

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Strasburg Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 409 S 3rd St Strasburg, ND 58573	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489</p> <p>Based on record review, review of facility policy, and resident and family interviews, the facility failed to ensure an alleged violation of misappropriation of resident property was reported within 24 hours to the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #20) with a report of missing money. Failure to report the alleged violation to the SSA placed Resident #20 and other residents at risk for misappropriation of property.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse, Neglect, Mistreatment, Exploitation &/or Misappropriation of Resident Property occurred on 01/23/25. This policy, dated October 2024, stated, . It is the policy of the facility to provide protections for the health, welfare and rights of each resident by taking appropriate steps to prevent . misappropriation of resident property, regardless of the resident's mental or physical condition. Alleged violations will be reported to . the State Survey & Certification Agency, in accordance with state law through established procedures.</p> <p>Review of Resident #20's medical record occurred on all days of survey. A Minimum Data Set (MDS), dated [DATE], identified intact cognition.</p> <p>During an interview on 01/21/25 at 3:43 p.m., Resident #20 stated, I had a check for \$100.00 from my wife that she had given to me for a Christmas gift. Last Friday I gave the check to my daughter to take to the bank and cash it for me. My daughter brought the money back to me in a bank envelope and it was five twenties. Then Sunday when I went to take a shower I took the envelope with the money in it and this notepad out of my shirt pocket and put it in this drawer. When I came back to my room after my shower the notepad was in the drawer, but the envelope with the money in was not there. So I told the nurse I was missing my money. When asked if the facility assisted the resident to look for his money, he stated, Yes, I told them they could look all they wanted but I already did and didn't find it. And they couldn't find it either.</p> <p>Review of Resident #20's progress notes included the following:</p> <p>* 1/19/25 at 1:16 p.m. Has been talking about an envelope with 100 dollars that he received the past several days, and lost the money. Nurse phoned [Resident #20's daughter] whom will talk to the resident (nothing mentioned about loosing [sic] money up until today), and then call the nurse back.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* 1/19/25 at 2:12 p.m. [Resident #20's daughter] called back, res. [resident] received the 100 dollars on 1-17 [January 17th, 2025]. Res. had told [Resident #20's daughter] he misplaced the money.</p> <p>* 1/19/25 at 5:29 p.m. Res. talked with the bathing CNA [certified nurse aide] from this morning, she explained to resident that he didn't have his shirt or vest on, then res. said 'I misplaced the money in a drawer' .</p> <p>* 1/21/25 at 10:19 a.m. He said he is missing \$100.00, said that 'someone had sticky fingers on his bath day, Monday' .</p> <p>During an interview on 01/23/25 at 9:33 a.m., an administrative nurse (#1) verified she had not reported Resident #20's missing money to the SSA.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489</p> <p>Based on record review, policy review, and staff, resident and family interviews, the facility failed to initiate an investigation of an alleged violation of misappropriation of resident property for 1 of 1 sampled resident (Resident #20) with reports of missing money. Failure to investigate the alleged misappropriation of the resident's property and ensure all residents are protected placed them at risk for emotional and mental distress.</p> <p>Findings include:</p> <p>Review of the facility policy titled Lost & Missing Items occurred on 01/23/25. This policy, dated January 2025, stated, . This facility maintains a safe and secure environment to minimize lost and/or missing items. When a resident reports a missing item a. Staff will complete the Missing Item form b. Staff will complete a search of the resident's room as well as nearby rooms c. Social Service staff will inform department heads at morning stand up d. A record of areas searched will be kept .</p> <p>Review of the facility policy titled Abuse, Neglect, Mistreatment, Exploitation &/or Misappropriation of Resident Property occurred on 01/23/25. This policy, dated October 2024, stated, . It is the policy of the facility . to prevent . misappropriation of resident property, regardless of the resident's mental or physical condition. The facility will thoroughly investigate all allegations . The facility will immediately engage in efforts to identify, intervene and correct situations in which . misappropriation of resident property have occurred or are more likely to occur.</p> <p>Review of Resident #20's medical record occurred on all days of survey. A Minimum Data Set (MDS), dated [DATE], identified intact cognition.