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 _____	03/23/2023

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 started on 03/20/23 and concluded on 03/23/23.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		4/25/23

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

Electronically Signed | 04/19/2023

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 _____	03/23/2023

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 578	Continued From page 1 individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of facility policy, and family and staff interviews, the facility failed to ensure the residents' right for legal representation for 2 of 15 sampled residents (Resident #17 and #24) reviewed for power of attorney/guardianship. Failure to ensure the medical record accurately reflected each resident's legal guardian limited the facility's ability to communicate and obtain authorization for care. Findings include: Review of the facility policy titled "Resident Rights Regarding Treatment and Advance Directives" occurred on 03/23/23. This policy, dated 11/10/22 stated, ". . . It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. . . . 5. The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions. . . ." - Review of Residents #17's medical record occurred all days of survey and identified	F 578	1. This facility failed to provide ensure the resident's right for legal representation for Resident #17 and #24 and ensure that the medical record accurately reflects the resident's legal guardian which limited our ability to communicate and obtain authorization for care. The facility is in the process of establishing appropriate guardians resident #'s 17 & 24. The facility has reached out to corporate agencies to get the process started. 2. All residents have the potential to be affected by this deficient practice. 3. We have reviewed the other residents and they have not been affected as they have guardianships in place. The facility will start the guardianship process when it becomes medically necessary or is requested by a resident. Don/IP/Social Worker will be in-serviced on 4/24/2023 on the facility policy and to follow the policy/procedure to start the process of an appropriate power of attorney/guardianship for all residents that are admitted to the facility to ensure the process of a power of attorney/guardianship is established. The	

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 _____	03/23/2023

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 578	Continued From page 2 diagnoses of bi-polar disorder and cerebral infarction. The current care plan stated, ". . . Resident has impaired cognition r/t [related to] bipolar disorder and hx [history of] CVA [cerebrovascular accident-a type of stroke] as E/B [evidenced by] resident has impaired decision making and has a guardian for decision making. . . ." Observation on 3/20/23 at 1:31 p.m. showed a sign on Resident #17's door that stated "Visitors please go to the nurse's station before visiting." When asked, a certified nursing assistant (CNA) (#7) stated, "The resident's daughter was her guardian and she wanted her Mom's visitors to be screened. But her daughter passed away and I don't know if she has another guardian yet." A review of the resident's face sheet lists the deceased daughter as legal guardian. During an interview on 03/22/23 at 11:06 a.m., an administrative staff member (#2) stated, "The resident's daughter was her guardian and passed away." The staff member confirmed the resident does not have a guardian since the daughter passed away in June 2022 and the facility "may need" to contact a guardianship agency. - Review of Resident #24's medical record occurred on all days of survey and identified a diagnosis of dementia. The current care plan stated, ". . . Resident has impaired cognitive process r/t [related to]diagnosis of dementia. . . ." The medical record included a contact name for emergencies and noted the contact was the resident's cousin.	F 578	date the in-service training will be completed is 04/24/2023. 4. Don/IP/Social Worker will do a quality monitoring on all residents that are admitted to the facility. This monitoring will include residents who do not have a guardian upon admission. Quality Monitoring will be completed 1 X weekly until 100% compliance is met for for 4 consecutive weeks, followed by monthly until 100% is met for 2 consecutive months. The status of guardianship shall be reviewed at least annually for all residents by the interdepartmental team during comprehensive care plan meetings with the resident/guardian. The above monitoring will be implemented on 4/25/2023. Results of the monitoring will be reviewed at the Quality Assurance meeting. 5. 04/25/2023 1. This facility failed to accurately document the code status for Resident #17. current POLST states DNR which was signed by the resident on 12/07/2022 and by the resident's Physician on 01/26/2023. The current POLST status are uploaded into the residents EHR. The facility will continue to upload current POLST into EHR. For Resident #28 the Code status has been implemented and charted correctly. Code status will be established on admission to the facility. 2. Resident #17 and #28 have the potential to be affected by this deficient practice. 3. Code level/POLST status will be	

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 _____	03/23/2023

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 578	Continued From page 3 During a phone interview on 03/21/23 at 1:33 p.m., Resident #24's emergency contact/family (#A) stated, "I am not looking after him [Resident #24]. They [the facility] just listed me because I go visit him sometimes. I have told them I do not want to be assigned as his representative." The medical record for Resident #24 included the following progress notes: * 06/13/2022 1:02 p.m., "Social Services: In regard to the appointment scheduled for June 9th, 2022, for cataract surgery, it was observed by physician and placed on hold for now as physician does not believe the resident has the capacity to make this decision for themselves. Social Worker will work on finding family to either act as a Representative for resident or guardian. . . ." * 11/24/2022 11:53 a.m., "MDS [minimum data set] quarterly interview . . . Residents BIMS [Brief Interview for Mental Status] score is a 3, which indicates severe impairment. . . ." During an interview on 03/22/23 at 11:00 a.m, an administrative staff member (#2) stated, "About a month ago I was updating the resident's POLST [Physicians Orders for Life sustaining Treatment] and the physician would not sign it because he does not feel the resident is capable of making his own decisions." The staff member (#2) stated she is aware the emergency contact listed does not want to be the resident's guardian, agreed Resident #24 is not capable of making his own decisions and agreed the facility failed to obtain a representative for the resident. 2. Based on record review, review of facility policy, and staff interview, the facility failed to	F 578	established for all new residents on admission to the facility. Don/IP/Social Worker will be in-serviced on 4/24/2023 on the facility policy/procedure to establish and document the appropriate code level/POLST status. The code level/POLST will be reviewed during the residents comprehensive care plan meetings by the IDT and resident and/or guardian. The date the in-service training will be completed is 04/24/2023. 4. Don/IP/Social Worker will do a quality monitoring on all residents that are admitted to the facility. Quality Monitoring will be completed 1 X weekly until 100% compliance is met. followed by monthly until 100% has been met for 2 consecutive months. The above monitoring will be implemented on 4/25/2023. Results of the monitoring will be reviewed at the Quality Assurance meeting. 5. 04/25/2023	

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 _____	03/23/2023

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 578	Continued From page 4	F 578		

ensure the residents' right to request, refuse, and/or discontinue treatment for 2 of 15 sampled residents (Resident #17 and #28) reviewed for advance directives. Failure to ensure the medical record accurately reflected each resident's code status limited the facility's ability to communicate to direct care staff and emergency personnel the residents' choice in the event of a medical emergency.

Findings include:

Review of the facility policy titled "Communication of Code Status" occurred on 03/23/23. This policy, revised September 2022, stated, ". . . When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to a. Full Code b. Do Not Resuscitate . . . The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record. . . ."

