North Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8094	A. BUILDING: _____ B. WING _____	01/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COMMUNITY NURSING HOME	15 FIRST 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) COMPLETE DATE
B 000	INITIAL COMMENTS The unannounced licensure survey, completed 01/06/2016, included a complete review of 1 current resident and 0 closed records. The facility total census of one resident, and no identified discharges, transfers, and/or deaths since initial licensure in 2012 provided no opportunity for review of any additional current residents or closed records. The survey identified no Tier I findings and two Tier II deficiencies.	B 000		
B 920	33-03-24.1-09,2 GOVERNING BODY 2. The governing body is responsible for approval and implementation of effective resident care and administrative policies and procedures for the operation of the facility. These policies and procedures must be in writing, signed, dated, reviewed annually, and revised as necessary, and shall address: This state licensing rule is not met as evidenced by: Based on review of the facility's Resident Care Policies/Procedures, and staff interview, the governing body failed to ensure annual review of the resident care policies/procedures occurred during 3 of 3 years (2013, 2014, and 2015) reviewed. Failure to review resident care policies/procedures does not ensure residents receive care/services consistent with current standards of practice and in accordance with the intentions and directives of the governing body. Findings include: Review of the facility's Resident Care Policies and Procedures occurred on 01/06/2016, and showed the facility had last reviewed the	B 920 B 920	1. The Nursing Home Administrator and DON have been identified by the DCNH Advisory Board to conduct annual reviews of the Basic Care Resident Care Policies/ Procedures annually. The DCNH Administrator and DON will review the Basic Care Policies/Procedures. 2. All DCNH Basic Care Residents have the potential to be affected by this deficient practice. 3. The DCNH Administrator and DON will review the Basic Care Resident Care Policies/Procedures annually. 4. Corrective Action will be completed by February 15, 2016. 5. The corrective action will be reviewed by the Administrator at the Quality Assurance Committee Meeting and monitored once a year annually for 2 years at the Quality Assurance Meeting to assure compliance.	

Health Resources Section

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

Gerald J. Brenno, Nursing Home Administrator — 1/27/2016

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B 920	Continued From page 1 policies/procedures in 2012 at the time of their initial licensure as a Basic Care provider. An interview occurred, on the afternoon of 01/06/2016, with management staff members (#1 and #2) who verified the policies/procedures had not been reviewed annually.	B 920		
B 926	33-03-24.1-09,2,f GOVERNING BODY f. A process for handling complaints made by residents or on behalf of residents. This state licensing rule is not met as evidenced by: Based on resident interview, review of facility grievance policies/procedures and staff interview, the facility failed to implement their existing grievance policy/procedure in response to a grievance/complaint verbally submitted by 1 of 1 resident (Resident #1) to a management staff member. Failure to implement the existing policy/procedure provided residents and family members does not allow them assurance their complaints are seriously considered and investigated by the facility, and complaints are resolved to their satisfaction. Findings include: Review, on 01/06/2016, of the facility's "Grievance Procedure for Basic Care Residents" stated the following: ". . . If there is anything about our services you do not understand or disagree with, we would like to know. If there is an issue which raises concern, please use the following procedure so that we can work together to resolve the problem. Step 1: Any grievance can be reported either verbally or in writing by the		B Tag 926 1.) DCNH must have a process for handling complaints made by residents or on behalf of residents. 2.) All residents have potential to be affected by this deficient practice. 3.) A.) The DCNH Grievance Procedure will be followed and completed for the grievance expressed by Resident #1. B.) DON will review the Grievance Procedure at a scheduled staff inservice. C.)DON will educate the nursing staff member on administration of suppositories and being respectful to residents and other staff members. Documentation of this will be placed in the appropriate file. 4.) 02-12-16 5.) The SSDD will audit each grievance x 12 months to ensure the procedure is being followed. This data will be reviewed by the Quality Assurance Committee at the scheduled QA Meeting.	

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B 926	Continued From page 2 resident or family. Step 2: All grievances can be forwarded to the Social Worker who will discuss the situation with you. Step 3: Within 7 working days, you will receive a written response from the Social Worker. If you are dissatisfies with the response, inform the Social Worker to proceed to Step 4. Step 4: The Social Worker will provide the Administrator a written and verbal account of the situation and response. Step 5. Within 7 working days, you will receive a written response from the administrator. If you are dissatisfied with the response, inform in writing the administrator to proceed to step 6. . . ." During an interview with Resident #1 at 1:30 p.m. on 01/06/2016, the resident stated a few weeks ago a member of the facility nursing staff (#3) had administered a rectal suppository to the resident and, "pushed it in so hard I cried out in pain. When I cried out [staff member #3] laughed at me." The resident indicated the incident made him feel disrespected and embarrassed. Resident #1 indicated he felt the staff member intentionally pushed the suppository in so it would hurt. Resident #1 said he had not experienced that degree of pain during administration of a rectal suppository prior to or after by other individuals who administered the suppository for him. Resident #1 stated this occurred about a month or two ago. Resident #1 indicated he had reported the incident to a management staff member (#2) soon after the incident occurred and had not heard anything regarding what had been done about his complaint. Resident #1 indicated he did not feel things had gotten better regarding this nursing staff member's interactions with residents and staff and provided an example of the nursing staff member "really going off on [name of	B 926		

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B 926	Continued From page 3 restorative staff person]" during his restorative session a few weeks ago. During an interview on the afternoon of 01/06/2016, with two management staff members (#1 and #2), the staff members indicated Resident #1 had come to one of the management staff member's office (#2) and provided a complaint/grievance regarding the above described incident regarding the staff member's (#3) insertion of a rectal suppository and laughter following the resident crying out from pain. The management staff member (#2) indicated a written record of the complaint made by Resident #1, investigation of the complaint, and resulting actions taken had not been maintained. The management staff indicated no response regarding facility investigation and outcome regarding the incident had been provided to Resident #1, and no follow-up regarding the resident's satisfaction of the facility's resolution of the problem had occurred.	B 926		