STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355068	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towner County Living Ctr	228 1st Ave Cando, ND 58324

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

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, review of facility policy, review of resident council minutes, review of the facility assessment, review of the dietary schedule, and staff interview, the facility failed to ensure sufficient staff for meal service in 1 of 1 dining room. Failure to serve resident meals in a timely manner did not enhance the dining experience for the facility's residents.Findings include:Review of facility policy titled Nutrition Services Staffing occurred on 01/14/26. This policy, revised 04/08/25, stated, . The department will be staffed adequately to meet the patient's nutritional needs with regular meals served to patient at 7:30am [morning], 11:45am and 5:30pm [evening]. The facility will provide sufficient support personnel to safely and effectively carry out the supportive functions of the Food and Nutrition Services. These functions include, but are not limited to: . Safe and timely meal preparation . Providing meals and/or supplements in accordance with residents' needs . Review of the resident council minutes occurred on all days of survey and showed the following:* August 2025, stated, . short staffed at this time. Residents continue to wait for food .* September 2025, stated, . Dietary: . The department continues to be short staffed at this time. Residents continue to wait for food longer than they would like.* October 2025, stated, . dietary is short staffed at times. the wait time for food it too long.* December 2025, stated, . wait time for food is too long .* January 2026, stated, . dietary is short staffed at times.Review of the facility assessment identified one full time dietary manager on the day shift, three dietary assistants for 8 hours on the day shift, and one dietary assistant for 2.5 hours on the day shift.Review of the dietary schedule from December 8, 2025, through January 18, 2026, identified 18 days of less than three dietary assistants during the noon meal. Review of the meal and snack times identified lunch served at noon. Observation of the noon meal on 01/12/26 at 12:33 p.m., showed the dietary manager (#6) and the cook (#7) prepared and served the meal. The residents in the dining room received their meal at 1:00 p.m., one hour past the posted serving time. During an interview on 01/14/26 at 4:00 p.m., the dietary manager (#6) stated she would expect three to four kitchen staff during both the day and evening shifts and meals to be served at the scheduled times.The facility failed to serve the residents meals in a timely manner.

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of resident council meeting minutes, review of facility policy, and resident and staff interviews, the facility failed to take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are identified and sustained. Failure to perform Quality Assurance and Performance Improvement Program (QAPI) for continued resident concerns placed all residents at risk for not having their needs met. Findings includeReview of policy, Quality Assurance & Performance Improvement Program occurred on 01/14/26. This undated policy stated, . the scope of the QAPI program encompasses all segments of TLCL ([NAME] County Living Center) including resident . feedback . Our organization will conduct Performance Improvement Projects [PIP] that are designed to take systemic approach to revise and improve care or services in the areas that we identify as needing attention. We will conduct PIPs (performance improvement plans) that will lead to changes and guide corrective actions in our systems . and have impact on quality of life and quality of care for the residents living in our community. We will conduct PIPs that will improve care and services delivery .- Observation of the noon meal on 01/12/26 at 12:33 p.m. showed the residents in the dining room received their meal at 1:00 p.m., one hour past the posted serving time.- During an interview on 01/12/26 at 1:20 p.m., a confidential resident (Resident A) stated, My main concern is with meals, we sit and wait for a long time, at least half an hour until our food is served. Resident A continued, We [the residents] have complained about long wait times for meals at the resident meetings and nothing ever happens about it. - During an interview on 01/12/26 at 1:40 p.m. Resident #1 stated, I eat in my room for now and I'm hungry. I haven't had my lunch tray yet. Depending on the day they are late getting me my food. I had my light on and requested food earlier. - Observation on 01/12/26 at 1:47 p.m. showed a lunch tray delivered to Resident #1's room, almost two hours past the serving time.Review of resident council meeting minutes for the past five months, (August 2025 through December 2025) showed the following:* August 4th, 2025: .Dietary: . Concerns: Residents continue to wait for food .* September 15th, 2025 Dietary: . Concerns: Residents continue to wait for food longer than they would like. Comments shared verbally with dietary manager.* October 6th, 2025 . Dietary: . Concerns: . residents report that the wait time for food is too long. Concerns e-mailed to and verbally discussed with dietary manager.* December 1st, 2025 . Concerns . residents report that the wait time for food is too long . Concerns verbally discussed with dietary manager.- During an interview on 01/14/26 at 4:22 p.m. an administrative staff member (#4) stated, food service complaints from resident council meetings are sent directly to the dietary manager, and she had not been notified of any dietary concerns. The staff member stated PIPs are prioritized by resident and staff concerns and verified the facility has not conducted a PIP related to long wait times for meal service.- During an interview on 01/14/26 at 4:41 p.m. an administrative staff member (#3) stated, The dietary manager has talked to me a couple of times about the concerns with long wait times for meal service. The facility failed to address and conduct a PIP related to continued resident complaints with long wait times for meal service. See F802

