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	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tioga Medical Center Ltc	810 N Welo St Tioga, ND 58852

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 46964 Based on review of the facility reported incident (FRI), policy review, and staff interview, the facility failed to protect a resident's right to be free from physical abuse for 1 of 2 sampled residents (Resident #1) who sustained a fracture. Failure to ensure an environment free from abuse resulted in a fracture to Resident #1 and placed all residents at risk for abuse, fear, and anxiety. Findings include: Review of the facility policy titled Abuse, Neglect, and Exploitation occurred on 02/11/25. This policy, dated June 2021, stated, . Resident to Resident Altercations . Residents who are abusive to other residents must be monitored . Documentation must be in place to identify steps taken . the corrective action taken, and follow-up monitoring . 6. Prevention of Abuse . b. Observe residents behavior and their reactions to other residents . Identify areas of the . environment that may make abuse . more likely to occur, such as secluded areas. Review of the initial FRI occurred on all days of survey and identified an altercation between Residents #1 and #2 which resulted in a fall and hip fracture for Resident #1 on 02/08/25. Review of Resident #1's medical record occurred on 02/11/25. Diagnoses included dementia and anxiety. The care plan, updated 01/14/25, stated, . I have a history of aggressive behavior towards other residents . ensure that I am monitored while around other residents. I will need redirection when I target another resident. I sit at the table closest to the dining room entry. Review of Resident #1's progress notes stated the following: * 01/12/25 at 5:25 p.m., . 1545 [3:45 p.m.] a family member came to notify this nurse that 2 residents were arguing in the dining room. This nurse went to investigate and found [Resident #1] pinned between the wall and the other resident's walker . There were no injuries sustained . All witnesses state. [Resident #1] came into the dining room . yelling and cursing directed towards another resident. [Resident #1] . took the bottles of hand sanitizer . and threw it [sic]. She then was bumping [Resident #2] with a chair. [Resident #2] . started pushing [Resident #1] around the dining room with his walker. He . pinned her between the wall and his walker. He was upset with her and verbally saying things to her as to how she was acting. [Resident #2] was escorted out of the dining room. (continued on next page)

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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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	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tioga Medical Center Ltc	810 N Welo St Tioga, ND 58852

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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 0600 Level of Harm - Actual harm Residents Affected - Few	* 02/08/25 at 8:30 p.m., . CNA [certified nurse aide] reports to nurse . Resident is on the floor in the dining room . nurse . responds to dining room to find resident . on the floor sitting up. She [Resident #1] is reporting 'he [Resident #2] pushed me' . This altercation was . witnessed by other residents. Other residents reported that she came into the dining room looking for her grandson, she had gone up to resident [Resident #2] . grabbed his wheelchair and opened up the seat, when he [Resident #2] stated, 'get out of my stuff' It was reported that resident than [sic] walked up to [Resident #2] and pushed him twice in the chest, leading him to push the resident. Resident . is sitting on the floor stating her leg hurts . She states 'ouch' and rubs her left thigh. * 02/08/25 at 8:37 p.m., . addendum: Event occurred at 1830 [6:30 p.m.] 02/08/25. Review of Resident #2's medical record occurred on 02/11/25. Diagnoses included anxiety disorder and dementia. The care plan, updated 01/14/25, stated, . monitor me for agitation when around other residents and provide redirection as needed. I sit at the table farthest away from the dining room entry near TV [television]. Review of Resident #2's progress notes stated the following: * 02/08/25 at 6:30 p.m., . Resident sitting at his table in dining room with two other residents and a resident from the independent living. CNA informs this nurse that another resident [Resident #1] is on the floor. This event was not witnessed by staff, but was witnessed by other residents. This nurse. responds to dining room. [Resident #2] reports he pushed resident [Resident #1] down because she opened his walker when he told her not to touch it the resident [Resident #1] had pushed his chest two times and [Resident #2] pushed her to the floor. [Resident #2] continues to tell resident to shut up, your [sic] faking it, your [sic] not really hurt you liar. During an interview on 02/10/25 at 5:10 p.m., an adminstrative nurse (#1) stated after the incident on 01/12/25, the facility changed the seating arrangments in the dining room and educated staff on the behaviors between Resident #1 and #2 and to redirect them as necessary. During an interview on 02/11/25 at 11:20 a.m., an administrative nurse (#1) stated facility staff were not present in the dining room at the time of the incident on 02/08/25. During an interview on 02/11/25 at 1:00 p.m., an administrative nurse (#1) stated staff received verbal education related to the plan of action for Resident #1 and #2 which included seating them at opposite sides of the dining room, observe and provide redirection when in close proximity of each other or when they target another resident, and at least one staff member in the dining room when residents are there.