- Review of Residents #17's medical record occurred all days of survey. The resident's face sheet and physician orders showed "Code Status: Full Code." The record showed the resident has a "Code Status" document signed and dated on 11/01/18 as code level I (All available reasonable technology will be used in the event of cardiac or respiratory arrest). A Physician Orders for Life Sustaining Treatment (POLST) signed and dated by the resident on 12/07/22 and attested by the resident's physician on 01/26/23 showed Do Not Attempt

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 _____	03/23/2023

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 578	Continued From page 5 Resuscitation (DNR). The medical record lacked the current code status for Resident #17. -Review of Resident #28's medical record occurred on all days of survey. The physician's order summary showed "Code Status: [blank]." The medical record showed a POLST signed on 12/07/22 and attested by the physician on 01/26/23 designating "full code." The medical record the current code status for Resident #28. During an interview on 03/23/23 at 10:41 a.m., an administrative staff member (#1) confirmed staff failed to update the medical record to accurately reflect Resident #17 and #28's code status.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		4/25/23

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 _____	03/23/2023

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 580	Continued From page 6 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to notify the physician of a change in the resident's weight for 1 of 1 sampled resident (Resident #18) with weight loss. Failure to notify the physician may result in a delay of treatment and further weight loss for Resident #18. Findings include:	F 580	1. Resident # 18 had a significant weight loss. The resident, guardian, and PCP have been notified of the significant weight loss and proper documentation has been completed. 2. All residents have the potential to be affected by this deficient practice. QA monitoring will be implemented 4/25/2023 to prevent this deficient practice from	

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 _____	03/23/2023

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 580	Continued From page 7 Review of the facility policy titled "DCNH [Dunseith Community Nursing Center] Weight Monitoring" occurred on 03/23/23. This policy, dated 09/22/22, stated, ". . . a. The physician should be informed of a significant change in weight and may order nutritional interventions. . . ." Review of Resident #18's medical record occurred on all days of survey. The care plan stated, ". . . Resident is risk for impaired nutrition . . . as evidence as resident has involuntary movements causing his food to miss his mouth . . . Staff to weigh me per DCNH [Dunseith Community Nursing Home] policy and monitor for stability of my weight. Implement interventions as needed. Resident will maintain a healthy weight. . . ." A quarterly Minimum Data Set (MDS), dated 01/08/23, identified Resident (#18) had a significant weight loss that was not physician prescribed. The record identified a 7.67 percent (%) significant weight loss in one month on 01/04/23 and a 9.48% significant weight loss in three months on 03/14/23, with a weight of 160.4 pounds. See F692. Resident #18's progress notes stated the following: * 01/08/23 3:15 p.m. "Dietary: Resident eats ruffly [sic] 26-50% of his meals when he does eat. Has had a weight change, talk with nurse. Current weight is 163.6 lbs. BMI [body mass index] 23.47. Will continue to monitor. . . ."	F 580	reoccurring. 3. All Nursing, and Dietary staff will be in-serviced on 4/24/2023 related to notifications of changes with will include but not limited to, accidents involving the resident which results in injury and/or has the potential for requiring physician intervention, a significant change in the residents physical, mental, psychosocial status, a need to alter treatment significantly or when a decision to transfer or discharge the resident from the facility, change in room or roommate assignment, change in resident rights under Federal or State law or regulations, the facility must record and periodically update the address (mail and email) and phone number of the resident representative(s). 4. DON/Designee will do a quality monitor on all Notification of Changes to ensure proper notification/changes are being completed accurately. Quality monitoring will be done 2x week X 16 weeks, then bi weekly X 16 weeks, followed by monthly for a total of 1 year. The above monitoring will be implemented on 04/25/2023. 5. 04/25/2023.	

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 _____	03/23/2023

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 580	Continued From page 8 During an interview on 03/23/23 at 10:30 a.m., an administrative nurse (#1) confirmed the facility had not notified the physician of Resident #18's significant weight loss.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		4/25/23

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 _____	03/23/2023

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 609	Continued From page 9 Based on record review, review of facility policy, and staff interviews, the facility failed to ensure a possible violation involving verbal abuse was reported to the State Survey Agency and the results of the investigation were reported within five working days for 1 of 1 sampled resident (Resident #19) with an allegation of verbal abuse. Failure to report the incident within two hours and report the results of the facility's investigation to the State Survey Agency placed Resident #19 and other residents at risk of potential abuse. Findings include: Review of the facility policy titled "Abuse, Neglect, Exploitation" occurred on 03/23/23. This policy, revised 01/30/23, stated, ". . . Reporting of all alleged violations to the . . . state agency . . . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . . ." Review of Resident #19's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 02/25/23, identified the resident had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. A progress note, dated 03/14/23 at 8:54 a.m., stated, "Social worker visited with parties involved in incident that got reported to social worker on 2-28-23 . . ." Staff interviews on 03/22/23 identified the following: * At 10:39 a.m., an administrative staff member	F 609	1. This facility did investigate the allegations of verbal abuse towards resident # 19 immediately upon notification of alleged abuse. This facility failed to correctly notify appropriate state agency within the time frame required. This facility reported the alleged allegation of verbal abuse on 3/23/2023. The employee was immediately suspended on 3/23/2023 pending state agency decision. 2. All residents have the potential to be affected by this deficient practice. 3. All staff members will be in-serviced on 4/24/2023 on facility policy for reporting alleged incidents of abuse, neglect, and exploitation. 4. DON/IP/Designee will do a quality assurance study that will include proper notification of state agencies and staff disciplinary action(s) to be taken when there are allegations of abuse, neglect, and/or exploitation. Quality monitor will be completed weekly on each incident that involved abuse, neglect and/or exploitation x 16 weeks, then Bi-weekly for until 100% compliance is met for 2 consecutive months. The above monitoring will be implemented on 4/25/2023. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 04/25/2023	

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 _____	03/23/2023

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 609	Continued From page 10 (#2) indicated she was notified of the incident involving possible verbal abuse and began her investigation "the same date as my progress note [dated 03/02/23 at 8:50 a.m., two days after the incident occurred]." This directly conflicts with the progress note listed above, dated 03/14/23 at 8:54 a.m., which indicated the incident "got reported to social worker on 2-28-23." * At 11:34 a.m., an administrative staff member (#1) stated she did not think the incident needed to be reported to the State Agency as Resident #19 was unharmed, the CNA (#13) no longer cared for Resident #19, and the resident seemed satisfied. The administrative staff members (#1 and #2) confirmed they failed to report the allegation of verbal abuse to the State Agency within two hours on the day they were made aware of the incident.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610		4/25/23

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 _____	03/23/2023

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 610	Continued From page 11 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and resident and staff interviews, the facility failed to thoroughly investigate an allegation of verbal abuse for 1 of 1 resident (Resident #19) with an allegation of verbal abuse. Failure to thoroughly investigate all abuse allegations, ensure residents are protected, and implement safety measures during the investigation placed all residents at risk for possible abuse. Findings include: Review of the facility policy titled "Abuse, Neglect, Exploitation" occurred on 03/23/23. This policy, revised 01/30/23, stated, ". . . An immediate investigation is warranted when suspicion of abuse . . . occur[s] . . . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . . . Providing complete and thorough documentation of the investigation. . . . Responding immediately to protect the alleged victim . . . Staffing changes . . . to protect the resident(s) from the alleged perpetrator . . ." Review of Resident #19's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke) and aphasia (difficulty comprehending and expressing language). A quarterly Minimum Data Set (MDS), dated 02/25/23, identified the resident had a Brief Interview for Mental Status (BIMS) score of 14	F 610	1. The facility failed to thoroughly investigate an allegation of verbal abuse for 1 of 1 resident (Resident #19) for an allegation of verbal abuse. An abuse investigation regarding an allegation of verbal abuse was completed and sent to the state health department for review. The CNA that was identified in the allegation was suspended on 3/23/2023 pending state agency decision. This CNA will no longer provide cares for this resident. 2. All residents have the potential to be affected by this deficient practice. 3. All staff will be in-serviced on 4/24/2023 on the process of proper procedure for reporting, documenting, and staff suspension per regulations/facility policy. 4. DON/Social Worker will do a quality monitoring related to all abuse allegations 2x weekly until compliance has been met for 2 consecutive months, then bi-weekly until 100% compliance has been met for 2 consecutive months. The above monitoring will be implemented 4/25/2023. Results of the monitoring will be reviewed at the Quality Assurance meeting. 5. 4/25/2023 see attachment	

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 _____	03/23/2023

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 610	Continued From page 12	F 610		

indicating intact cognition. The resident's care plan stated, ". . . He is able to make needs known. . . ."

