

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Dunseith Com Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 15 1st St NE Dunseith, ND 58329	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility reported incident s(FRI), review of facility policy, and staff interviews, the facility failed to ensure residents remained free from abuse for 2 of 2 sampled residents (Resident #1 and #6) intimidated and yelled at by staff members (Resident #6) and verbal outbursts/physical behaviors towards other residents (Resident #1). Failure to protect residents from abuse resulted in physical, verbal, and mental abuse, pain and has to potential to affect all residents. Findings include: Review of the facility's policy titled Abuse, Neglect, and Exploitation occurred on 12/22/25. This policy, revised 07/01/24, stated, . Abuse . the willful infliction of injury . intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and . resident to resident altercations. 'Mental Abuse' includes, but is not limited to . humiliation, harassment, threats of punishment or deprivation. 'Physical Abuse' includes, but is not limited to hitting, slapping, punching . 'Verbal Abuse' means the use of oral . or gestured that willfully includes disparaging and derogatory terms to residents . regardless of their age, ability to comprehend, or disability. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anxiety, conduct disorder, and depression. Medications included Sertraline daily for depression. The quarterly Minimum Data Set (MDS), dated [DATE], identified moderate cognitive impairments and delusions. The current care plan stated, . Provide quiet, non-hurried environment, free of background noises and distractions. Staff will . redirect resident for any disruptive behaviors. Resident needs extensive assistance for toileting, R/T [related to] frequent episodes of incontinence. Resident is at risk for falls related to poor safety skills and with the use of a standard walker. Staff to assist resident with all cares . Assist x [times] 1 with personal hygiene, toileting, and dressing . transfer with assist of 2 with gait belt and FWW [front wheeled walker] . The initial FRI report, dated 12/10/25 at 5:43 p.m., stated, . Several CNAs [certified nurse aides] were involved in an incident with resident [Resident #6] during attempts to get her up for supper. Staff consistently reported that [Resident #6's] bed was wet, she was distressed, yelling, and at times refusing to get up or cooperate. Multiple CNAs . were in and out of the room. During attempts to move [Resident #6], she ended up naked on the bathroom floor. Conflicting accounts were given about how she got to the floor, though several reported she refused to stand or get herself up. A gait belt was applied directly to her bare skin, and staff lift [sic] her with it at least once. Several CNAs . were reported to have hollered at [Resident #6], pointing in her face, and insisted that she apologize, [another CNA] entered later, found [Resident #6] crying on the floor, and noted scratches on [Resident #6's] left arm. No staff could provide a clear explanation for the scratches. [The last CNA to enter the room] refused to leave [Resident #6] on the floor and ultimately calmed, cleaned, dressed, and brought her to supper. Charge Nurse . reported she was only told that [Resident #6] had a behavior and that the gait belt was used. She was not informed about [sic] yelling, the resident being on the floor naked, the number of staff involved, or any injuries. Overall, staff consistently note yelling towards the resident, difficulty during transfer, [Resident #6's] distress and that the full details were not reported to the charge nurse at the time. The final FRI investigation, received from the facility on 12/12/25, stated CNA (#5 and #6) removed and suspended. A Behavior/Mood Event report, dated 12/04/25 5:28 p.m., stated, . resident was yelling and refusing to get up and changed before supper. Three aides were needed in order to get her to cooperate. Gait belt was needed in order to get her toileted . Client did apologize to staff after . No further concerns at this time. [No] injuries noted. During an interview on 12/21/25 at 2:10 p.m., when asked about the incident on 12/04/25, a CNA (#3) reported hearing Resident #6 screaming from across the hall. When she entered Resident #6's room, she saw her naked on the bathroom floor. She indicated Resident #6 was crying and looked scared, while CNA (#6) was in her face, screaming 'Get up. Get up and apologize. Apologize right now.' The CNA (#3) also reported seeing three large, fresh scratches on the resident's upper arm and noticed CNA (#6) was not wearing gloves and had really long nails. Two of the CNAs (#5 and #6) denied scratching her, blaming the injury on her gait belt. The CNA (#6) told the others to Leave her. She can get up on her own. We need to feed the others. The CNA (#3) stayed with the resident, helped her get dressed, and assisted her to the dining room. During this time, Resident #6 alleged CNA (#5) threatened to withhold her snack, because she wasn't listening to them. The CNA (#3) admitted she reported her observations/concerns to the Director of Nursing a few days after the incident. During an interview on 12/22/25 at 10:47 a.m., when asked about the incident on 12/04/25, a CNA (#4) described Resident #6's clothing and bedding as soiled with urine and indicated the resident was able to</p>		

