STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355034	A. BUILDING _____ B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIOGA MEDICAL CENTER LTC	810 N WELO ST TIOGA, ND 58852

(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 03/10/25 and concluded 03/12/25.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 5 of 12 sampled residents (Resident #3, #8, #9, #17 and #20) and one supplemental resident (Resident #6). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION H: BLADDER AND BOWEL The Long-Term Care Facility RAI User's Manual, revised October 2024, page H-6, stated, ". . . H0200: Urinary Toileting Program . . . Steps for assessment: H200C, Current Toileting Program . . . 1. Review the medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period. Note the number of days during the look-back	F 641	1.Residents #3, #6, #8, #9, #17, #20 MDS was corrected and resubmitted on 3/13/25. All residents in the facility MDS□s were reviewed and corrected according to CMS/QIES and ND Department of Human Services. Billing adjustments were made according to the ND Department of Human Services. 2.All residents have the potential to be affected by the facilities failure to ensure accurate coding of the MDS. 3.MDS Coordinator/ DON will review Sections H and P for correct coding of bowel and bladder and restraints and alarms. Staff will be educated on the accurate coding of the MDS at the mandatory all staff meeting on 3/27/25 and 4/7/25 4.All current MDS section H & P will be reviewed to ensure it is accurately coded. All residents in the facility MDS□s were reviewed and corrected according to CMS/QIES and ND Department of Human Services. Billing adjustments were made according to the ND Department of Human Services. QI	4/11/25

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

Electronically Signed | 03/27/2025

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F 641	Continued From page 1 period that the toileting program was implemented or carried out. . . . Coding Instructions . . . Code 1, yes: for residents who are being managed during 4 or more days of the 7-day look-back period, with some type of systematic toileting program (i.e., bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding). . . ." - Review of Resident #9's medical record occurred on all days of survey. An annual MDS, dated 01/04/25, showed facility staff coded H200C "1," indicating a daily toileting program. The medical record lacked evidence of an individualized/resident-centered toileting program. - Review of Resident #20's medical record occurred on all days of survey. A quarterly MDS, dated 01/08/25, showed facility staff coded H200C "1," indicating a daily toileting program. The medical record lacked evidence of an individualized/resident-centered toileting program. During an interview on 03/12/25 at 1:15 p.m., an administrative staff member (#2) confirmed Residents #9 and #20 did not have an individualized/resident-centered toileting program. SECTION P: RESTRAINTS AND ALARMS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages P1-5, stated, ". . . PHYSICAL RESTRAINTS: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's	F 641	monitoring will be implemented on residents #9, #20 for section H and #3, #6,#8, #17, #20 for section P of MDS quarterly x 1 year. QI will be done on 3 random residents section H and P of MDS weekly x4, monthly x2 then quarterly x2 unless determined otherwise by the QI committee at the monthly meetings. 5.DATE: 4/11/25	

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F 641	Continued From page 2 body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. . . . P0100: Physical Restraints . . . Coding Instructions: . . . After determining whether or not an item . . . is a physical restraint and was used during the 7-day look-back period, code the frequency of use: Code 0, not used: if the item was not used during the 7-day look-back or it was used but did not meet the definition. . . . Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period. . . ." - Review of Resident #3's medical record occurred on all days of survey. A "Bed Rail Assessment," dated 02/05/25, stated, ". . . Would the side rail be considered a restraint? . . . 'No.' If no the side rails do not meet the definition of a restraint for this resident. . . ." A quarterly MDS, dated 03/01/25, showed facility staff coded section P0100A, bed rail as "2 used daily." - Review of Resident #17's medical record occurred on all days of survey. A "Bed Rail Assessment", dated 02/05/25, stated, ". . . Would the side rail be considered a restraint? . . . 'No.' If no the side rails do not meet the definition of a restraint for this resident. . . ." A quarterly assessment MDS, dated 02/20/25, showed facility staff coded section P0100A, bed rail as "2 used daily." During an interview on 03/12/25 at 1:15 p.m., an administrative staff member (#2) confirmed bed rails were not a restraint for Residents #3 and #17 and staff failed to code the quarterly MDSs correctly.	F 641		

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F 641	Continued From page 3	F 641		

The Long-Term Care Facility RAI User's Manual, revised October 2024, pages P-9 through P-11 stated, "An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected. . . . Code 2, used daily: if the device was used daily during the look-back period [seven days]. . . . Other alarm includes devices, such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms or seatbelt alarms. . . ."