The progress notes identified the following:
* 03/02/23 at 8:50 a.m., "Social worker got a written letter from Residents [sic] daughter about an incident that happened on 2-28-23. In regard to a [sic] having an incident with a CNA [certified nurse aid], residents' [sic] daughter has requested that this specific CNA can no longer work with resident. . . ."
* 03/02/23 at 11:01 a.m., "Social worker visited with resident about incident. . . ."
* 03/02/23 at 3:15 p.m., "Residents [sic] daughter wanted the Social worker and DON [Director of Nursing] to call her and discuss the incident."
* 03/14/23 at 8:54 a.m., "Social worker visited with parties involved in incident that got reported to social worker on 2-28-23, Visited with CNA and got a written statement about situation. . . . Charge Nurse assigned Abuse Neglect training to all the CNA [sic]/LPNs [License Practical Nurses]/and RNs [Registered Nurses]. . . ."

The facility provided a copy of the letter Resident #19's daughter submitted to them. This letter, dated 03/01/23, identified the following:
* The resident was crying when she entered the room.
* The resident described a CNA (#13) as "being mean," "man handling," and "being really rough with him."
* When Resident #19 told the CNA (#13) to be careful he was in pain, the CNA told him to shut up and stated, "that's why no one wants to come help you in here. Your [sic] always crying around and your room smells like [feces]! She also told

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 _____	03/23/2023

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 610	Continued From page 13	F 610		

him no one wants to come clean him up because you get [urine] all over your bed."
* When the resident asked the CNA (#13) to leave his room, she responded, "good I dont [sic] want to be in here anyway it stinks" and "Why do you think no one visits you?"
* Resident #19's daughter stated, "To me? that is Abuse. No one deserves to be treated that way" and "I don't want her [CNA #13] anywhere near my father if that can be possible."

Interviews on 03/22/23 identified the following:
* At 10:39 a.m., an administrative staff member (#2) indicated she was notified of the incident involving possible verbal abuse and began her investigation "the same date as my progress note [03/02/23 at 8:50 a.m., two days after the incident occurred]." The staff member (#2) also indicated she interviewed both CNAs (#13 and #14) involved in the incident and only one of them (#13) provided a written statement.
* At 10:52 a.m., Resident #19 confirmed his daughter accurately described the incident that occurred on 02/28/23. During the interview, a CNA entered the room to deliver a snack and as the CNA exited the room, the resident stated, "That's her [CNA #13]." When asked if he was comfortable with the CNA (#13) entering his room, the resident shrugged his shoulders. The facility failed to ensure the CNA (#13) did not enter Resident #19's room as family requested.
* At 11:34 a.m., When asked when she started her investigation, an administrative staff member (#1) stated, "It started the same day [as the incident, on 02/28/23]." When asked if she had any supporting documentation, she replied, "No. The only documentation is what staff member (#2) put in her progress notes [on 03/02/23]." The

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 _____	03/23/2023

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 610	Continued From page 14	F 610		

staff member (#1) confirmed the nurse (#4) failed to write a progress note, the nurse (#4) and one of the CNAs (#14) failed to submit a written statement regarding the incident, and the facility allowed the accused CNA (#13) to provide resident cares during the five-day investigation period.

Review of the staff schedule confirmed the CNA (#13) worked on all five days of the investigation period (February 28-March 4, 2023). During the investigation, the facility failed to implement staffing changes to protect residents from the alleged perpetrator.

During an interview on 03/23/23 at 8:54 a.m., a nurse (#4) confirmed she worked the morning the incident occurred, overheard parts of the conversation between the Resident #19 and the CNA #13, and "briefly spoke" with administrative staff member (#1) about the incident. When asked why she did not write a progress note, the nurse (#4) replied, "I'm not sure why I didn't." The nurse (#4) failed to document the events related to the incident between the Resident #19 and the CNA (#13) and failed to prevent possible further abuse from occurring when she allowed the CNA to continue providing cares throughout the shift.

During an interview the afternoon of 03/23/23, the administrative staff (#1) stated they placed the CNA (#13) on administrative leave today while "we do the investigation the right way."

The facility failed to complete the following:
* Document/report the allegation of verbal abuse within two hours of being notified.
* Immediately begin an abuse investigation.

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 _____	03/23/2023

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 610	Continued From page 15 * Protect Resident #19 and other residents by implementing staffing changes/removing the accused CNA (#13) from resident cares on the day of the incident and throughout the five-day investigation period. * Thoroughly investigate the allegation of verbal abuse. * Ensure the CNA (#13) did not enter Resident #19's room as family requested.	F 610		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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	F 657		4/25/23

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 _____	03/23/2023

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 657	Continued From page 16 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident, family, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the residents' current status for 5 of 15 sampled residents (Residents #1, #8, #10, #18, and #24). Failure to review/revise the care plans to reflect the residents' current status limited the staff's ability to communicate needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Dunseith Community Nursing Home Comprehensive Care Plans" occurred on 03/23/23. This policy, dated July 2018, stated, ". . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment. . . ." - Observation on 03/20/23 at 1:29 p.m. in Resident #1's room showed a soiled mechanical lift sling, a soiled wheelchair with a missing right arm pad and right brake handle topper, a glued crack on the left pedal frame, and torn outer covering on the wheelchair cushion. The resident stated concern the staff send the sling to laundry and never return the sling. During interviews on the morning of 03/23/23, an administrative staff member (#3) stated Resident #1 removed the wheelchair arm rest himself, refused a new wheelchair cushion and a new	F 657	1. Care plans for Residents #1, #8, #10, #18, and #24 have been reviewed and revised. This facility failed to review and update care plans for #1, #8, #10, #18, and #24. Failure to review/revise the care plans to reflect the residents' current status limited the staff's ability to communicate needs and ensure continuity of care for each resident. These care plans were reviewed and revised to reflect the residents current status. 2. All residents have the potential to be affected by this deficient practice. 3. All Nursing staff will be in-serviced on 4/24/2023 to educate staff on the importance of an accurate, current care plan necessary to provide the optimal care for our residents and staff will be in-serviced on the proper procedure for documentation. 4. DON/IP/Designee will do a quality monitoring on Nursing staff to ensure staff is following the policy/procedure related to care planning and assessments. Quality monitor will be done 2x weekly X 16 weeks, then monthly until 100% compliance is met for 2 consecutive months. The above monitoring will be initiated starting 04/25/2023. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 04/25/2023	

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 _____	03/23/2023

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 657	Continued From page 17	F 657		

wheelchair the facility ordered for him, and the resident "is a fixer" and doesn't like when things are taken out of his room,.

During an interview on the afternoon on 03/20/23, administrative staff members (#1 and #3) stated facility staff believe Resident #1 is inflicting self-harm to the chronic wounds to the back of both legs and sacral area.

Resident #1's care plan failed to address the resident's behaviors related to inflicting self-harm to his wounds, fears surrounding items being removed from his room, wanting to "fix" his own equipment, and refusal of new equipment offered.

- Review of Resident #8's medical record occurred on all days of survey and included a diagnosis of type II diabetes mellitus. The current care plan stated, "Resident will have blood glucose levels assessed bid [twice a day] with alternating times and as needed . . ."

During a phone interview on 03/21/23 at 10:14 a.m., Resident #8's family member (B) indicated the resident has a continuous blood glucose monitoring (CGM) device inserted in her arm.

