." - Observation on 05/27/25 at 11:50 a.m. showed nurse (#3) primed Resident #9's insulin pen with the needle cap on. - Observation on 05/28/25 at 7:25 a.m. showed a nurse (#4) primed Resident #17's insulin pen holding the pen downward.	F 658	1.Director of Nursing immediately Re-Educated Nurse (#3) and Nurse (#4) after exit interview 05/29/2025 on proper insulin administration techniques, including priming insulin pens, and reviewed facility policy on Insulin Administration and Blood Glucose Monitoring to Re-Educate Nurse (#3) and Nurse (#4) on reporting critical/out of range results to physician and documenting properly that physician was notified in progress note. Resident (#8) (#9) (#10) (#17) medical documentation reviewed March 1st-May 28th by Director of Nursing for any possible adverse effects and no negative oncomes were noted. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Inservice education with all licensed staff on Professional standards of quality ensuring care and services are provided according to accepted standards of clinical practice. Review on Facility policy Insulin Administration with demonstration of proper way to prime insulin pen. Review on Facility policy on Blood Glucose Monitoring and ensuring proper documentation is completed immediately after physician is notified with critical/out	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 658	Continued From page 3 - Observation on 05/28/25 at 7:38 a.m. showed a nurse (#4) primed Resident #8's insulin pen holding the pen downward. - Observation on 05/28/25 at 7:48 a.m. showed a nurse (#4) primed Resident #10's insulin pen holding the pen downward. During an interview on 05/28/25 at 2:08 p.m., an administrative nurse (#2) stated she expected staff to prime an insulin pen with the needle cap off and the needle pointing up. Review of the facility policy titled "Blood Glucose Monitoring" occurred on 05/29/25. This policy, dated 09/22/23, stated, ". . . Report critical/out of range results to physician. . . ." Review of Resident #10's medical record occurred on 05/29/25. Diagnoses included Type 2 diabetes mellitus. A physician's order stated, "Fiasp U-100 Insulin [long acting insulin] per Sliding Scale; If Blood Sugar is less than 100 milligrams per deciliter [mg/dl], call MD [physician]. . . . If Blood Sugar is greater than 450 mg/dl, call MD." Review of the resident's blood sugar levels from March 1 through May 28, 2025 identified the following: * 03/05/2025 at 6:30 a.m.: 73mg/dL * 03/11/2025 07:20 a.m.: 72mg/dL. * 05/07/2025 11:57 a.m.: 492 mg/dL Resident #10's medical record lacked documentation staff notified the physician regarding out-of-range blood sugars. During an interview on 05/09/25 at 12:52 p.m., an administrative nurse (#2) confirmed staff failed to	F 658	of range results on 06/16/2025. 4.Infection Preventionist will conduct quality monitoring on proper insulin administration techniques and documentation of notification of physician with critical/out of range results to ensure nursing staff are following professional standards of practice on two licensed nurses weekly for four 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. 5.Completion Date: All corrective actions will be fully implemented by 6/17/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 658	Continued From page 4 notify the physician regarding the out-of-range blood sugars.	F 658		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he	F 801		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 801	Continued From page 5 or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 801	Continued From page 6 food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure 1 of 1 dietary manager (#1) obtained the proper qualifications to serve as the director of food and nutrition services. Failure to ensure the facility had a qualified dietary management to carry out the functions of food and nutrition services may result in foodborne illness to residents, staff, and visitors. Findings include: During an interview on the afternoon of 05/27/25, the dietary manager (#1) stated she had not completed the certified dietary manager course and received an extension to complete the course. The facility failed to ensure the dietary manager (#1) completed the required education for a certified dietary manager, certified food service manager, or a national certification for food service management and safety from a national certifying body.	F 801	1. The Administrator immediately re-educated after exit interview on 5/29/2025 on the policy of the Qualified Dietary Staff. Dietary Manager will continue enrolled course UND work until completion. In addition Dietary Manager is currently enrolled in the IFSEA and that will be completed 7/03/2025. 2. Dunseith Community Nursing Home has determined that all residents have the potential to be affected by the deficient practice. 3. Inservice educated provided to the Dietary Manager and reeducated on the Qualified Dietary Staff policy. The Dietary Manager is currently enrolled through UND at Grand Forks to complete the required certification. In addition Dietary Manager is currently enrolled in the IFSEA and that will be completed 7/02/2025. 4. The Administrator will conduct quality monitoring of the progress of the CDM class at UND monthly for the next 5 month. In addition the Dietary Manager is currently enrolled in the IFSEA and that will be completed 7/03/2025. 5. The above monitoring will implemented 7/3/2025.	