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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>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** Based on record review, review of the facility reported incident (FRI), and staff interview, the facility failed to report an incident of abuse to the administrator and the State Survey Agency (SSA) within the required time frames for 1 of 1 sampled resident (Resident #6) who experienced mental, verbal, and physical abuse from staff. Failure to ensure incidents of abuse are reported immediately, but not later than 2 hours after the allegation is made, may result in continued abuse, fear, anxiety, and psychosocial harm. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anxiety and conduct disorder. The Minimum Data Set (MDS), dated [DATE], identified moderate cognitive impairments and delusions. A Behavior/Mood Event report, dated 12/04/25 at 5:28 pm., stated, . resident was yelling and refusing to get up and changed before supper. Three aides were needed in order to get her to cooperate. Gait belt was needed in order to get her toileted . Review of the initial FRI, received by the SSA on 12/10/25, stated the following, Date of allegation: 12/04/2025 . Several CNAs [certified nurse aides] were involved in an incident with resident [Resident #6] during attempts to get her up for supper. Staff consistently reported that [Resident #6's] bed was wet, she was distressed, yelling, and at times refusing to get up or cooperate. Multiple CNAs [names of CNAs] were in and out of the room. During attempts to move [Resident #6], she ended up naked on the bathroom floor. Conflicting accounts were given about how she got to the floor, though several reported she refused to stand or get herself up. A gait belt was applied directly to her bare skin, and staff lifted her with it at least once. Several CNAs mainly [two CNA's names] reported to have hollered at [Resident #6], pointing in her face, and insisted that she apologize. [CNA name] entered later, found [Resident #6] crying on the floor, and noted scratches on [Resident #6's] left arm. No staff could provide a clear explanation for the scratches. [CNA name] refused to leave [Resident #6] on the floor and ultimately calmed, cleaned, dressed, and brought her to supper. Charge Nurse [name] reported she was only told that [Resident #6] had a behavior and that a gait belt was used. She was not informed about yelling, the resident being on the floor naked, the number of staff involved, or any injuries. Overall, staff consistently note yelling toward the resident, difficulty during the transfer, [Resident #6's] distress, and that the full details were not reported to the charge nurse at the time. During an interview on 12/22/25 at 4:10 p.m. an administrative nurse (#1) stated facility staff failed to report the incident in a timely manner and it not acceptable for staff to holler at or threaten residents.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to review and revise care plans to reflect the resident's current status for 1 of 7 sampled residents (Resident #1). Failure to update/revise care plans limited the staff's ability to communicate residents needs and ensure continuity of care. Findings Include: The facility failed to provide a copy of their care plan policy per request.- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included chronic pain and dementia with agitation. The admission Minimum Data Set (MDS), dated [DATE], identified behaviors directed towards others that significantly disrupt care or living environment. Review of Resident #1's progress notes from 10/09/25 to 12/21/25 identified the following: * 21 occasions of pain and/or requested pain medication. * Two occasions of verbal and/or physical aggression with other residents. * 23 occasions of verbal and/or physical aggression with staff. Resident #1's current care plan lacked problems, goals, and interventions addressing pain and verbal/physical aggression towards others. During an interview on 12/22/25 at 1:30 p.m., two administrative staff members (#1 and #2) confirmed Resident #1's care plan required updates/revisions.</p>		