Observation on 03/22/23 at 11:43 a.m., showed a licensed nurse (#6) obtained a blood glucose check on Resident #8 using the CGM device in the resident's left upper arm.

During an interview on 03/23/23 at 9:15 a.m., an administrative nurse (#1) confirmed Resident #8 does have a CGM device in the left arm and the staff are using the CGM device for monitoring the

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 _____	03/23/2023

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 657	Continued From page 18	F 657		

resident's blood glucose levels.

Resident #8's care plan failed to address the CGM device.

- Review of Resident #10's medical record occurred on all days of survey and identified a diagnosis of dysphagia (difficulty swallowing). Provider's orders, dated 12/30/22, stated, "Special Instructions: May have small sips if [sic] nectar thick liquid throughout the day. . . ."

Resident #10's care plan stated, "Problem Start Date: 03/26/2021 . . . Resident is a risk for aspiration and requires a feeding tube R/T [related to] dysphagia. . . . Approach Start Date: 05/20/2021: NPO [nothing by mouth] except glycerin swabs [relieves dry mouth]. . . ."

Resident #10's care plan failed to reflect the change in NPO status.

- Review of Resident #18's medical record occurred on all days of survey. The current care plan stated, ". . . 04/09/19 . . . Nutritional Status. . . Resident is [sic] risk for impaired nutrition . . . Staff will provide resident with a regular diet with half finger foods, half pureed foods, due to choking. . . . Staff will offer fluids with and between meals. . . ."

Observation on all days of survey showed Resident #18 received a pureed diet and nectar thickened liquids.

Physician orders included Nectar thickened liquids three times a day, start date 02/02/23, and Pureed diet, start date 03/20/23.

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 _____	03/23/2023

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 657	Continued From page 19 Review of Resident #18's quarterly MDS, dated 01/08/23, identified a significant weight loss that was not physician prescribed. Resident #18's care plan failed to address weight loss, nectar thickened liquids, and the current diet order. - Review of Resident #24's medical record occurred on all days of survey and included a diagnosis of dementia. The current care plan included the following: * 09/22/2022, ". . . Resident will follow the DCNH [Dunseith Community Nursing Home] smoking policy over the next 90 days. . . . Resident will keep all smoking materials at nurses station per DCNH smoking policy. . . ." * 03/05/21, ". . . Independent with ambulation and locomotion on/off unit with use of FWW [front wheeled walker]. . . ." * 07/20/21, ". . . Encourage assist x 1 [with one staff member] with FWW in the hallways. . . ." Observation on 03/21/23 at 12:03 p.m. showed Resident #24 in the wheelchair with a gait belt on, FWW in front of him and two CNAs (#11 and #12) attempting to assist the resident with ambulation. The resident refused to ambulate. The CNA (#12) stated, "He [Resident #24] requires extensive assist with two staff for ambulation. We try to encourage him to ambulate to meals." Observation on all days of survey showed Resident #24 using the wheelchair as his primary mode of transportation.	F 657		

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 _____	03/23/2023

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 657	Continued From page 20 During an interview on 03/23/23 at 8:20 am., an administrative staff nurse (#1) confirmed Resident #24 had not smoked cigarettes for several months and staff failed to revise the care plan to reflect this. Resident #24's care plan failed to accurately reflect the level of assistance required with ambulation, his primary mode of locomotion with the wheelchair, and nonsmoking status.	F 657		
F 658 SS=D	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 observation, record review, review of facility policy, and family and staff interviews, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #8) observed with a continuous glucose monitor (CGM). Failure to monitor blood glucose levels according to the attending physician's orders and/or obtain a physician's order for the CGM may result in inconsistency of obtaining blood glucose levels and potential errors in the amount of insulin required. Findings include: Review of the facility policy titled "Blood Glucose Monitoring" occurred on 03/23/23. This policy, dated 09/20/22, stated, ". . . Policy Explanation and Compliance Guidelines: 1. The facility will	F 658	1. This facility failed to monitor blood glucose levels according to the attending physician's orders for CBG for resident # 8. Nursing staff obtained an updated order for blood glucose monitoring for resident #8. 2. All residents who require blood glucose monitoring have the potential to be affected by this deficient practice. 3. All Nursing staff will be in-serviced on 4/24/2023 related to preforming blood glucose monitoring as per physician's orders. Nursing staff will perform the blood glucose test utilizing the appropriate glucometer. Staff will be in serviced on correct documentation for the use of an alternative device such as (CGM Monitor). Physician notification of	4/25/23

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 _____	03/23/2023

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 21 perform blood glucose monitoring as per physician's orders. 2. The nurse will perform the blood glucose test utilizing the facility's glucometer as per manufacturer's instructions. . . ." The policy failed to include the use of a continuous blood glucose monitor. During a phone interview on 03/21/23 at 10:14 a.m., Resident #8's family member (B) indicated the resident has a continuous blood glucose monitoring (CGM) device in her arm since 04/22/22 when the resident was admitted to the facility. The family member (B) also stated she changes out the CGM device when it is due, "Because the facility doesn't do that and the doctor doesn't like them." Review of Resident #8's medical record occurred on all days of survey and included a diagnosis of type II diabetes mellitus. Physician's orders included sliding scale insulin four times a day and "Accu Check [glucometer monitoring device] PRN [As Needed] . . ." Observation on all days of survey showed a CGM device present to Resident #8's left upper arm. Observation on 03/22/23 at 11:43 a.m., showed a licensed nurse (#6) obtained a blood glucose check on Resident #8 using the CGM device in the resident's left upper arm and administered the resident's sliding scale insulin based on the result of the CGM device. During an interview on 03/23/23 at 9:15 a.m., an administrative nurse (#1) stated, "We don't use	F 658	usage of an alternative device along with proper documentation if there is a order for a change in device. 4. DON/Designee will do a Quality Monitoring on Nursing staff to ensure staff is following the policy/procedure for correct documentation, Physician notification and use of Blood Glucose Monitoring. Quality monitor will be done weekly until 100% compliance has been met for 2 consecutive months. The above monitoring will be initiated starting 04/25/2023. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 04/25/2023	

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 _____	03/23/2023

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 22 the CGM devices here and that is why the resident's family member is changing the CGM device. The administrative nurse (#1) also stated Resident #8's doctor "Does not feel the CGM devices are accurate and he doesn't like to order them." The facility failed to notify the physician of Resident #8's use of the CGM device, obtain a physician's order for the CGM device, educate and train staff on the use of the CGM device, and document when the CGM device is changed.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and resident and staff interview, the facility failed to provide appropriate treatment and services to promote healing and prevent deterioration of pressure ulcers for 1 of 2 sampled residents (Resident #1) reviewed with pressure ulcers.	F 686	1. This facility failed to provide appropriate treatment and services to promote healing and prevent deterioration of pressure ulcers for Resident #1. Pressure ulcers were assessed and staged appropriately by PCP on 3/27/2023, 4/3/2023, 4/10/2023,	4/25/23