- Review of Resident #6's medical record occurred on all days of survey. A significant change assessment MDS, dated 12/24/24, showed the facility coded "other" alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as "other."

- Review of Resident #8's medical record occurred on all days of survey. A significant change assessment MDS, dated 02/04/25, showed the facility coded "other" alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as "other."

- Review of Resident #20's medical record occurred on all days of survey. A quarterly MDS, dated 01/08/25, showed the facility coded "other" alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as "other."

During an interview on 03/12/25 at 9:55 a.m., an administrative staff member (#2) confirmed, the facility staff coded the facility's exit doors as the "other" alarm and verified the MDSs for Residents #6, #8 and #20 were coded incorrectly.

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F 684 SS=D	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 observation, record review, and resident and staff interview, the facility failed to ensure appropriate care and services for 1 of 2 sampled residents (Resident #26) reviewed for edema (fluid retention). Failure to ensure consistent implementation and resident refusals of support stockings may result in worsening edema. Findings include: Review of Resident #26's medical record occurred on all days of survey and identified a diagnosis of congestive heart failure. A physician's order, dated 01/23/25, stated, "Ted Hose [support stockings to control edema] on in the AM and Off at HS [bedtime] . . . for Edema." The current care plan stated, ". . . I have a diagnosis of . . . congestive heart failure . . . edema . . . I will remain free of complications related to diagnosis through next review date. . . . I would like staff to monitor for and document any edema and notify my provider as needed. . . ." A nursing progress note, dated 01/24/25 at 9:37	F 684	1.Nursing staff including CNA #4 and Nurse #5 were educated on the professional standards of practice for resident #26. 2.All residents have the potential to be affected by the facilities failure to follow professional standards of practice. 3.Nursing staff were re-educated on professional standards of practice on the week of 3/12/25. All staff will be educated on the professional standards of practice at the mandatory all staff meeting on 3/27/25 and 4/7/25. 4.QI will be implemented for residents #26 and 3 random other residents to ensure professional standards of practice are being followed. QI will be done by DON/QI designee weekly x4, monthly x2 then quarterly x2 unless otherwise noted by QI committee at the monthly QI meeting. 5.DATE 4/11/25	4/11/25

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F 684	Continued From page 5	F 684		

a.m., stated, ". . . Does have edema noted to bilateral [both] lower legs at which time resident stated her legs feel itchy at those times . . ."

A provider progress note, dated 02/25/25, stated, ". . . Doing ok. . . Also wondering if her LE [lower extremities] edema will ever resolve. . . . Plan . . . 3. Regarding her edema - encouraged to elevate legs as much as possible. . . ."

Observation on 03/10/25 at 10:56 a.m., showed Resident #26 seated in the recliner with her feet on the floor, visible swelling to both lower legs, and no support stockings present. The resident stated, "I'm supposed to wear them [support stockings] but I refuse because they hurt." A note on the resident's dresser stated, "Put your feet up when in your chair." The resident stated, "I forget," when asked about elevating her feet.

Observation on 03/11/25 at 7:47 a.m., showed Resident #26 seated on the toilet in the bathroom, dressed, visible swelling present, and without support stockings present. A certified nurse aide (CNA) (#4) stated, "She refused to wear them [support stockings]."

Review of Resident #26's medication administration record (MAR) dated March 10-11, 2025, showed the ted hose documented as applied on both days.

