STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8033	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEACH HOME	714 N 4TH ST WAHPETON, ND 58075

(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 For the unannounced onsite complaint survey completed on 10/22/25, the sample included 10 residents for complete review and two closed records for review. Tier II citations included B0924 and B1540.	B 000		
B 924	33-03-24.1-09,2,d GOVERNING BODY d. Infection control practices, including provision of a sanitary environment and an active program for the prevention, investigation, management, and control of infections and communicable diseases in residents and staff members. This State Licensing Rule is not met as evidenced by: Based on observation, review of facility policy, and staff interviews, the facility failed to follow standards of infection control for 1 of 1 sampled resident (Resident #6) observed during insulin administration. Failure to perform hand hygiene, remove soiled gloves, sanitize the medication cart, and secure a soiled insulin needle prior to disposal, puts residents at risk for a needle stick and the spread of infection. Findings include: Review of the facility policy titled "Hand Washing" occurred on 10/22/25. This policy, dated September 2016, stated, ". . . Careful hand hygiene must be performed . . . before and after gloves are used . . ."	B 924	TMA involved in the incident was immediately re-educated by RN DON on proper hand hygiene, glove removal, cart sanitization, and safe needle disposal procedures. TMA was able to re-demonstrate correct procedure to nurse. Staff education and review of hand washing policy for all TMA's to be held with RN Administrator and RN DON on November 25th from 2p-4p and December 2nd from 2p-4p. All staff will review policy and be able to demonstrate correctly to nursing and signed off policy. Nursing staff will observe TMA's twice a week on this procedure and document for 1 month. Then a nurse will observe and document weekly for one month and documer	

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B 924	Continued From page 1 Review of the facility policy titled "Injection (Subcutaneous [under the skin] Insulin Pen)" occurred on 10/22/25. This policy, dated February 2016, stated, ". . . Giving the injection . . . Pull the needle out of the skin. Carefully remove the needle from the pen and discard properly in sharps container. Wash hands. . . ." Review of Resident #6's medical record occurred on 10/22/25. A physician's order, dated 09/18/25, identified Novolog (an insulin medication to control blood sugar) 17 units subcutaneous at breakfast, lunch, and supper. Observation on 10/22/25 at 11:45 a.m. showed a medication aide (MA) (#4) administered Resident #6's insulin. The MA completed hand hygiene, applied gloves, and entered Resident #6's room to complete a blood sugar check. The MA (#4) exited the room, placed the soiled glucometer on top of the medication cart, wiped the glucometer with a sanitizing wipe, placed the glucometer in the top drawer of the medication cart, typed on the computer, and removed the soiled gloves. Without sanitizing the top of the medication cart, the MA #4 performed hand hygiene, applied gloves, and prepared Resident #6's insulin. After administering the resident's insulin, the MA exited the room, carried the uncapped insulin pen to the medication cart, capped and removed the needle, discarded it into the sharps container, and removed the gloves. The MA (#4) failed to disinfect the top of the medication cart prior to preparing insulin, remove gloves and perform hand hygiene prior to exiting the resident's room, before performing other tasks, and safely secure a soiled needle. During an interview on 10/22/25 at 4:00 p.m., an	B 924	Policy for Glucometer updated, which includes cleaning Glucometer following each use. Policy posted for review for all nursing staff and to sign off policy. All nursing staff to sign off policy for injections by December 1, 2025. Re-education and training of nursing staff at annual all staff meeting, at new hire, and audits performed by RN's. Staff education and review of hand washing policy for all TMA's to be held with RN Administrator and RN DON on November 25th from 2p-4p and December 2nd from 2p-4p. All staff will review policy and be able to demonstrate correctly to nursing and signed of Medication cart was immediately disinfected and TMA was re-educated on this process by RN DON and redemonstrated correctly. Top of medication cart is to be disinfected prior to preparing insulin for each resident with Sani-cloths and included to facility injection policy. All nursing staff to sign off policy for review of injection policy by December 1, 2025. Re-education and training of staff at annual all staff meeting, at new hire, and observed by a nurse twice a week and documented for one month. The TMA will then be observed and documented weekly by a nurse for one month and documented. Nursing staff will observe TMA twice a week on procedure and document for 1 month, then will observe and document weekly for one month and document.	

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B 924	Continued From page 2 administrative staff member (#1) confirmed she expected staff to secure a needle prior to disposing and perform hand hygiene between glove changes.	B 924		
B 950	33-03-24.1-09,5 GOVERNING BODY 5. The governing body shall ensure sufficient trained and competent staff are employed to meet the residents' needs. Staff must be in the facility, awake and prepared to assist residents twenty-four hours a day. This State Licensing Rule is not met as evidenced by: Based on observation, record review, review of the North Dakota Administrative Code (NDAC) Chapter 33-43-01, and staff interview, the facility failed to ensure competent staff were available to meet the needs of residents for 1 of 1 Medication Aide (MA #4) observed administering routine and PRN (as needed) insulin. Failure to ensure appropriately trained staff administered subcutaneous insulin increases the residents' risk of adverse consequences. Findings include: NDAC, Section 33-43-01-17 "Routes or types of medication administration" stated, ". . . Medication assistants I and II may administer medications by the following routes only when specifically delegated by a licensed nurse for a specific client: . . . Subcutaneous [under the skin]	B 950	Resident was assessed for any signs of injury related to incident by Margo Mumm, RN DON, no injuries were found on assessment. Facility will not accept PRN insulin dose calculation with ranges for extra insulin administration without appropriate nursing oversite and direction. Diabetic pharmacist at Sanford updated on facility protocol. **Insulin orders** Nurse Note Residents blood sugars reviewed by diabetic pharmacist- -Discontinue PRN insulin orders as requested (due to state regulations/scope of practice of TMA's) -Increase Lantus to 30 units subcut q12hr -Continue Novolog 17 units TID before meals.	

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B 950	Continued From page 3 . . ." Section 33-43-01-16 Specific delegation of medication administration stated, ". . . The individual on the department's nurse aide [registry] is taught by a licensed nurse for each specific client's medication administration which includes verbal and written instruction . . . is observed by a licensed nurse administering the medication to the specific client until competency is demonstrated. . . . has been verified as competent by a licensed nurse . . ." Section 33-43-01-19 ". . . Medication interventions that may not be delegated. The medication assistant I or II . . . may not perform the following acts even if delegated by a license nurse: Conversion or calculation to medication dosage . . ." Review of Resident #6's medical record occurred on 10/22/25. A physician's order, dated 09/18/25, stated, "Novolog (insulin aspart) inject 17 units subcutaneously at breakfast, lunch, and supper for blood sugar regulation. Blood sugar checks done prior to administration. Give additional 1 unit if BG [blood glucose] is 200- 250." Observation on 10/22/25 at 11:40 a.m. showed the MA (#4) entered Resident #6's room and performed a blood glucose check which read 236 milligrams per deciliter. The MA referred to the resident's medication administration record and stated the resident is ordered to have 17 units of Novolog insulin plus an additional 1 unit due to a blood glucose result between 200 and 250. The MA (#4) primed the insulin pen, dialed the pen to 18 units, and administered the insulin. During an interview on 10/22/25 at 3:52 p.m., two administrative staff members (#1 and #2) confirmed MAs administer routine insulin and PRN insulin and lacked documentation to show the facility's MAs received specific resident	B 950		

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B 950	Continued From page 4 instruction by the nurse to administer insulin. The facility allowed the MA (#4) to perform a calculation of the medication dosage (PRN) and failed to provide documentation the MA received specific resident instruction by the nurse to administer insulin, a subcutaneous medication.	B 950		