STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355048	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prince of Peace Care Center	201 8th St N Ellendale, ND 58436

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility reported incident (FRI), and staff interview, the facility failed to ensure adequate supervision for 1 of 1 closed record (Resident #54) reviewed with a choking incident. Failure to prevent a resident from accessing and ingesting food inconsistent with their diet resulted in a choking incident and death. This citation is considered past non-compliance based on the corrective action the facility implemented immediately following the incident. Findings include: This surveyor determined a deficient practice existed on 01/06/26. The facility implemented and completed corrective action on 01/12/26. Review of Resident #54's medical record occurred on April 15-16, 2026. Diagnoses included adjustment disorder with mixed disturbance of emotions and conduct, Alzheimer's disease and dysphagia. Physician's orders included IDDSI (International Dysphagia Diet Standardization Initiative) level 4, pureed. An annual Minimum Data Set (MDS), dated [DATE], identified coughing or choking during meals or when swallowing and a mechanically altered diet. Review of the FRI, dated 01/06/26, stated, On 1/6/2026 at approximately 1543, the resident [Resident #54] was observed on the unit while independently mobilizing in his wheelchair, which is his baseline, and engaged in a phone call. Staff noticed he was getting increasingly agitated. He had been agitated throughout the day. At the time of the incident, [Resident #54] took a brownie from the snack cart and placed a piece of the brownie in his mouth. Staff immediately attempted to intervene as he was grabbing the brownie. He started hitting the staff to get them away from him when he took a piece of the brownie into his mouth. The staff member attempted to get the brownie out of his mouth and as she was attempting, and he was striking out, he shoved the entire piece of brownie into his mouth and gulped it down. The Heimlich maneuver was initiated promptly, and staff were directed to call 911. Suctioning was performed . Emergency Medical Services [EMS] arrived approximately 10 minutes after the 911 call. Despite continued life-saving measures, the resident was pronounced deceased by EMS at the scene. During an interview on 04/16/26 at 8:30 a.m., an administrative nurse (#1) confirmed Resident #54 had access to a snack cart and ingested a food item not consistent with the resident's prescribed diet and choked. The administrative nurse (#1) reported food items were arranged openly on the top of the snack cart without protective coverings, allowing residents access to items. The administrative nurse (#1) reported, at the time of the incident, a certified nurse aide (CNA) (#3), an activity staff member, and an administrative staff member were present on the unit. During an interview on 04/16/26 at 9:25 a.m., the CNA (#3) reported leaving the snack cart unattended to converse with another resident. While conversing, Resident #54 appeared visually agitated, self-propelled to the snack cart, and obtained a brownie. The CNA reported responding immediately, but Resident #54 had placed the brownie fully into their mouth and began choking. The CNA (#3) responded immediately and called for assistance. An administrative staff member and the administrative nurse (#3) responded. The CNA (#3) confirmed awareness of Resident #54's prescribed pureed diet, and the brownie was not consistent with the resident's diet order. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions for residents who may be affected by the deficient practice as follows: * The (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility completed an investigation identifying the problem, factors, root causes, corrective action, identification of other residents at risk, systemic changes, and monitoring. * Provided education to nursing and dietary staff regarding supervision of snack carts and not to leave unattended in resident-accessible areas and must be secured when not in use. * Identified residents with dysphagia, altered diets, and/or behaviors related to food. Residents were reviewed and care plans were updated. * Reviewed facility policy and procedure for snack cart delivery and supervision with nursing and dietary staff. * Implemented covered containers for units with locking mechanisms to prevent or slow residents from obtaining food items not consistent with prescribed diet. * On 01/12/26, all staff educated on choking risks, diet compliance, and the cardiopulmonary resuscitation (CPR)/choking policy/procedure. * Quarterly audits conducted by a Registered Dietitian for residents with dysphagia and behavioral risk factors.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a Significant Change in Status Assessment (SCSA) for 1 of 15 sampled residents (Resident #22) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facilities ability to identify and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.20.1), dated October 2025, page 2-24 stated, . A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. Page 2-27 stated, An SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. Any decline in an ADL [activities of daily living] physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individuals functioning. Review of Resident #22's medical record occurred on all days of survey. A Minimum Data Set (MDS) SCSA, dated 11/06/25, identified set-up or clean-up assistance with upper and lower body dressing and personal hygiene. A quarterly MDS, dated [DATE], identified substantial/maximum assistance with upper and lower body dressing and personal hygiene. The facility failed to complete a SCSA related to Resident #22's decline in ADLs. During an interview on 04/15/26 at 2:43 p.m., an administrative nurse (#2) confirmed the facility should have completed a SCSA.

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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, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 13 sampled residents (Resident #22 and #23) observed during cares. Failure to practice infection control standards related to hand hygiene and glove usage has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Hand Hygiene occurred on 04/15/26. This policy, dated September 2023, stated, . Times to perform Hand Hygiene are, but not limited to: . Before and after direct resident contact . Before and after entering isolation precaution setting . Before and after assisting a resident with personal cares . Before and after assisting a resident with toileting - wash hands with soap and water . Review of Resident #22's medical record occurred on all days of survey. The current care plan stated, . Enhanced Barrier Precautions r/t [related to] diagnosis of MRSA [Methicillin-resistant Staphylococcus aureus] . Staff are to . sanitize hands after PPE [Personal Protective Equipment] removal. - Observation on 04/13/26 at 12:49 p.m. showed a certified nurse aide (CNA) (#3) entered Resident #22's room, performed hand hygiene, applied a gown and gloves, and assisted the resident to the bathroom. After providing perineal cares, the CNA (#3) removed the gown and gloves and assisted Resident #22 into a recliner. The CNA then proceeded to care for another resident without performing hand hygiene. The CNA (#3) failed to perform hand hygiene after assisting Resident #22 with cares and before assisting another resident. -Observation on 04/14/26 at 9:29 a.m. showed a CNA (#4) entered Resident #23's room to assist with toileting. The CNA performed hand hygiene, applied gloves, removed Resident #23's soiled brief, placed it in the trash and removed the soiled gloves. Without performing hand hygiene, the CNA (#4) applied new gloves, assisted Resident #23 to stand and performed perineal care. The CNA (#4) removed the soiled gloves, applied a new brief and pulled up Resident #23's pants. Without performing hand hygiene, the CNA (#4) applied new gloves and transferred Resident #23 into a wheelchair. The CNA then used wipes to clean stool from the toilet seat and removed the soiled gloves. The CNA failed to perform hand hygiene between glove changes. During an interview on the afternoon of 04/15/26, an administrative nurse (#1) confirmed staff should perform hand hygiene between residents and after removing soiled gloves and applying clean gloves.