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of the facility reported incident (FRI) investigation, record review, review of facility policy, and staff and resident interviews, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 1 sampled resident (Resident #4) investigated for a fall. Failure to ensure staff provided hands on assistance with ambulation resulted in a fall with injury to Resident #4 and has the potential for all residents who require hands on assistance with ambulation to experience falls and/or injury.Findings includeReview of the facility policy titled Fall Prevention Policy occurred on 01/14/26. This policy, dated 10/03/24, stated, . Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.Review of the FRI investigation, received from the facility on 03/19/25, stated, . RN [registered nurse] [#9] verbally reported CNA [#8] called her into the room and when she came in found [Resident 4] on the floor with a quarter size open flap to right posterior head with active bleeding. RN [#9] reported she asked CNA [#8] twice if she lowered her to the ground. RN [#9] reported the CNA did not answer her. LBSW [licensed baccalaureate social worker] [#5] interviewed [Resident #4], about the fall she had. [Resident #4] stated she was walking to the bathroom and fell part way between the area by the sink and the toilet. [Resident #4] stated the CNA [#8] put a gait belt on her and opened the door for her. [Resident #4] stated she walked to the bathroom by herself and the CNA was in the bedroom. When asked where the CNA was at this time, [Resident #4] stated she was in the bedroom beside her recliner. [Resident #4] stated she tried to catch her balance but was unable to do so. She hit her head on the countertop. [Resident #4] stated, I really cracked it, I can still hear the sound. This writer asked if the other CNA's hold onto her when she walks to the bathroom. She said yes, they all hang onto me, even the men do. [Resident #4] stated the CNA [#8] put the belt on her but did not walk in with her. It is noted [Resident #4] visited with three different staff members, and each time she reported she walked into the bathroom alone, and the CNA [#8] was in the other room.Resident #4's nursing progress notes stated the following:* 03/16/25 at 12:00 p.m. CNA called me to the BR [bathroom]. Res sitting on her buttocks in front of the sink area. CNA [#8] states she was walking her to the toilet when her rt [right] ankle twisted and she began to fall. Hit her head on the countertop. Has quarter sized open flap to rt post [posterior] head with active bleeding. Alert, oriented to what happened . Admits to pain at open site only. Denies HA [headache].During an interview on 01/13/26 at 9:45 a.m., Resident #4 stated she has not had any recent falls, Since I cracked my head on the countertop. When asked about that fall and if CNA helped her walk to the bathroom, Resident #4 stated, No she put the belt on me but did not walk with me into the bathroom. She was in the other room by my recliner.During interview on 01/14/26 at 2:43 p.m., an administrative staff member (#2) stated she expected staff to ensure residents received adequate assistance and followed the residents care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility policies, and staff interview, the facility failed to ensure food is stored in accordance with professional standards for food service sanitation in 1 of 1 kitchen. Failure to ensure food is stored, prepared and served in a sanitary environment, and to ensure sanitary strips are not expired, may result in contamination of foods and foodborne illness. Findings include:Review of the facility policy titled Food Storage occurred on 01/14/26. This policy dated September 2010, stated, . The store room will be clean . Items stored under refrigeration that are ready to eat and potentially hazardous shall be marked with date prepared. Potentially hazardous [foods] like meats, spreads and salads will be kept for three days after date prepared . Other less hazardous foods like gelatin and canned fruit will be kept five days after date opened. Food must be stored sufficiently above floor level . 6-12 off the floor . Lighting, ventilation and humidity should be controlled to meet requirements and prevent both condensation and the growth of microorganisms. All food products opened or placed in another container must be labeled, dated and covered.Review of the facility policy titled Sanitation and Infection Control occurred on 01/14/26. This policy, dated March 2007, stated, .The general responsibilities of the director of dietary and dietitians are: . To supervise sanitation and cleaning procedures in the Dietary Department. Dietary employees will be given a daily cleaning checklist that they must check off through their shift until completed and initialed. All floor surfaces must be wet-mopped daily and as needed. Food service equipment will be cleaned according to cleaning schedule.The initial observation of the kitchen occurred on 01/12/26 at 11:35 a.m. and showed the following:Walk-in cooler: * One container of meatballs and gravy not labeled or dated. * One container of an unknown food item not labeled or dated. * One container of tomato sauce dated 12/22.* Opened and undated containers of dressings (Mayo, Catalina, Frank's Red Hot, Italian Salad Dressing and coleslaw dressing). * One container of an unknown meat product dated 12/21. Walk-in freezer: * French fries and other food debris on the floor.* One box of English muffins stored on the floor. Stand up freezer #3:* One undated, unlabeled and unsealed bag of pastries. Dry storage: * Two unlabeled and undated containers of dry cereal not in original packaging. * Individual jelly packets and debris on the floor under the shelving.Observation of the kitchen on 01/14/26 at 9:50 a.m. showed the following:* Two large plastic containers of flour. One container not labeled or dated and a measuring cup in the second container.* One plastic container of sugar not labeled or dated.* Microwave dirty with food particles. * The inside of a deep fryer lined with old food debris.* Quaternary Ammonia Sanitizer test strips, used by staff to test the concentration sanitizer solution, with an expiration date of December 2025.Walk-in cooler: * The same open and undated dressings listed in initial walk through.* One large plastic container of unlabeled and undated mixed lettuce. * Deli meat dated 12/21. * Debris on the floor. Walk-in freezer: * One large plastic tote with individual unlabeled or undated foods stored in Ziplock baggies. * Ice buildup on the light above the fan. Stand up freezer #3:* Red liquid spillage frozen under the bottom drawer.Dry storage:* Debris on the floor under the canned good storage shelving.* One large bag of croissants dated 12/08/25. * Two clear plastic containers of chocolate glaze dated 11/11, not in original packaging. Small fridge #5: * One open and undated container of thickened cranberry juice.During an interview on 01/14/26 at 11:45 a.m., the dietary manager (#6) stated she expected prepared foods to be covered and labeled including the date and opened food containers to be labeled and dated. She confirmed the sanitizer test strips were outdated and new strips had been ordered. She expected staff to clean daily, and confirmed no daily cleaning checklist for staff to initial.