</p> <p>During an interview on 01/21/25 at 3:43 p.m., Resident #20 stated, I had a check for \$100.00 from my wife that she had given to me for a Christmas gift. Last Friday I gave the check to my daughter to take to the bank and cash it for me. My daughter brought the money back to me in a bank envelope and it was five twenties. Then Sunday when I went to take a shower I took the envelope with the money in it and this notepad out of my shirt pocket and put it in this drawer. When I came back to my room after my shower the notepad was in the drawer, but the envelope with the money in was not there. So I told the nurse I was missing my money. When asked if the facility assisted the resident with looking for his money, he stated, Yes, I told them they could look all they wanted but I already did and didn't find it. And they couldn't find it either.</p> <p>Review of Resident #20's progress notes included the following:</p> <p>* 1/19/25 at 1:16 p.m. Has been talking about an envelope with 100 dollars that he received the past several days, and [sic] lost the money. Nurse phoned [Resident #20's daughter] whom [sic] will talk to the resident (nothing mentioned about losing [sic] money up until today), and then call the nurse back.</p> <p>* 1/19/25 at 2:12 p.m. [Resident #20's daughter] called back, res. [resident] received the 100 dollars on 1-17 [January 17th, 2025]. Res. had told [Resident #20's daughter] he misplaced the money.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* 1/19/25 at 5:29 p.m. Res. talked with the bathing CNA [certified nurse aide] from this morning, she explained to resident that he didn't have his shirt or vest on, then res. said 'I misplaced the money in a drawer'.</p> <p>* 1/21/25 at 10:19 a.m. He said he is missing \$100.00, said that 'someone had sticky fingers on his bath day, Monday.' .</p> <p>During an interview on 01/22/25 at 4:23 p.m., Resident #20's daughter, (Family member A), stated, He [Resident #20] might misplace things like we all do for a short time and then find them. It is not normal behavior for my dad to say he is missing things which he is not, and he has a very good mind.</p> <p>During an interview on 01/22/25 at 4:53 p.m., Resident #20's daughter, (Family member B), stated, Last Friday I took the check to the bank for my dad per his request and cashed it. I then took the bank envelope with five twenty dollar bills to me dad. He [Resident #20] didn't go anywhere to spend the money so where did it go?</p> <p>During an interview on 01/23/25 at 9:33 a.m., an administrative nurse (#1) verified the facility had not started and/or completed an investigation for Resident #20's missing money.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46964</p> <p>Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 2 of 3 residents (Resident #9 and #12) observed for insulin preparation and administration. Failure to prime insulin pens correctly may result in residents receiving an inaccurate dose.</p> <p>Findings include:</p> <p>Review of the facility policy titled Insulin Pens occurred on 01/22/25. This policy, dated 01/06/25, stated, . 5. Prime the pen, a. Dial 2 units by turning the dose selector. b. Remove the cover from the needle and hold the pen with needle pointed upward.</p> <p>- Observation on 01/21/25 at 5:23 p.m. showed a nurse (#3) prepared Resident #12's insulin pen for administration. The nurse failed to prime the insulin pen upward.</p> <p>- Observation on 01/22/25 at 7:59 a.m. showed a nurse (#4) prepared Resident #9's insulin pen for administration. The nurse failed to prime the insulin pen upward.</p> <p>During an interview the morning of 01/23/25, an administrative staff member (#1) stated she expected staff to follow the policy for priming insulin pens.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>40489</p> <p>Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received the necessary service to maintain personal hygiene for 1 of 8 sampled residents (Resident #18) who required staff assistance for personal hygiene. Failure to assist residents who cannot perform personal hygiene independently may result in poor hygiene, skin issues, and decreased self-esteem.</p> <p>Findings include:</p> <p>Review of the facility policy titled ADLs (Activities of Daily Living) occurred on 01/23/25. This policy, dated October 2024, stated, . It is the policy of the facility to provide ADL care to residents as needed to ensure all ADL needs are met are on a daily basis.</p> <p>Review of Resident #18's medical record occurred on all days of survey. The current care plan stated, . The resident has an ADL self-care performance deficit r/t [related to] dementia PERSONAL HYGIENE: she needs set up help and verbal reminders for personal hygiene.</p> <p>Observation on 01/22/25 at 8:17 a.m. showed a nurse (#3) assisted Resident #18 to pick out her clothing, placed the clothing in the bathroom, and asked, Do you want me to help you? The resident answered, yes, and without providing assistance or verbal reminders for personal hygiene, the nurse assisted the resident to remove her pajamas and put on new clothing. After exiting the room, when asked if the resident needs assistance with personal hygiene, the nurse (#3) stated, When she will allow us to help her.