During an interview on 03/11/25 at 4:50 p.m., an administrative nurse (#1) confirmed she expected the CNAs to inform the nurse if the resident refused to wear the ted hose, the nurse to visualize the ted hose are in place prior to documenting on the MAR, and document any

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F 684	Continued From page 6 refusals.	F 684		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		4/11/25

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F 732	Continued From page 7 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy, and staff interview, the facility failed to ensure posting of staff information on 2 of 3 days of survey (March 10-11, 2025). Failure to post staffing data does not allow residents and visitors information related to the number of licensed and unlicensed staff on duty each shift. Findings include: Review of the facility policy titled "Nurse Staffing Posting Information" dated 10/01/24, stated, ". . . The Nurse Staffing Sheet will be posted on a daily basis . . . The facility will post the Nurse Staffing Sheet at the beginning of each shift. . . . Nursing schedules and posting information will be maintained in the Human Resources Department for review. . ." Observation on all days of survey showed a "Nurse Staffing Posting Information" form posted on a board in the hall by the residents' dining room. Review of the staffing form on 03/10/25 and 03/11/25 showed the staffing form dated 03/07/25. The facility failed to post a current staffing form for March 10th and 11th, 2025. Review of previous staff posting identified staff failed to complete the staffing form for March 8-11, 2025. During an interview on 03/12/25 at 9:51 a.m., an administrative nurse (#1) stated the night shift is responsible for staff posting, and confirmed the it	F 732	1.Nursing staff were educated on the importance of nurse staffing posting being up to date daily during the week of 3/17/25. 2.All residents have the potential to be affected by the failure to post staffing data which doesn□t allow residents and visitors information related to the number of licensed and unlicensed staff on duty each shift. 3.Nursing staff were re-educated on the importance of posting updated daily nurse staffing sheet, policy updated. All staff will be educated on the importance of posting daily staffing sheet at the mandatory all staff meeting on 3/27/25 and 4/7/25. 4.QI will be implemented to randomly check daily nursing staffing sheet is updated. QI will be done by DON/QI designee weekly x4, monthly x2 then quarterly x2 unless otherwise noted by QI committee at the monthly QI meeting. 5.DATE 4/11/25	

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F 732	Continued From page 8 had not been completed for March 8-11, 2025.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		4/11/25

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F 758	Continued From page 9 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from unnecessary psychotropic medications for 1 of 2 sampled residents (Resident #12) reviewed for as needed (PRN) psychotropic medication use. Failure to limit PRN psychotropic medication use to 14 days unless re-evaluated by a practitioner placed the resident at risk of receiving unnecessary medications and experiencing adverse drug effects and consequences related to their use. Findings include: Review of the facility policy titled "Use of Psychotropic Medication" occurred on 03/12/25. This policy, dated February 2023, stated, ". . . PRN orders for all psychotropic drugs shall be used . . . for a limited duration (i.e. 14 days) . . . If the . . . prescribing practitioner believes that it is appropriate for the PRN order to extend beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order. . . ."	F 758	1.Resident #12 medications were reviewed by Sanford Huntington Team and MD on 3/17/25. 2.All residents have the potential to be affected by the facilities failure to ensure residents remain free from unnecessary psychotropic medications. 3.Nursing staff were educated on psychotropic medications and MD was educated the week of 3/12/25. Staff will be educated on ensuring PRN psychotropic or drugs are limited to 14 days on 3/27/25 and 4/7/25. 4.QI monitoring will be implemented for resident #12 along with 3 random residents on psychotropic medication for accurate length of use of PRN medication. QI monitoring will be done by DON/QI Designee weekly x4, monthly x2, then quarterly x2 unless determined otherwise by the QI committee at the monthly meetings. 5.DATE 4/11/25	

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F 758	Continued From page 10 Review of Resident #12's medical record occurred on all days of survey. A current physician's order included Ativan (an antianxiety medication) 0.5 milligrams (mg) intramuscularly every six hours as needed for anxiety, with a start date of 06/26/24. The order lacked a stop date. The medical record lacked follow-up documentation from the provider since ordering the PRN medication and within the limited duration (14-day) period. During an interview on 03/12/25 at 11:25 a.m., an administrative nurse (#1) confirmed the facility failed to have the provider reevaluate the resident for further need of the antianxiety medication after 14 days.	F 758		
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,	F 880		4/11/25

