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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355049	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strasburg Nursing Home	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for 1 of 14 residents (Resident #21) reviewed for self-administration of medication (SAM). Failure to assist/observe residents who are not SAM take their medications may result in adverse health consequences.Findings include:Review of the facility policy titled Self-Administration of Medications occurred on 04/01/26. This policy, dated 01/16/26, stated, . A licensed nurse will complete the Self-Administration of Medications [SAM] screen . The Interdisciplinary team (IDT) will make a determination based on the screen . Re-assessment will be completed quarterly and PRN [as needed].Review of Resident #21's medical record occurred on all days of survey. A SAM assessment, dated 01/19/26, lacked the resident's choice to not self-administer his medications. A progress note, dated 01/28/26 at 1:54 p.m., stated, . Quarterly hospital return MDS completed . Resident does not wish to participate in SAM.Observation on 04/01/26 at 7:41 a.m. showed Resident #21 seated for the morning meal. A nurse (#5) prepared the resident's medications and stated, He is SAM. The nurse placed a cup of pills on the table, mixed a powdered stool softener in a glass of water, and returned to the medication cart. The nurse (#5) failed to assist/observe Resident #21 with his medications. During an interview on 04/01/26 at 11:40 a.m., a staff nurse (#4) confirmed the nurse should observe/assist Resident #21 taking his medications.

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 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 professional reference, and staff interview, the facility failed to ensure medication labels and provider's orders matched for 1 of 8 residents (Resident #21) observed during medication pass. Failure to ensure medication labels matched the provider's order placed residents at risk for medication errors.Findings include: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 838-840, stated, . Obtain the appropriate medication. Compare the label of the medication container or unit-dose package against the order on the MAR [medication administration record] or computer printout. Rationale: This is a safety check to ensure that the right medication is given. If these are not identical, recheck the prescriber's written order in the client's chart. If there is still a discrepancy, check with the pharmacist. Prepare the medication. While preparing the medication, recheck each prepared drug and container with the MAR again. Rationale: This second safety check reduces the chance of error.Review of Resident #21's medical record occurred on all days of survey. A provider's order, dated 02/11/26, identified to increase dicyclomine (treats irritable bowel) to 20 milligrams (mg) twice a day. Observation on 04/01/26 at 7:41 a.m. showed a nurse (#5) prepared Resident #21's medications. The MAR identified dicyclomine 20 mg twice a day. The medication label indicated to administer half tablet (10 mg) twice a day. The nurse confirmed the provider's order and administered 20 mg.During an interview on 04/01/26 at 10:40 a.m., an administrative nurse (#1) confirmed Resident #21's dicyclomine label did not match Resident #21's MAR.

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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 2 of 2 sampled residents (Resident #2 and #24) observed during dressing changes. Failure to practice infection control standards related to use of personal protective equipment (PPE) for a resident in enhanced barrier precautions (EBP), hand hygiene, and providing a clean surface area for dressing supplies has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Enhanced Barrier Precautions (not regular isolation precautions) occurred on 04/01/26. This policy, dated 04/01/24, stated, . 'Enhanced barrier precautions' refers to use of gown and gloves during high-contact resident care activities . High contact resident care activities do include . Chronic wound care and dressing change . Review of the facility policy titled, Dressing Changes occurred on 04/01/26. This policy, dated 11/25/25, stated, . 1. Wash hands thoroughly 2. [NAME] [apply] clean gloves 3. Remove dressing and discard 4. Remove soiled gloves and discard 5. Perform hand hygiene 6. Put on clean disposable gloves . 8. Apply treatment as ordered 9. Apply dressing as ordered 10. Remove gloves and discard 11. Perform hand hygiene . Dressings, gloves, plastic bags, etc. are never to be placed on the resident's bed; use an over-the bed table to put supplies on, making sure it is left clean and neat. Wipe over-the-bed table off with disinfectant wipe before dressing change and after. -Review of Resident #2's medical record occurred on all days of survey. The care plan identified EBP related to the suprapubic catheter (urine drainage tube inserted through the abdomen) with chronic cellulitis (bacterial skin infection) and wound drainage around the site. Observation on 04/01/26 at 9:58 a.m. showed a sign on Resident #2's door indicating EBP, the resident in bed, and a basket of wound supplies on the bedside table. A nurse (#3) entered the room, performed hand hygiene, applied gloves, and removed a soiled dressing from the resident's suprapubic catheter site. The nurse removed the soiled gloves, and without performing hand hygiene, applied clean gloves. The nurse cleansed the catheter site as ordered and applied a clean dressing. The nurse removed the soiled gloves, and without performing hand hygiene, placed the wound supplies into the basket, placed the basket into the nightstand drawer, and applied the resident's shoes. The nurse (#3) then performed hand hygiene and exited the room. The nurse (#3) failed to apply a gown prior to completing Resident #2's dressing change and use appropriate hand hygiene during the dressing change. During an interview on the morning of 04/01/26, an administrative nurse (#1) stated she expected staff to wear a gown when caring for residents with catheters and utilize proper hand hygiene/glove use during dressing changes. - Review of Resident #24's medical record occurred on all days of survey. The current care plan stated, The resident has a pressure ulcer to right heel . Goal: The resident's pressure ulcer will show signs of healing and remain free from infection.Observation on 04/01/26 at 10:22 a.m. showed Resident #24 in a wheelchair. The nurse (#3) removed dressing supplies from a plastic basin, opened a package of gauze, and placed the gauze directly on a cloth chair. The nurse then placed the scissors, tape, and cleaning solutions on the chair. The nurse failed to use a clean surface for the dressing supplies.