

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Tioga Medical Center Ltc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the residents' right to request, refuse, and/or discontinue treatment for 1 of 12 sampled residents (Resident #6) reviewed for advanced directives. Failure to ensure the medical record accurately reflected each resident's code status limited the facilities ability to communicate to direct care staff and emergency personnel the residents' choice in the event of a medical emergency. Findings include: Review of facility policy titled Advance Directives Policy occurred on 06/03/26. This policy, dated June 2017, stated, Policy: It is the resident's right to formulate an Advance Directive, and to accept or refuse medical or surgical treatment. On admission, the facility will determine if the resident has executed an Advance Directive and if not, determine whether the resident would like to formulate an Advance Directive. copies will be made and placed on the chart . facility will periodically assess the resident . Review of Resident #6's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated [DATE], identified impaired cognition. A physician's order signed on 05/12/25 stated code level: DNR (do not resuscitate). The health care directive, signed by Resident #6 on 04/04/21, stated, Health Care Directive . 3. Regarding end of life matters: . (a) [Resident #6's initials] I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless. I direct that: I WOULD ACCEPT: CONTINUOUS CIRCULATION FOR CELL SALVAGE, HEART-LUNG MACHINE, DIALYSIS, FRACTIONS-DISCUSS, I HAVE A PACEMAKER, MEDICATIONS. The medical record lacked documentation reflecting the accurate code status for Resident #6. During an interview on 06/03/26 at 2:26 p.m., an administrative staff member (#1) confirmed staff failed to obtain an updated advance directive to reflect Resident #6's code status.		

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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Tioga Medical Center Ltc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's provider of a change in condition for 1 of 1 sampled resident (Resident #3) reviewed for hospitalization. Failure to notify the provider timely of a change in condition delayed physician testing/treatment and contributed to Resident #3's hospitalization. Findings include: Review of the facility policy titled Notification of Changes occurred on 06/02/26. This undated policy, stated, . The facility must inform the resident/patient, consult with the resident's/patient's physician . when there is a change requiring such notification. Circumstances requiring notification include: Significant change in the resident's/patient's physical, mental or psychosocial conditions such as deterioration in health, mental or psychosocial status. This may include: Life-threatening conditions, or Clinical complications. Review of Resident #3's medical record occurred on all days of survey and identified current use of anticoagulants (a medication to thin the blood/prevent blood clots). The nurse progress notes, dated Friday, 12/12/25, stated the following: * 2:12 p.m., CNA [certified nurse aide] reported that the resident had a black tarry stool. All four quadrants active upon auscultation. Resident reports no pain. Notified the DON [Director of Nursing]. Will continue to monitor. Stool sample will be collected with the next bowel movement. * 3:40 p.m., Obtained stool specimen, taken to lab for evaluation. * 5:10 p.m., D.O.N. spoke with the Provider on call and he didn't want to give any new orders regarding the positive stool specimen results. Provider suggested we wait for the Provider on Monday to give any orders. D.O.N. did mention to the Provider on call that resident was a full code, but Provider on call cont [sic] to suggest waiting for the Provider on Monday [12/15/25]. A provider telephone encounter note, dated 12/17/25 (Wednesday), stated, Patient notified to have dark tarry stools. Provider that was on ordered FOBT [fecal occult blood test] which is positive. Hgb [hemoglobin] drawn today shows 5.8 [normal range: 13.5 to 17.5 grams per deciliter]. Last Hgb was 8.6 on 10/23/25. [Name of hospital] called. Accepting Attending is [name of physician]. Ground transport being set up. During an interview on 06/02/26 at 4:30 p.m. an administrative staff member (#2) confirmed the provider notification occurred on 12/17/25 and not on 12/15/25 as requested. The facility failed to contact the provider on 12/15/25 as directed by the on-call provider, which resulted in delayed treatment and hospitalization.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Tioga Medical Center Ltc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1), the facility failed to complete a Minimum Data Set (MDS) that accurately reflected the resident's status for 1 of 1 sampled resident (Resident #22) with a restraint. 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: The Long-Term Care Facility RAI User's Manual, revised October 2025, pages P-1 and P-5, stated, . PHYSICAL RESTRAINTS: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body . Coding Instructions . code the frequency of use: Code 0, not used . Code 2, used daily .Review of Resident #22's medical record occurred on all days of survey. Diagnosis included Huntington's disease (a disease that causes involuntary, irregular, and unpredictable muscle movements often affecting the arms and legs). The current care plan stated, . I prefer to use Huntington's package thigh belts [a belt attached to the chair and over the thighs] to provide safety and allow me to sit upright in my Broda chair. Staff will monitor belt use and ensure my comfort with this device. Please remove my thigh belt at my request .Observation on 06/01/26 at 12:40 p.m. showed Resident #22 seated in wheelchair with the straps of the thigh belt fastened behind the chair. When asked if the resident could release the strap, the resident stated, No. Review of the Resident #22 quarterly MDS, dated [DATE], showed the facility failed to code the thigh belt as a restraint.		