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		6/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 812 SS=F	Continued From page 7 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 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 dishwasher temperature log, review of professional reference, and staff interview, the facility failed to ensure the high temperature dishwasher provided adequate heat sanitization for dishes and utensils washed in 1 of 1 kitchen (main kitchen). Failure to monitor the dish temperatures during the high temperature dishwash cycle may result in inadequate sanitation of dishware and foodborne illness. Findings include: The Food and Drug Administration (FDA) Food	F 812	1.Dietary Manager immediately completed re-educated all staff after exit interview on 5/29/2025. Reeducation on food procurement, store, prepare, serve-sanitary. The Dietary Manager Reeducated using a Dishwasher thermometer plate device that is used to monitor the temperature of the dual cycle hot temp dishwasher. The Temperature was maintained at the required temperature using the dishwasher temperature plate device. 2.Dunseith Community Nursing Home has determined that all residents, visitors	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 812	Continued From page 8 Code 2022, Annex 3 Public Health Reasons/Administrative Guidelines, page 169 states, "4-302.13 Temperature Measuring Devices . . .. Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. . . . mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the warewashing machine meet or exceed the required . . . (160°F) [degress Fahrenheit]. . . . Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical warewashers, the measurements displayed by these devices may not always be sufficient to determine that the surface temperatures of utensils are reaching 71°C [celsius] (160°F). The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of . . . (160ºF) . . ." Observation in the main kitchen on 05/27/25 at 1:20 p.m. showed a high temperature dishwasher in use. Review of the May 2025 dishwasher temperature log showed dietary staff documented the morning and evening temperature readings of the external temperature gauge/dial for the dishwasher. When asked, dietary staff member (#5) placed the surveyor's dish thermometer in with the tray of plates to be washed. It took up to five wash/rinse cycles before the dish thermometer registered 160 degrees Fahrenheit (F) and above. The dietary manager (#1) reported the dietary staff do not check dishwash temperatures at the	F 812	and staff have the potential to be affected by deficient practice. 3.Dietary Manager re-educated on maintaining dish washing sanitation. All kitchen staff have been re-educated on properly using the high temp dishwasher and how to use the dishwashing thermometer plate device. Staff will run a cycle to ensure the temp is at a minimum of 160 degrees before proceeding with dishwashing each day. Staff will also run a final cycle after all dishes have been cycled through the dishwasher. Staff will document the temperature after the first cycle and will run a cycle at the end of the day for their final cycle and will record the temperature on their daily Temperature log sheet that is kept in the dishwashing room. Review of the facility policy food procurement, completed by Dietary Manager on 6/16/2025 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. The Dietary Manager will be monitoring temperature documentation bi-weekly for 4 weeks and then monthly until sustained compliance has been achieved and will be reviewed in QAA meetings. 5.The above monitoring will be implemented on 06/16/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 812	Continued From page 9 plate level during a wash/rinse cycle. When asked about the availability of a thermometer, the dietary manager retrieved the dish plate thermometer and stated it was not functioning and needed the battery replaced. The facility failed to have a process or a functioning dish thermometer to monitor adequate heat sanitization of dishware.	F 812		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are	F 868		6/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 868	Continued From page 10 necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Quality Assurance Performance Improvement (QAPI) program committee minutes, review of facility policy, and staff interview, the facility failed to ensure the QAA (Quality Assessment and Assurance) Committee, and all the required members met at least quarterly for 2 of 5 quarters (June 2024 and September 2024) reviewed. Failure to meet quarterly and have the medical director participate in the facility's quality assurance activities may result in an ineffective QAPI program and deprives the committee of the physician's unique contributions for analysis of quality concerns and assisting with decision making based on identified concerns. Findings include: Review of the facility policy titled "Quality Assurance and Performance Improvement (QAPI)" occurred on 05/29/25. This policy, dated December 2024, stated, ". . . The QAA Committee shall be interdisciplinary and shall . . . a. Consist at a minimum of: The Director of Nursing Services; The Medical Director or his/her designee . . . b. Meet at least quarterly and as needed to coordinate and evaluate activities	F 868	1.Director of Nursing completed a comprehensive audit of QAA meeting records over the last five quarters on 05/30/2025. The audit confirmed that the committee failed to meet in 2 of the last 5 quarters and the medical director did not participate in any meetings during this period. The Infection Preventionist revised QAA Outlook Calendar to ensure the committee meets at least once every quarter. A written reminder will be sent to the Medical Director, a minimum of 7 days before each scheduled meeting. Infection Preventionist Re-Educated Medical Director on regulatory participation requirements and Medical Director has committed regular involvement by signing written notification of participation and re-education. The QAA template updated to include a roll call and documentation of attendance with emphasis on medical director participation. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 868	Continued From page 11 under the QAPI program. . . ." Review of the QAA Committee meeting minutes from March 2024 to March 2025 showed the committee failed to meet in June and September of 2024. The medical director failed to attend any of the meetings. During an interview on 05/29/25 at 12:10 p.m., an administrative staff member (#7) confirmed the QAA committee had not met on a quarterly basis and failed to ensure the required quarterly attendance of the medical director.	F 868	3. Administrator will conduct audits on QAA records monthly for the next 6 months. Audits will focus on adherence to QAA documentation, meeting frequency and Medical Director attendance. The Administrator will discuss QAA findings with the governing body during board meetings. If a meeting is missed or if the Medical Directors participation is not documented, immediate corrective action will be taken, by rescheduling within 7 days and Outlook Calendar notification to committee members. 4.Completion Date: All corrective actions will be fully implemented by 06/17/2025	
F 880 SS=D	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	F 880		6/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 880	Continued From page 12 facility assessment conducted according to §483.71 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: (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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 880	Continued From page 13 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. 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 and prevention for 1 of 1 sampled resident (Resident #1) observed during wound care. Failure to practice infection control standards related to dressing changes has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Clean Dressing Change" occurred on 05/29/25. This policy, dated November 2024, stated, ". . . Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application: If the table is soiled, wipe clean. Place a disposable cloth or linen saver on the overbed table. . . . Wash hands and put on clean gloves. . . . Loosen the tape and remove the existing dressing . . . Discard into appropriate receptacle. . . . Remove gloves . . . Wash hands and put on clean gloves. Cleanse the wound as ordered . . . pat dry with gauze. . . . remove gloves and wash hands . . . put on clean gloves. . . . Secure dressing. . . Discard disposable items and gloves into appropriate trash receptacle and wash hands. . . ."	F 880	1.Infection Preventionist immediately Re-Educated Nurse (#8) after exit interview on 05/29/2025. Re-Education on facility policy clean dressing change was provided and Infection Preventionist observed Nurse (#8) while completing wound care for resident (#1).Nurse (#8) completed wound dressing using proper infection control techniques, including hand hygiene, proper PPE use, and sterile technique. Wound assessed with no signs of infection. 2.Dunseith Community Nursing Home has determined that all residents have the potential to be affected by deficient practice. 3.Inservice education provided to licensed staff and re-education on appropriate infection control practices, with an emphasis on hand hygiene, glove use, PPE, and sterile technique during dressing changes. Review of facility policy clean dressing change completed by Infection Preventionist on 06/17/2025 4.Infection Preventionist will conduct audits on wound care practices on two licensed nurses weekly for four weeks, then monthly for two months until compliance has been met 100% for two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	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 880	Continued From page 14 Findings include: Review of Resident #1's medical record occurred on all days of survey. A physician's order stated, "Mepilex Transfer [a type of wound dressing] over open wound areas, apply ABD [dressing for wound drainage], and tape. Change daily and as needed." The current care plan stated, ". . . Resident has impaired skin integrity r/t [related to] chronic posterior [back of] left thigh and bilateral [both] buttocks . . . Dressing changes as ordered by MD . . ." Observation on 05/28/25 at 10:20 a.m. showed a nurse (#8) performed hand hygiene, applied a gown and gloves, and placed supplies for Resident #1's dressing change on the bedside table without sanitizing the table and placing a barrier between the suppleis and table. The nurse (#8) removed the soiled dressings, cleansed the wounds, and applied clean dressings without changing gloves or performing hand hygiene between steps. The nurse (#8) removed her gown and gloves, performed hand hygiene, and exited the room. During an interview on 05/29/25 at 10:20 a.m., an administrative nurse (#2) confirmed staff failed to follow infection control practices when completing Resident #1's dressing change.	F 880	(2) consecutive months. The plan of correction will be reviewed/monitored at the monthly quality assurance meeting until consistent substantial compliance has been met. 5.Completion Date: All corrective actions will be fully implemented by 6/17/2025.	