</p> <p>During an interview on 01/23/25 at 9:33 a.m., an administrative nurse (#1) stated she expected the nurse (#3) to assist Resident #18 with personal hygiene while she assisted the resident with dressing.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>40489</p> <p>Based on observation, record review, and resident and staff interview, the facility failed to ensure appropriate care and services for 1 of 2 sampled residents (Resident #16) with an indwelling urinary catheter. Failure to empty Resident #16's catheter bag may result in urinary tract infections (UTIs), unnecessary discomfort, and urinary retention and/or obstruction.</p> <p>Findings include:</p> <p>Review of the facility policy titled Catheter Care occurred on 01/23/25. This policy, dated October 2024, stated, . Empty drainage bag at the end of each shift [i.e., three times per day] .</p> <p>Review of Resident #16's medical record occurred on all days of survey. Diagnoses included obstructive and reflux uropathy (blockage that hinders urinary flow), benign prostatic hyperplasia (enlarged prostate that can cause blockage of urine flow from the bladder as well as urinary tract and kidney problems), and history of UTIs. The care plan stated, . The resident has an indwelling suprapubic catheter related to urinary obstruction.</p> <p>Observations on 01/21/25 of Resident #16 showed the following:</p> <p>* 4:43 p.m. Approximately 1200 cubic centimeters (cc) of urine in the catheter bag. The resident stated, It feels like it might explode.</p> <p>* 5:50 p.m. Approximately 1300 cc of urine in the catheter bag.</p> <p>Resident #16's output record showed staff emptied the catheter bag on 01/21/25 at 7:53 p.m., and it contained 2000 cc of urine.</p> <p>The medical record also showed four days from January 6th to January 20th, 2025, staff emptied the resident's catheter bag twice in a 24-hour period.</p> <p>During an interview on 01/23/25 at 9.33 a.m., an administrative staff (#1) confirmed staff should have emptied Resident #16's catheter before 8:00 p.m. on January 21st, and stated she expected certified nurse assistants to empty catheter bags at least once per eight-hour shift.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46964</p> <p>51999</p> <p>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 2 sampled residents (Resident #9) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP) and hand hygiene has the potential to spread infection throughout the facility.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Enhanced Barrier Precautions occurred on 01/22/25. This policy, dated 04/01/24, stated, . It is the policy of this facility to implement enhanced barrier precautions to prevent the transmission of multidrug-resistant organisms (MDRO) during high-contact activities for residents with chronic wound or indwelling medical devices, even if the resident is not known to be infected or colonized with a MDRO. 'Enhanced Barrier Precautions'. refers to the use of gown and gloves during high-contact resident care activities for residents. at increased risk of MDRO acquisition (e.g., .indwelling medical devices). urinary catheters .) . High-Contact Resident Care Activities may include: Transferring.</p> <p>Review of the facility's policy titled Hand Hygiene occurred on 01/21/25. This policy, dated 11/20/24, stated, . Each staff member is responsible to practice hand hygiene. The use of gloves does not replace hand hygiene. perform hand hygiene prior to donning gloves and immediately after removing gloves.</p> <p>- Review of Resident #9's medical record occurred on all days of survey. A current physician's order stated, Enhanced Barrier Precautions every shift for foley catheter.</p> <p>Observations of Resident #9 showed the following:</p> <p>* 01/21/25 at 5:01 p.m., Resident #9 had a catheter drain bag. Two certified nurse aides (CNA) (#6 and #7) transferred Resident #9 from the recliner to the wheelchair. The CNA (#6) moved the catheter bag to the wheelchair. The CNAs (#6 and #7) failed to don a gown or gloves before they transferred Resident #9.</p> <p>* 01/22/25 at 9:13 a.m., Two CNAs (#5 and #8) failed to don a gown or gloves prior to transferring the resident from the toilet to the wheelchair.</p> <p>* 01/22/25 at 4:03 p.m., a CNA (#6) donned a gown and gloves and entered the bathroom where Resident #9 sat on the toilet. The CNA (#6) emptied Resident #9's catheter drainage bag, removed her gloves, and without performing hand hygiene, donned new gloves, raised Resident #9 to a standing position with a mechanical stand lift, and performed bowel movement cares. The CNA removed her gloves, and without performing hand hygiene, donned new gloves, adjusted the resident brief and clothes, and transferred the resident to the recliner. The CNA (#6) removed her right glove, and without performing hand hygiene, applied Resident #9's oxygen cannula.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/25 at 11:35 a.m., an administrative nurse (#1) confirmed the facility failed to educate staff on the use of gown and gloves for transfers of residents in enhanced barrier precautions, and stated she expected staff to perform hand hygiene after removing gloves and before putting on new gloves or touching other surfaces per policy.		