STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Catherines Living Center	1307 N 7th St Wahpeton, ND 58075

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, review of facility policy, and resident and staff interviews, the facility failed to ensure a clean and homelike environment for 2 of 9 sampled residents (Resident #9 and #34) with a shared bathroom. Failure to maintain a clean and sanitary bathroom does not promote a homelike living environment or enhance the resident's quality of life. Findings include:Review of the facility policy titled Environmental Services - Cleaning occurred on 01/29/25. This policy, dated 2020, stated, . It is the policy of Benedictine communities that they be maintained in a clean and hygienic condition . Clean surfaces such as . toilet seats . according to the schedule established by EVS [environmental service] supervisor. Community trash containers should be lined .Observations of Resident #9 and #34's shared bathroom showed the following:*01/25/26 at 2:01 p.m., Bowel movement (BM) splattered throughout the inside of the toilet bowl and smeared on the back and top of the toilet seat. A trash can without a liner located beside the toilet contained several soiled wipes. Resident #34 stated housekeeping had not cleaned her bathroom yet today.*01/25/26 at 2:28 p.m., Resident #34 stated staff just completed her toileting cares in her bathroom. BM remained present in the toilet bowl and on the toilet seat.*01/26/26 at 8:10 a.m. and 1:54 p.m., BM splattered in the toilet bowl and smeared on the toilet seat. Resident #34 stated housekeeping had still not been in to clean her room/bathroom.*01/26/26 at 4:44 p.m., The toilet bowl and seat remained the same. Resident #34 stated no housekeeping occurred in her room again today.During an interview on 01/26/26 at 8:35 a.m., a housekeeping staff member (#5) indicated housekeeping staff are present at the facility seven days a week. During an interview on 01/26/26 at 4:53 p.m., an administrative staff member (#1) stated she expects staff to notify housekeeping to address bathroom cleanliness or clean areas with sanitizing wipes after care provided.

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.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, review of the facility reported incident (FRI) and investigation, and review of facility policy, the facility failed to ensure residents remained free from abuse for 1 of 1 closed record (Resident #51) who displayed physical behaviors towards another resident. Failure to protect residents from physical abuse resulted in injury and pain. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident.Findings include: Review of the facility policy titled Abuse Prevention Plan occurred on 01/29/26. This policy, dated year 2017, stated, . In order to prevent abuse . the facility shall do the following . Identify, correct, and intervene in situations where abuse . occurs. Assess residents with needs and behaviors that might lead to conflict . The facility will develop an individual abuse prevention plan for each vulnerable adult who receives services in the facility. The plan shall contain an individual assessment of . The resident's risk of abusing other vulnerable adults; and Specific measures to be taken to minimize the risk of abuse . of residents and other vulnerable adults. Once suspected abuse . has been identified, safety measures will be implemented to ensure the safety of the suspected vulnerable adult and other residents.The surveyor determined a deficient practice existed on 03/27/25 when Resident #51 punched Resident #19 in the face. The facility implemented and completed corrective action on 04/03/25.Review of Resident #19's medical record occurred on all days of survey and identified diagnoses of traumatic brain injury and dementia with behaviors. A Brief Interview for Mental Status (BIMS), completed on 03/27/25, identified a score of 11 indicating moderately impaired cognition. Review of Resident #51's medical record occurred on all days of survey and identified diagnoses of mild vascular dementia with agitation and moderate recurrent major depressive disorder. A BIMS, completed on 03/27/25, identified a score of 13 indicating minimal cognitive impairment. The care plan identified . Behavioral Symptoms. I have a hx [history] of socially inappropriate/disruptive behavioral symptoms such as threatening to cause harm to other residents, not being receptive to staff when trying to redirect or re orientate, being verbally aggressive towards other residents, and a hx of becoming physically abusive towards other residents. Staff updated the care plan after the incident on 03/27/25. The medical record identified Resident #51 transferred to another facility on 04/03/25.Review of the FRI report/final investigation, dated 04/03/25, stated, . Resident [#19] was hit in the face by another resident [Resident #51]. Residents involved were immediately separated by staff witnessing incident. Resident [#19] sent to Emergency Department [ED] for further evaluation. Police on site investigating. Investigation indicated that allegation of abuse was verified as occurring and meeting the