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 _____	03/23/2023

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 686	Continued From page 23 Failure to follow physician's orders, accurately apply wound treatment/dressings, and ensure adequate assessment of the ulcers may result in delayed healing. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 894, stated, "Stages of pressure injuries [ulcers]. . . . Stage 1: skin is unbroken and reddened, but does not blanch. . . . Stage 2: partial-thickness skin loss. . . . Stage 3: full-thickness skin loss and damage that may reach as deeply as the fascia [connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber and muscle in place]. . . . Page 902 stated, ". . . Pressure Injuries: When a pressure injury is present, the nurse notes the following: Location of the injury . . . Size of injury in centimeters. Measure greatest length, width, and depth. . . . . Stage of the injury . . ." Page 914 stated, ". . . Securing Dressings: The nurse tapes the dressing over the wound, ensuring that the dressing covers the entire wound . . . The tape should adhere to intact skin. . . ." Review of the facility policy titled "TREATMENT OF PRESSURE SORES" occurred on 03/23/23. This policy, revised in 2005, stated, ". . . Equipment . . . treatment medication ordered by MD [medical doctor]. . . . Safe Clens [wound cleanser] or Normal Saline [mixture of sodium chloride (salt) and water] . . . Procedure . . . Rinse reddened or excoriated areas with Normal Saline or Safe Clens and apply medication or trmt [treatment] per order of MD. . . ."	F 686	4/24/2023. Orders were reviewed at that time by PCP and care plan was updated. 2. All residents have the potential to affected by this deficient practice. 3. All Nursing staff will be in-serviced on 4/24/23 the policy/procedure for treatment of pressure sores. Pressure ulcer staging will be completed by qualified staff/PCP. The Nursing staff will be responsible to follow the physician orders and complete accurate documentation of pressure ulcer/wound assessment/treatment. 4. DON/IP/Designee will do quality monitoring on all pressure wounds weekly until 100% compliance is met for 2 consecutive months. The above monitoring will be initiated started 04/25/2023. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 04/25/2023	

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 _____	03/23/2023

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 686	Continued From page 24 Review of the facility policy titled "Skin Condition" occurred on 03/23/23. This policy, updated April 2001, stated, "To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. . . ." During an interview on 03/20/23 at 1:29 p.m., Resident #1 stated he has open areas behind both of his upper legs and his left leg bleeds more than his right. Review of Resident #1's medical record occurred on all days of survey. Diagnoses included paraplegia (paralyzed from the waist down); pressure ulcer of unspecified buttock, unspecified stage; and pressure ulcer of sacral region, unspecified stage. Physician's orders stated, "Cleanse with Normal Saline, Apply Ostomy Powder [a non-medicated powder that is designed to absorb moisture from raw or broken skin] to bilateral [both] thighs, then apply calmo [calmoseptine - a moisture barrier ointment] and silvadene [medication used to help prevent and treat wound infections], cover with telpha (sic) [a non-absorbent, dry dressing pad that won't stick to the wound] BID [Twice A Day] . . ." and "Complete Wound Measurements on all wounds and document under wound management every Friday. . . ." A quarterly Minimum Data Set (MDS0, dated 01/01/23, identified three Stage 2 pressure ulcers. Review of the most recent wound assessments,	F 686		

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 _____	03/23/2023

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 686	Continued From page 25	F 686		

dated 03/16/23, identified two right thigh abrasions, three left thigh abrasions, and two gluteal fold abrasions.

Observation on 03/21/23 at 11:14 a.m. showed a staff nurse (#4) entered Resident #1's room to perform wound care. The resident rolled to the left side and showed large open areas with varying degrees of skin/subcutaneous tissue loss to the back of both legs extending up to both buttocks. With a gloved hand, the nurse (#4) mixed calmoseptine, silvadene, and bag balm together in a plastic cup, and without cleansing the wounds, applied it over the visible affected areas. The nurse covered the visible wounds with large pieces of telfa secured with paper tape. Two certified nurse aids (CNAs) (#7 and #9) then assisted Resident #1 to standing position which showed part of the wounds on the residents left buttock lacked medication/ointment and telfa from the wound treatment just provided by the nurse (#4). Tape that secured the existing telfa ran across a portion of the left buttock wound (tape on the wound).

During an interview on 03/23/23 at 8:52 a.m., the nurse (#4) stated she added bag balm to the calmoseptine and silvadene "to increase the spreadability," when performing the wound assessments she did not "really know what to call them [wounds]," and she did not measure depth of the wounds because "It [the electronic wound assessment program] doesn't ask for that." The nurse (#4) confirmed she did not contact the physician and/or pharmacist regarding the addition of bag balm to the treatment regimen.

The facility failed to follow physician's orders for

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 _____	03/23/2023

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 686	Continued From page 26 wound care and altered the wound treatment without notifying the provider. The facility also failed to ensure all areas of the wounds received the ordered treatment, apply tape only to intact skin, and complete accurate wound assessments.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and resident and staff interview, the facility failed to ensure resident safety for 5 of 15 sampled residents (Residents #10, #12, #18, #19 and #24). Failure to ensure the safety of residents with exit-seeking behavior and residents who smoke and failure to properly dispose of narcotic patches placed the residents at risk for adverse events and injury. Findings include: ELOPEMENT - Review of Resident #18's medical record occurred on all days of the survey. The quarterly Minimum Data Set (MDS), dated 10/08/22, identified the resident required supervision with	F 689	1. Staff will be in-serviced on the need to monitor residents #18 and #24 when they are in or around entry's. Staff will be in-serviced to notify the charge nurse of time when resident #12 goes outside to smoke. Staff will be in-serviced on the disposition of fentanyl transdermal patch. The disposition of fentanyl patches for resident # 10 and #19 is completed by two licensed staff, which consists of removing the patch, folding in half, discarding into "RX destroyer with solvent" bottle and this is completed in the locked med room and is then locked in the medication cabinet. 2. All residents have the potential to be affected by these deficient practices. 3. All Staff will be in-serviced 4/24/2023 on the safety of residents with	4/25/23

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 _____	03/23/2023

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 689	Continued From page 27 walking in room and corridor. The current care plan stated, ". . . Resident has a history of elopement and exit seeking. Resident continuously walks by entrance of door setting off wander guard alarms. . . ." The progress notes for Resident #18 included the following: * 10/29/22 at 3:04 p.m., "Post Elopement: Resident had just left bingo, had been walking towards his room. Charge nurse had got a call 5-10 minutes later that the resident was sprinting towards [name of local restaurant] and the caller was attempting to get him in her vehicle to return him. Med aid [sic] took off to assist returning resident, resident was escorted by police to return to nursing home. No injures noted upon arrival. . . ." - Review of Resident #24's medical record occurred on all days of the survey and identified the facility placed a wanderguard on the resident's walker and wheelchair on 09/17/2022. The quarterly MDS, dated 11/24/22, identified the resident requiring supervision with walking in room and corridor. The current care plan stated, ". . . Resident has a history of behavioral issues r/t [related to] history of elopements as evidence by resident attempts to go to store to get cigarettes or smokeless tobacco. . . . Wander guard placed on walker and wheelchair . . ." Progress notes for Resident #24 included the following: * 09/19/22 at 2:25 p.m. "Resident was found in the town at [local business]. Resident was found by staff . . . Resident was in a pleasant mood and no injuries were observed. Resident was then	F 689	exit-seeking behaviors and the resident who does smoke. Staff have been in-serviced on the procedure that the charge nurse will be notified when the Resident is going out to smoke and when resident comes back from smoking. All staff will also be in-serviced on 4/24/2023 on how to properly dispose of narcotic patches. The policy has been reviewed and revised to reflect the proper disposal of fentanyl transdermal patches. 4. DON/IP/Designee will do a quality monitor on staff to ensure staff are following policy/procedure related to resident environments to remain free of accidental hazards as possible and that each resident receives adequate supervision. DON/IP/Designee will do a quality monitoring related to the disposal of fentanyl patches by folding in half and disposing down the toilet immediately. Quality monitoring will be done weekly until 100% compliance is met for 4 consecutive weeks followed by monthly until 100% compliance is met for 2 consecutive months. The above monitoring will be implemented 4/25/2023. Results of the monitoring will be reviewed at the Quality Assurance meeting. 5. 04/25/2023	