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F 880	Continued From page 11 visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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TIOGA MEDICAL CENTER LTC	810 N WELO ST TIOGA, ND 58852

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 2 sampled residents (Resident #3 and #26) observed in enhanced barrier precautions (EBP). Failure to practice infection control standards related to EBP, catheter care, and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 03/12/25. This policy, dated April 2024, stated, ". . . an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. . . . PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities . . . High-contact resident care activities include: . . . dressing . . . providing hygiene . . . assisting with toileting . . . device care or use . . ." Review of the facility policy titled "Hand Hygiene"	F 880	1.Nursing staff including CNA #4 and Nurse #5 were educated on the hand hygiene policy; infection control standards and EBP precautions for all residents including resident #3, #26 on the week of 3/12/25. 2.All residents have the potential to be affected by the facilities failure to follow infection control standards with the potential to transmit infections to residents, staff and visitors. 3.Nursing staff were re-educated on infection control standards on the week of 3/12/25. All staff will be educated on infection control standards at mandatory all staff meeting on 3/27/25 and 4/7/25. 4.QI will be implemented for residents # 3, #26 and 2 random other residents to ensure proper infection control standards are followed. QI will be done by DON/QI designee weekly x4, monthly x2 then quarterly x2 unless otherwise noted by QI committee at the monthly QI meeting. 5.DATE 4/11/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 13	F 880		

occurred on 03/12/25. This policy, revised August 2022, stated, ". . . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, patients, and visitors. . . . 'Hand hygiene' is a general term for cleaning your hands . . . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. . . ."

- Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, ". . . I require Enhanced Barrier Precautions (EBP) related to my suprapubic catheter . . ."

Observation on 03/10/25 at 10:44 a.m. showed an enhanced barrier precaution sign outside of Resident #3's room.

Observation on 03/11/25 at 10:24 a.m. showed Resident #3 seated in a wheelchair in his room. The certified nurse aide (CNA) (#4) entered Resident #3's room wearing a gown and gloves. The CNA (#4) emptied the resident's catheter collection bag into a urinal, changed gloves without performing hand hygiene, placed a barrier on the resident's side table next to the resident's water glass, and placed the urinal containing urine on the barrier to read the measurement. The CNA (#4) emptied the urinal into the toilet, rinsed and stored the urinal, and changed gloves without performing hand hygiene. The CNA (#4) applied a gait belt to Resident #3 and assisted the resident to bed. The CNA removed her gloves, and without performing hand hygiene, covered the resident

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F 880	Continued From page 14 with a blanket and adjusted the side table. The CNA (#4) failed to perform hand hygiene when changing or removing gloves and touching other surfaces, and failed to follow infection control practices when emptying the catheter. - Review of Resident #26's medical record occurred on all days of survey. The current care plan stated, ". . . I require Enhanced Barrier Precautions (EBP) related to my Jackson-Pratt (JP) Drain [a closed-suction medical device used to collect fluids from surgical sites] . . ." Observation on 03/10/25 at 10:56 a.m. showed an enhanced barrier precautions sign outside Resident #26's room. Observation on 03/11/25 at 7:47 a.m. showed Resident #26 seated on the toilet, a JP drain present, and the CNA (#4) wore gloves and performed perineal cares. After cares, the CNA removed her gloves and adjusted the resident's brief and pants. Observation on 03/11/25 at 10:55 a.m. showed Resident #26 seated in the recliner. A nurse (#5) washed her hands, donned gloves, and emptied the resident's JP drain. The CNA (#4) and the nurse (#5) failed to don a gown when performing high-contact resident care activities. During an interview on 03/12/25 at 8:40 a.m., an administrative nurse (#3) confirmed she expected staff to wear proper PPE when performing high-contact resident care activities, perform	F 880		

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F 880	Continued From page 15 hand hygiene when removing gloves and before applying new gloves, and follow proper infection control techniques when emptying a catheter.	F 880		