definition for abuse. [Resident #51] was asked in an interview with SSD [social service director] if he meant to cause physical harm and wished to cause pain, this resident stated 'yeah, that's why I punched him.' .Resident #51's progress note, dated 03/27/25 at 5:14 p.m., stated, At 4:45pm heard hollering coming from commons area. Assessed situation and witnessed resident [Resident #51] standing over a male resident [Resident #19] while holding his fist up towards resident. RN [registered nurse] present and intervened, preventing resident throwing another punch. This nurse assisted resident [#51] back to his room via wheelchair. Resident appeared angry with red eyes. Resident comments on how he 'hates that guy', 'I just wanted to hit him'. Interview completed with resident [#51]. Resident states, 'My lady bumped into him [Resident #19] and he [Resident #19] told her to knock it off. I told him [explicative] and punch [sic] him in the face'. Informed resident [Resident #51] there will likely be consequences, resident states 'I don't care, it was worth it!' Resident told to stay in his room. Resident states understanding. SW [social worker] and administrator informed right after.Resident #19's progress (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	note, dated 03/27/25 at 4:45 p.m., stated, . On initial assessment, resident [Resident #19] complained of pain on left temporomandibular area. Noted redness on said area with no immediate swelling. Re-assess after 10 minutes and resident still complains of pain and claims to be increasing; resident rated 7-8/10 headache. Rated pain on mentioned area on face as 2/10; no worsening of swelling or redness noted. sending resident to ER [emergency room] for further evaluation. A note, dated 03/27/25 at 8:12 p.m., stated, . Resident returned from ED . with no new orders. Noted to have mild redness on left side of face without bruising developing. Resident rates pain on area 1/10 and denies headache.Based on the following information, non-compliance at F0600 is considered past non-compliance. The facility implemented corrective actions for the residents affected by the deficient practice as follows:*Staff immediately intervened, separated the residents, assessed for injury, and sent Resident #19 sent to the ER for further evaluation.*Notified the Executive Director and SSD. Camera footage reviewed.*Notified local law enforcement and law enforcement took statements.*Notified family, primary care providers, and psychiatric providers for both residents.*Notified the State Ombudsman.*Resident #51's medication reviewed by psychiatric provider.*Interviewed Resident #19 and #51.*Implemented one-to-one support and 15-minute safety checks for both residents. *Educated Resident #51 on nursing home guidelines and physical aggression is not tolerated. *Care plans updated for both residents.*Held a team huddle with staff on duty to discuss the incident, immediate actions taken, how to handle resident to resident altercations, and reviewed the facility abuse policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure accurate medication labeling and storage for 1 of 1 resident (Resident #3) observed receiving insulin and 1 of 3 medication carts (cart #700). Failure to ensure proper medication labeling and storage may result in medication errors and unauthorized access to medications.Review of the facility policy titled Labeling of Medications due to order change occurred on 01/28/26. This undated policy stated, . 1. If change in medication dose pharmacy either A) sends a see mar for orders label . or B) sends new label . 2. If pharmacy does not send a see mar for order label the nursing staff are to continue to administer the correct does per the physician orders in the electronic records until pharmacy has complied.Review of the facility policy titled Administering Medications occurred on 01/28/26. This policy, revised on 08/31/23, stated, . 14. Medication cart is to be locked at all times when unattended. - Observation on 01/26/26 at 9:12 a.m. showed the label on Resident #3's insulin pen identified Lantus Solostar (an insulin medication) ten units in the morning. A nurse (#2) prepared twelve units of insulin and stated the provider changed the insulin order on 11/17/25, and the correct dose of 12 units is in the electronic medication administration record (eMAR).Review of Resident 3's eMAR occurred on 01/26/26 showed Lantus Solostar twelve units; with a start date of 11/17/2025. During an interview on 01/26/26 at 4:00 p.m., an administrative nurse (#1) confirmed the medication label did not match the physician's order in the eMAR. The administrative nurse (#1) stated the insulin pen labels typically say, See MAR for dose and she expects staff to follow the eMAR.-Observation on 01/25/26 at 4:00 p.m. showed a medication cart (#700) unlocked and unattended and a staff nurse (#4) down the hallway.