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 _____	03/23/2023

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 689	Continued From page 28 picked up by another staff member with facility van and resident willingly entered van to return to facility. . . ." * 09/20/22 at 8:17 p.m. "Resident was observed trying to leave facility grounds and staff did have difficulty redirecting at first. About 15 min later, resident did come back to facility. . . ." * 10/05/22 at 6:15 p.m. " . . . : Resident left facility before 15 min elopement check. Resident found across the road at post office, trying to go to the store . . . Resident redirected back into facility. Agitated when telling him he couldn't be outside by himself. . . ." On 03/22/23 at 11:53 a.m., two administrative staff (#1 and #3) demonstrated the wanderguard door alarm system was operational. During an interview on 03/22/23 at 11:13 a.m., two administrative staff members (#1 and #3) stated they felt the above elopements occurred due to another resident with a wander guard in close proximity to the door and staff reset the wanderguard alarm prior to checking the perimeter for potential other resident elopements. Administrative staff member (#1) states she expects staff to check the perimeter/grounds of the facility prior to re-setting the wanderguard alarm. The administrative staff member (#1) stated she educated the staff scheduled when the above elopements occurred, did not document that education and did not educate all staff. SMOKING During an interview on the afternoon of 03/20/23, an administrative staff member (#3) stated the	F 689		

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 _____	03/23/2023

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 689	Continued From page 29	F 689		

facility had one resident (Resident #12) who smoked independently in a designated smoking area.

During an interview on 03/20/23 at 3:39 p.m., Resident #12 stated she smokes "out back in a shed" and indicated she has to ask the nurses for her cigarettes and lighter.

Review of the facility policy titled "RESIDENT SMOKING POLICY" occurred on 03/23/23. This policy, dated September 2022, stated, ". . . Residents who choose to smoke will be allowed to smoke in a designated smoking area that is located outside of the facility. . . . Residents who chose to smoke will be evaluated on their ability to smoke independently. If the resident can smoke independently, they will be allowed to smoke without supervision in the designated smoking area . . ."

Review of Resident #12's medical record occurred on all days of survey. The resident's care plan stated, ". . . Resident is an unsupervised smoker. Smoking schedule as follows 8am-8pm every two hours weather permitting. . . . Resident will frequently try to go outside throughout the day to try to smoke during unscheduled times. Resident has been observed taking butts off ground . . ."

A smoking assessment completed on 10/18/22 indicated Resident #12 can safely smoke independently.

Observation on 03/21/22 at 10:03 a.m. showed Resident #12 obtain a container with a cigarette and lighter inside from a nurse. The resident

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 _____	03/23/2023

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 689	Continued From page 30	F 689		

walked down a back hallway, entered a code on a keypad located beside the door, exited the building, and walked to a shed. The resident applied a smoking apron, sat down in one of the three chairs, smoked her cigarette, and reentered the building using a code on a keypad next the door. The resident returned her container with the lighter to a nurse.

During an interview on 03/23/23 at 8:43 a.m., when asked how the facility staff ensure Resident #12 returns to building in a timely manner, an administrative staff member (#3) stated, "She has to return her smoking materials to the nurse." When asked what processes were in place to call for help if Resident #12 suffered a fall or medical emergency while outside or in the shed, the staff member (#3) stated, "I have no answer for that."

The facility's smoking plan/policy lacked a method/procedure or call system to ensure Resident's #12's safety while outside the building/smoking.

NARCOTIC DISPOSITION

Review of the "Fentanyl Transdermal [delivery of medication through the skin usually through a patch] System" prescribing information found at https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=e15a7e9b-8025-49dd-9a6d-bafcccf1959f&type=display, stated, ". . . Disposal Instructions. . . . A considerable amount of active fentanyl remains in fentanyl transdermal system even after used as directed. . . . Placing fentanyl transdermal system in mouth, chewing it, swallowing it, or using it in ways other than indicated . . . has resulted in accidental

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 _____	03/23/2023

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 689	Continued From page 31 exposures and deaths. . . . Disposing of a fentanyl transdermal system. Fold the used fentanyl transdermal system in half so that the sticky side sticks to itself . . . Flush the used fentanyl transdermal system down the toilet right away . . ." Observations of fentanyl patch removal showed the following: * 03/21/23 at 11:50 a.m., a nurse (#4) removed a fentanyl patch from Resident #10's upper arm, folded it in half, and disposed of it in a sharps container attached to the nurse's medication cart. * 03/22/23 at 11:08 a.m., a nurse (#5) removed a fentanyl patch from Resident #19's upper back, folded it in half, handed it to a nurse (#6) who rolled the patch inside her glove when she doffed it. Prior to exiting the room, the nurse (#6) handed the glove with the patch in it to the nurse (#5) who placed the glove in a sharps container attached to the nurse's medication cart. The nurse (#6) stated, "I always put them [fentanyl patches] in the sharps container. I am not sure if that's right or not." During an interview on 03/22/23 at 11:23 a.m., an administrative nurse (#1) stated the facility did not have a policy for the disposal of fentanyl patches.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692		4/25/23

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 _____	03/23/2023

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 692	Continued From page 32 ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 1 of 3 sampled resident (Resident #18) with significant weight loss. Failure to implement interventions, adequately assess the effectiveness of existing interventions, ensure consistent implementation, and re-evaluate the need for updated or additional interventions resulted in a significant weight loss. Findings include: Review of the facility policy titled "DCNH (Dunseith Community nursing Home) Weight Monitoring" occurred on 03/23/23. This policy, dated 09/22/22, stated, ". . . 1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: a. Identifying and assessing each resident's nutritional status and risk factors. b.	F 692	1.The facility will ensure nutritional assessment by dietician is completed no less than quarterly for Resident #18. This facility will document and assess supplement intake for resident #18. The facility will continue to weigh resident #18 weekly and be sure proper documentation is recorded. The care plan for resident # 18 has been updated to reflect current interventions. Resident #18 care plan now includes addition of mighty shakes six times per day. Resident #18 weekly weights have shown resident has not had a significant change in his weight. 2. All residents have the potential to be affected by this deficient practice. 3. All nursing staff/dietary manager/dietician will be provided education relating to nutritional assessments and supplemental intake assessments on 4/24/2023. The Staff	

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 _____	03/23/2023

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 692	Continued From page 33 Evaluating/analyzing the assessment information. c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary . . . 6. ". . . A significant change in weight is defined as: a. 5% [percent] change is weight in 1 month (30 days) b. 7.5% change in weight in 3 months (90 days) c. 10% change in weight in 6 months (180 days) . . ." Review of Resident #18's medical record occurred on all days of survey. The care plan stated, ". . . Resident is risk for impaired nutrition . . . as evidence as resident has involuntary movements causing his food to miss his mouth . . . Staff to weigh me per DCNH policy and monitor for stability of my weight. Implement interventions as needed. Resident will maintain a healthy weight. . . ." Physician orders included the following: * 01/06/21 Mighty Shake Special Instructions: 6 times a day, 1 each with meals and snacks * 02/02/23 Nectar Thickened Liquids Three Times A Day * 03/20/23 Pureed diet A quarterly Minimum Data Set (MDS), dated 01/08/23, identified Resident #18 had a significant weight loss that was not physician prescribed. The record identified the following weights: * 07/08/22 - 175.6 pounds (lbs) * 12/07/22 - 177.2 lbs * 01/04/23 - 163.6 lbs (7.67 % weight loss in 1 month)	F 692	have been educated on the policy/procedure related to weight monitoring, identifying and assessing resident's nutritional status and risk /analyzing the assessment information. Developing and consistently implementing effective interventions, monitoring to be sure whether or not they are working and revising them as indicated. 4.DON/Dietary Manager will do QA monitoring that the documentation of weekly weights has been completed and assessed by nursing staff to identify weight changes and that any nutritional interventions are included on the resident care plan. Quality monitoring weekly X 16 weeks, then monthly until 2 consecutive months are met at 100%. The above monitoring will be implemented 04/25/2023. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 04/25/2023	