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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 1 of 1 sampled resident (Resident #3) observed during cares. Failure to apply appropriate personal protective equipment (PPE) when providing care to residents in enhanced barrier precautions (EBP) has the potential to spread infection to residents, staff and visitors. Findings include: Review of the facility policy titled, Infection Control-Enhanced Based Precautions occurred on 01/14/25. This policy, revised September 2025, stated, . Enhanced Barrier Precautions require the use of gowns and gloves . For residents for whom enhanced Barrier Precautions are indicated, Enhanced barrier Precautions is employed the preforming resident care activities: . Transferring. Changing briefs or assisting with toileting . Review of Resident #3's medical record occurred on all days of survey. A physician's order dated, 06/26/24, stated Enhanced Barrier Precautions due to indwelling catheter - G-Tube [feeding tube] Observation on 01/12/26 at 2:24 p.m. identified an EBP signage and PPE supplies outside Resident #3's door. A certified nurse aid (CNA) (#1) entered Resident #3's room, applied gloves, transferred the resident from wheelchair to the toilet, provided toileting hygiene, and transferred the resident back to the wheelchair. The CNA (#1) failed to apply a gown prior to providing cares. During an interview the afternoon of 01/14/26, an administrative nurse (#2) confirmed she expected staff to wear a gown when transferring and toileting residents in EBPs.