-Observation on 01/27/26 at 7:45 a.m. showed a medication cart (#700) unlocked and unattended. Eight minutes later, an administrative nurse (#1) walked by the medication cart (#700) and locked it.During an interview on 01/27/26 at 3:39 p.m., an administrative nurse (#1) stated she expects staff to lock the medication cart when unattended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and review of professional reference, the facility failed to maintain a clean and sanitary kitchen for 2 of 2 kitchens (North Kitchen and South Kitchen). Failure to ensure tableware is placed on resident meal trays in a sanitary manner and ensure floors, cabinets, and the warewashing machine are free from food, dust, and mineralization debris has the potential for contamination of dishware/food and may result in foodborne illness to residents, staff, and visitors. Findings include:The 2022 Food and Drug Administration (FDA) Food Code, Section 4-904.13, page 455, stated, The presentation or setting of . cleaned and sanitized utensils shall be done in a manner designed to prevent the contamination of food- and lip-contact surfaces. Section 6-501.17, page 476, stated, Cleanliness of the food establishment is important to minimize attractants for insects and rodents, aid in preventing the contamination of food and equipment, and prevent nuisance conditions. Observations on 01/25/26 at 12:20 p.m. showed the following:* North Kitchen: Burnt loose and baked-on debris in two ovens located under a stove and scattered food/debris on the floors throughout the kitchen and in the mechanical warewashing room.* South Kitchen: Burnt loose and baked-on debris in the double ovens, an approximate 14-inch linear area of dried food on the side of a silver lower cabinet, scattered food/debris on the floors throughout the kitchen, and mineral buildup and food debris located under the handwashing sink.Observations on 01/27/26 at 9:30 a.m. showed the following:* North Kitchen: Loose debris, dust, and mineralization accumulated on the top of the mechanical warewashing machine and the scattered food/debris remained on the floors throughout the kitchen and the mechanical warewashing room.* South Kitchen: Dried food on the side of the cabinet and the scattered food/debris remained on the floors throughout the kitchen and under the handwashing sink. New debris present on the floor from cleaning the double ovens. - Observation on 01/28/26 at 8:20 a.m. showed two unidentified dietary staff members failed to perform hand hygiene and touched the rims of the water, juice, milk, and coffee cups with their bare hands when removing the covers and/or arranging them onto the resident meal plates.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, review of facility policy and staff interview, the facility failed to follow standards of infection control and prevention for 1 of 3 sampled residents (Resident #14) and one supplemental (Resident #30) observed during cares. Failure to practice infection control standards related to glove use and hand hygiene has the potential to spread infection throughout the facility.Review of the facility policy titled Hand Hygiene occurred on 01/29/26. This policy revised September 2023, stated, . Times to Perform Hand Hygiene are, but not limited to: . Before and after direct resident contact . assisting a resident with personal cares . assisting a resident with toileting . After removing gloves . - Observation on 01/25/26 at 1:12 p.m. showed a certified nurse aide (CNA) (#3) transferred Resident #30 to the toilet using a stand lift. Without wearing gloves, the CNA (#3) removed the resident's wet brief, applied gloves without performing hand hygiene, placed a clean brief on the resident, removed her gloves and wiped her hands on her pants. Without completing hand hygiene, the CNA (#3) applied new gloves and completed perineal care for Resident #30, removed her gloves, assisted the resident to bed and exited the room without completing hand hygiene. During an interview on 01/28/26 at 10:45 a.m., an administrative nurse (#1) stated she expects staff to perform hand hygiene with an alcohol-based hand sanitizer after resident cares and in between glove changes. -Review of Resident #14's medical record occurred on all days of survey. The care plan stated, . I require enhanced barrier precautions [EBP] r/t [related to] chronic ulcer on right thigh and colostomy . suspected carrier of MRSA [methicillin resistant Staphylococcus aureus]. Observation on 1/26/26 at 10:10 am. showed a nurse (#6) applied a gown and gloves and entered Resident #14's room. The nurse (#6) obtained supplies from a dresser in the resident's room and placed the supplies on the bedside table. The nurse (#6) removed the dressing from Resident #14's right hip wound and cleaned the drainage from the wound. Without removing the soiled gloves, the nurse opened clean dressings, cleansed the wound with normal saline, and patted it with a gauze. The nurse (#6) opened another dressing, placed it on the wound, and taped the dressing in place. The nurse (#6) then removed the gown and soiled gloves and exited the room. The nurse failed to perform hand hygiene before entering and exiting the resident's room and failed to remove the soiled gloves and perform hand hygiene between soiled and clean dressing changes. During an interview on 01/28/26, an administrative nurse (#1) stated she expected staff to perform hand hygiene with dressing changes.