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 _____	03/23/2023

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 692	Continued From page 34 * 03/14/23 - 160.4 lbs (9.48% weight loss in 3 months) Meal intake records included percentages of all fluids consumed by Resident #18, but did not show specifically the percentage of the mighty shakes he consumed. Resident #18's progress notes stated the following: * 01/08/23 3:15 p.m., "Dietary: Resident eats ruffly [sic] 26-50% of his meals when he does eat. Has had a weight change, talk with nurse. Current weight is 163.6 lbs. BMI [body mass index] 23.47. Will continue to monitor. . . ." * 01/08/2023 5:59 p.m., "Nursing: Sat with resident and tried to assist with feeding. Allowed a couple spoons of potatoes . . . Dietary manager assured me he is getting enough calories via mighty shakes, and ice creams, etc. . . ." * 02/20/23 4:16 p.m., "Nursing: Discussed with Dietary Supervisor her concerns with resident having a hard time swallowing his liquids lately. Phone call to [Dr's name] to discuss. New order: Nectar Thickened liquids. Will further discuss on DCNH Rounds 02/28/23. . . ." * 03/10/23 2:30 p.m., "Nursing: Resident did have a choking episode this afternoon. Was given a banana for snack and choked on a piece. Was able to dislodge per self. No adverse side effects noted. . . ." * 03/11/23 7:44 p.m., "Nursing; did feed resident this morning. Noted when taking bites of pureed eggs and sausage, resident was not able to swallow without liquids. When giving a bite of oatmeal with milk, resident was able to swallow on his own. Will continue to monitor. No further concerns. . . ."	F 692		

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 _____	03/23/2023

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 692	Continued From page 35 * 03/20/2023 7:04 p.m., "Nursing: This writer fed resident all meals on 7am-7pm shift. Resident has not been able to eat finger food or chopped foods without having hard time swallowing. Resident has been tolerating pureed foods well. Resident refuses to grab his food per self. Discussed with [name of doctor]. New order: Pureed Diet at all times. Resident is tolerating thickened liquids well. No further concerns at this time. . . ." * 03/23/23 8:53 a.m., "Dietician: Spoke with food service manger 03/20/23 regarding (Resident #18's name) increasing difficulty tolerating current diet consistency. . . . Continue with previous nutrition plan of mighty shake supplements at all meals and snacks for calories, protein, vitamins & minerals due to previous weight change. Calorie needs higher due to constant uncontrolled movements. Weight 3/14/23 160.4#, 3/8/23 162.4# without significant change over 2-3 months. . . ." Note the resident had a significant weight loss in the past three months. The last dietary assessment was completed on 03/24/21, two years ago. During an interview on 03/23/23 at 10:30 a.m., an administrative nurse (#1) confirmed the facility failed to re-assess interventions put in place, document intake of supplements (mighty shake), care plan previous and/or current weight loss interventions, and recognize continued weight loss for Resident #18. The facility failed to: * Complete a nutritional assessment by the dietician routinely or in a timely manner related to	F 692		

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 _____	03/23/2023

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 692	Continued From page 36 weight loss. * Document and assess supplement intake of supplements * Recognize continued weight loss despite receiving supplements and initiate/monitor additional interventions * Care plan the various interventions they had attempted, identifying if they were successful or needed to be modified.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the	F 693	1. This facility will flush the gastrostomy tube with at least 15 mL of water the	4/25/23

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 _____	03/23/2023

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 693	Continued From page 37 facility failed to provide the necessary care and services to prevent complications for 1 of 1 sampled resident (Resident #10) observed with a feeding tube. Failure to flush a gastrostomy (gastric) tube (tube surgically inserted into the stomach) as ordered before and after administration of medications and/or start of a feeding may result in adverse effects. Findings include: Nursing skills information found at https://med.libretexts.org/@go/page/44641, updated February 2022, stated, "15.6: Checklist for Enteral [intake of food via the gastrointestinal (GI) tract] Tube Medication Administration . . . flush the tube with at least 15 mL [milliliters] of water to verify patency. Administer diluted medication. . . . After all medications are administered, flush the tube with at least 15 mL of tepid [moderately warm] water. . . . it is essential to flush the tube when beginning and ending medication administration to prevent tube clogging. . . ." Review of Resident #10's medical record occurred on all days of survey. The resident's care plan stated, ". . . requires a feeding tube R/T [related to] dysphagia (difficulty in swallowing). . . ." Physician's orders included "Isosource [liquid nutrition] . . . 4x [times] a day. . . ." and "May Crush all medications and give at one time via peg [feeding] tube as long as dissolved in warm water . . ." Observation on 03/21/23 at 11:50 a.m. showed a staff nurse (#4) prepared and crushed five oral medications, placed them into a paper cup, and	F 693	gastrostomy tube per policy for resident #10 before and after administration of medication. The facility will ensure staff will properly follow facility policy/procedure when providing enteral nutrition to prevent any avoidable adverse effects. 2. Any residents who is provided Enteral Nutrition have the potential to be affected by this deficient practice. 3. All nursing staff will be in-serviced on 4/24/2023 updated facility policy related to Enteral Nutrition. 4. DON/IP will do quality monitoring on Nursing staff to ensure staff are following policy/procedure related to Enteral Nutrition. Quality Monitoring will be completed weekly X 16 weeks, then monthly until 100% is met for 2 consecutive months. The above monitoring will be implemented 4/25/2023. 5. 4/25/2023	

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 _____	03/23/2023

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 693	Continued From page 38 then diluted the medications with warm tap water. The nurse administered the medications via the feeding tube and then started the resident's Isosource. The nurse (#4) failed to flush the feeding tube with water before and after administering the medications. During an interview on 03/23/23 at 11:46 a.m., an administrative nurse (#1) stated she expects nursing staff to flush feeding tubes with water before and after medication administration and before starting tube feedings.	F 693		
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 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,	F 812	1. The facility will ensure refrigerator and	4/25/23

