

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

PRINTED: 08/26/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355114		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2025	
NAME OF PROVIDER OR SUPPLIER NORTH DAKOTA VETERANS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1600 VETERANS DRIVE LISBON, ND 58054			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 684 SS=G	An unannounced onsite investigation survey regarding four facility reported incidents (FRIs) was completed on March 12-13, 2025. During the investigation the facility was found in compliance with regulatory requirements for the FRIs addressing elopement, missing property, and unwitnessed falls, and in noncompliance with regulatory requirements for the FRI addressing a choking episode. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #1) received the care and services necessary to attain the highest degree of safety possible during mealtime. Failure to ensure staff served Resident #1 food items consistent with his prescribed diet resulted in his choking episode/death. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include:			F 684	Past noncompliance: no plan of correction required.		

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

TITLE

(X6) DATE

Electronically Signed

03/28/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1 Review of the facility policy titled "Diets Available on Skilled Care Unit" occurred on 03/13/25. This policy, revised 03/12/25, stated, "... Consistency adjustments are determined based on swallow studies, physician orders, and speech therapy evaluations. ... Menu cards are used to ensure the correct diet and consistency are provided for each resident. ... The following Consistencies are offered in the facility ... Dental Soft (Mechanical Soft) ... the diet consists of food of nearly regular textures but eliminates very hard, sticky, crunchy or hard to chew foods. Foods should be moist and fork tender. Meat is ground . . . and should be held with a minimal amount of prepared broth, gravy, or other type of moistening agent . . . to keep the product moist. Hot ground meats should be topped with gravy or sauce at the point of service. . . ." Review of the facility policy titled "Menu Cards" occurred on 03/13/25. This policy, revised 03/12/25, stated, "... Selective menu cards will be used to guide meal service, ensuring that residents receive meals that meet their prescribed diets . . . Each resident's menu card will include their prescribed diet, texture modifications, and any special notes related to dietary needs or restrictions. . . . Menu cards will list foods that align with the resident's prescribed diet. . . ." Review of the facility policy titled "Feeding a Resident" occurred on 03/13/25. This policy, revised 03/13/25, stated, "... Staff delivering meals will confirm that: The correct resident receives the correct meal. Any diet modifications are properly followed. If an error is identified, the plate will be returned to the cook for correction. . . ."	F 684			

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F 684	Continued From page 2 ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included adult failure to thrive, Alzheimer's disease, dementia, dysphagia (swallow disorder), functional quadriplegia, and weakness. A "Speech Therapy Evaluation and Plan of Care," dated 12/10/24, stated, ". . . SLP [speech language pathologist] completed bedside swallowing evaluation during meal. Mechanical soft: prolonged mastication, slow AP [anterior/posterior] transit, suspected premature loss [of bolus] over tongue base. Reduced elevation, no overt s/s [signs/symptoms] of penetration [food/liquid entering the airway above the vocal folds]. Mildly thick liquids: Suspected premature loss [of bolus] over tongue base, suspected delay of onset of swallow, no overt s/s of penetration. SLP recommends diet of mechanical soft solids, ground meats, mildly thick liquids. . . . Pt does have risk of aspiration [food/liquid entering the airway below the vocal folds], as VFSS [videofluoroscopic swallow study] did reveals [sic] deep laryngeal penetration without reaction [silent aspiration]. . . ." A physician's order, dated 12/12/24, stated, ". . . Mechanical Soft, Nectar Thickened Liquids . . . Ground meat . . ." The nutrition care plan stated, ". . . [Resident #1's] Nutritional status is altered due to his decline. . . . [Resident #1] needs 1:1 [one-on-one] assist with feeding . . . [Resident #1] was hospitalized with a diagnosis of aspiration pneumonia . . ."	F 684			

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F 684	Continued From page 3 Resident #1's "Lunch Menu Card" for 03/10/25 stated, ". . . Ground Marinated Sirloin Steak w [with]/Gravy . . ." The "Facility Reported Incidents Reporting Form," dated 03/10/25, stated, ". . . Resident began choking. Staff attempted the heimlich maneuver and were unsuccessful in dislodging the item. They also used [a] life vac to attempt to dislodge [the] item. Unable to remove [the] item. Resident passed away. . . ." An attached written statement indicated a dietary staff member (#2) spoke to an administrative dietary staff member (#1) after the dinner service. The dietary staff member (#2) ". . . noted that she got the tray card and plated the food for [Resident #1]. . . . She noted to us that she said that this needs to be chopped, then stated [certified nurse aide (CNA) (#3)] said it was fine. . . . [CNA (#3)] left the kitchen. . . . [Dietary staff member (#2)] did note . . . that she did not follow the diet, and did not grind the food and the plate left the kitchen uncompleted. . . ." During an interview on 03/12/25 at 4:00 p.m., four administrative staff members (#1, #4, #5, and #6) reported they "reeducated everyone who worked on Monday, before supper was served, and reeducated everyone [nurses, CNAs, and Dietary staff] who has worked since. We have a nurses' meeting tomorrow and a Dietary staff meeting next week. We will be going over the whole process, menu cards again. They [nurses, CNAs, and Dietary staff] were also assigned a [name of company] online course. We are also going to finish tweaking our policies before the meeting." The four administrative staff members	F 684			

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F 684	Continued From page 4 (#1, #4, #5, and #6) also confirmed monitoring the residents' tray cards/plated food items, stating, "Yes. We only have one resident on a modified diet right now. The resident is on a pureed diet." As per facility policy and Resident #1's physician's orders, the facility failed to ensure Resident #1 received food items consistent with his prescribed diet. Based upon the following information, non-compliance at F684 is considered past non-compliance. The facility implemented corrective actions for other residents who may be affected by the deficient practice by: * Completing an investigation into Resident #1's choking episode/death. * Updating facility policies regarding modified diets on 03/12/25, menu cards on 03/12/25, and meal assistance on 03/13/25. * Educating staff regarding modified diets, menu cards, and meal assistance immediately and all staff that have worked since. * Completing audits on prescribed diets/meal service.			F 684			