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 _____	03/23/2023

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 39 and staff interview, the facility failed to ensure food is stored, prepared, and served in a sanitary manner for 2 of 2 kitchens (Main and Utility Room C also known as the "small kitchenette") and 1 Dry Storage Room. Failure to store food properly, use food by the "use by" date, and label food may result in the spread of foodborne illness to residents, staff, and visitors. Findings include: Review of the facility policy titled, "Use and Storage of Food Brought in by Family of Visitors" occurred on 03/20/23. This policy, revised February 2023, stated, ". . . All food items . . . brought in must be labeled with content and dated. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. The prepared food must be consumed by the resident within 3 days. If not consumed within 3 days, food will be thrown away . . ." The facility failed to provide further food storage and labeling policies upon request. Observation of the main kitchens and dry storage area occurred on 03/20/23 at 12:10 p.m. with a dietary staff member (#10) and showed the following: Main Kitchen Walk-In Cooler: - Undated and un-labeled - An approximately five cup plastic container with a red meat sauce, identified by the dietary manager as "Chili from the previous week-end," a container of "cooked sausage links," a container of "cooked carrots," and a container of "cooked mixed vegetables." - Large grey tubs labeled with the corresponding food item containing large frozen bags of	F 812	freezer temperature logs are logged daily to prevent the use of expired food. The facility did clean the spilled food on the bottom of the freezer and the dented can was removed immediately. Spills will be cleaned up immediately as they happen and dented cans will be sent back to supplier. The chest freezer has been defrosted and cleaned. The four bags of dry cereal without expiration dates were disposed of. These corrections have been corrected to eliminate any avoidable harm to the residents, staff, and/or visitors. 2. All residents, visitor and staff have the potential to be affected by these deficient practices. 3. All Kitchen staff will be in-serviced on 4/24/2023 on facility policy related to dating all food containers. All Kitchen staff will be in-serviced on daily temperature logs for the refrigerators and freezers to prevent the potential spread of illness and/or foodborne illness to residents/staff. The freezer will be defrosted quarterly to prevent ice build up. All kitchen staff and Nursing staff will be in-serviced on ridding of expired food which include the utility room C, Small Kitchenette, dry storage room. All Kitchen staff will be in serviced on adding the dates of the food and their expiration dates. 4. DON/IP/Dietary Manager will do a quality monitor on Kitchen staff to ensure staff are following policy/procedure on dating/labeling and logging refrigerator/freezer temperatures daily. Freezer will be defrosted quarterly to	

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 _____	03/23/2023

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 40 unopened chicken nuggets and chicken patties with no use by or expiration dates. *Storage shelves: - Undated covered plastic containers identified by the dietary manager as containing dry cereal. - A box with an opened multi-use bag of taco seasoning with no opened date. The dietary staff member (#10) stated staff brought the bags of cereal from the dry storage room and poured them into the plastic tubs and agreed the bulk seasoning should be dated when opened. * Utility Room C/Small Kitchenette: - Two 4-ounce containers the dietary manager identified as "Ham Spread" with a use by date of 03/18/23, two days prior to observation. - One 4-ounce container of orange slices with a use by date of 03/19/23, one day prior to observation. - The freezer compartment contained an undated plastic bag of what was identified as "Corn Dogs" with frost build-up in the bag. The dietary staff member (#10) stated snacks prepared by the kitchen and items brought in by family, must be labeled and dated and must be thrown away after 3 days. *Dry Storage Room - A chest type freezer containing numerous bags of frozen vegetables. The temperature log shows only one temperature taken on 02/17/23 since the end of December 2022. A layer of frost approximately one inch thick is observed on the sides and top ledge of the freezer where the freezer door shuts. Observation also showed the	F 812	avoid ice build up. All canned goods will be inspected prior to shelving, all dented cans will be disposed of. Any packages that are removed from their original packaging will be dated prior to shelving. Quality Monitoring will be done 2x weekly until 100% compliance is met for two consecutive months, followed by monthly total of 1 year. Frequency of QA monitoring will increase if study falls below 100%. The above Monitoring will be implemented 4/25/2023. Results of the monitoring will be reviewed at the Quality Assurance meeting. 5. 04/25/2023.	

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 _____	03/23/2023

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 41 presence of spilled vegetables on the bottom of the freezer. - A one-gallon can of La Victoria Salsa dented near the top seam. - Four of six bags of dry cereal lacked expiration dates. A dietary staff member (#10) stated staff removed the bags from the shipping box with the expiration date to save space. The dietary staff member (#10) confirmed the freezer lacked temperature logs and should have been defrosted, and the dented can of salsa should have been returned per their policy.	F 812		
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 facility assessment conducted according to §483.70(e) and following accepted national	F 880		4/25/23

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 _____	03/23/2023

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 42 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. Personnel must handle, store, process, and transport linens so as to prevent the spread of	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 _____	03/23/2023

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 43 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, facility policy review, and staff interview, the facility failed to follow standard infection control practices for 1 of 1 sampled resident (Resident #8) on isolation. Failure to follow infection control practices related to proper procedure for personal protective equipment (PPE) usage and isolation signage may result in the spread of infection to residents, staff, and/or visitors. Findings include: Review of the facility policy titled "DCNH [Dunseith Community Nursing Home] Transmission-Based (Isolation) Precautions" occurred on 03/23/23. This policy, revised 09/20/22, stated, ". . . It is our policy to take appropriate precautions to prevent transmission of pathogens. 8. Contact Precautions- . . . c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident . . ." Review of Resident #8's medical record occurred on all days of survey and included a diagnosis of Methicillin-resistant Staphylococcus aureus (MRSA) right heel wound. - Observation on 03/20/23 at 1:15 p.m. showed Resident #8's door open with an isolation cart by	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consist with the requirements of ¿483.80 for the infection control deficient practices identified in the deficiency. The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director, shall identify and implement standards for the following: (1) Provide the appropriate signage on the use of specific PPE required for staff before entering an isolation room consistent with nursing facility guidelines from Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services. (2) Identify and implement new and/or revised facility policy and procedures related to infection control standards and practices for proper PPE use with isolation precautions. 2. Identification of Others: The IP and DON, in conjunction with the interdisciplinary team (IDT) will review current isolation precautions (all types of isolation) for nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified	

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 _____	03/23/2023

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 44 the room but no sign on the door to indicate what type of isolation the resident required or PPE to be worn by staff. During an interview on 03/20/23 at 2:21 p.m., an administrative nurse (#1) stated Resident #8 was on contact precautions for MRSA in her heel wounds. - Observation on 03/21/23 at 8:50 a.m., showed two CNAs (#8 and #9) entered Resident #8's room without hand sanitizing and only wearing a surgical mask. The CNAs then donned gloves and transferred Resident #8 from the specialized wheelchair to the bed using a full body mechanical lift. Prior to exiting the room, the CNAs removed their gloves and performed hand hygiene. The CNAs failed to hand sanitize, and donn an isolation gown and gloves prior to entering the resident's room. During an interview on 03/21/23 at 2:22 p.m. a wound nurse (#4) stated Resident #8 is on contact precautions and staff are expected to wear a surgical mask, gown and gloves when entering the resident's room for any cares, not just when doing wound care. During an interview on 03/22/23 at 4:12 p.m., a staff nurse (#5) when asked what kind of precautions staff used with Resident #8 stated, "I think It's contact precautions but let's ask [staff nurse #6] to make sure." During an interview on 03/22/23 at 4:45 p.m., an administrative nurse (#1) stated she expected staff to wear a surgical mask, gown and gloves anytime they enter Resident #8's room and	F 880	non-compliance. 3. System Changes: On or before April 25, 2023 the facility shall complete the following actions: (1) The DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: failure to ensure signage is posted on the specific use of PPE for staff members before entering an isolation room and for proper PPE use when entering an isolation room. (2) The DON and IP will ensure education is provided for the use of the appropriate signage posted required for an isolation room and ensure education is provided for proper PPE use for isolation room. 4. Monitoring: Monitoring of approaches to ensure infection control and prevention are effective will include: (1) Weekly for no less than 12 weeks, the IP, DON and applicable IDT members will conduct on-going monitoring via observation to ensure the facility is complying with requirements for posted signage and wearing proper PPE in isolation room. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrate	

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 _____	03/23/2023

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 45 agreed the facility failed to have appropriate signage posted on the outside of the resident's door identifying what type of isolation precautions and the type of PPE to be worn in the room.	F 880	sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date: 04/25/2023_____	