

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  05/29/2025
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)
<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>Based on review of facility policy and family and staff interviews, the facility failed to provide the resident's representative a copy of quarterly financial statements for 1 of 1 sampled resident (Resident #19) reviewed for personal fund accounts. Failure to provide quarterly statements to the individual designated by the resident to make financial decisions on their behalf prevented the representative from verifying transactions and fund balances.</p> <p>Findings include:</p> <p>Review of facility policy titled Resident Personal Funds occurred on 05/29/25. This policy, dated May 2024, stated, . The individual financial record must be available to the resident through quarterly statements .</p> <p>During an interview on 05/27/25 at 6:00 p.m., Resident #19's financial power of attorney (POA) stated she had not received any quarterly financial statements.</p> <p>During an interview on 05/29/25 at 8:50 a.m., a business office staff member (#6) confirmed staff failed to send quarterly statements to Resident #19's financial POA.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed professional standards of practice for 4 of 4 supplemental residents (Resident #8, #9, #10, and #17) observed during insulin preparation and 1 of 1 supplemental resident (Resident #10) reviewed for insulin use. Failure to properly prime an insulin pen and follow physician's orders regarding out-of-range blood sugar levels, may result in residents receiving an inaccurate dose of insulin and/or possible adverse events.</p> <p>Findings include:</p> <p>Review of the facility policy titled Insulin Pen occurred on 05/28/25. This policy, dated 07/14/23, stated, . screw the pen needle onto the insulin pen. Twist open and remove outer cover from the pen needle. With the needle pointing up, push the plunger, and watch to see that at least a drop of insulin appears on the tip of the needle.</p> <ul style="list-style-type: none"> <li>- Observation on 05/27/25 at 11:50 a.m. showed nurse (#3) primed Resident #9's insulin pen with the needle cap on.</li> <li>- Observation on 05/28/25 at 7:25 a.m. showed a nurse (#4) primed Resident #17's insulin pen holding the pen downward.</li> <li>- Observation on 05/28/25 at 7:38 a.m. showed a nurse (#4) primed Resident #8's insulin pen holding the pen downward.</li> <li>- Observation on 05/28/25 at 7:48 a.m. showed a nurse (#4) primed Resident #10's insulin pen holding the pen downward.</li> </ul> <p>During an interview on 05/28/25 at 2:08 p.m., an administrative nurse (#2) stated she expected staff to prime an insulin pen with the needle cap off and the needle pointing up.</p> <p>Review of the facility policy titled Blood Glucose Monitoring occurred on 05/29/25. This policy, dated 09/22/23, stated, . Report critical/out of range results to physician.</p> <p>Review of Resident #10's medical record occurred on 05/29/25. Diagnoses included Type 2 diabetes mellitus. A physician's order stated, Fiasp U-100 Insulin [long acting insulin] per Sliding Scale; If Blood Sugar is less than 100 milligrams per deciliter [mg/dl], call MD [physician]. If Blood Sugar is greater than 450 mg/dl, call MD. Review of the resident's blood sugar levels from March 1 through May 28, 2025 identified the following:</p> <ul style="list-style-type: none"> <li>* 03/05/2025 at 6:30 a.m.: 73mg/dL</li> <li>* 03/11/2025 07:20 a.m.: 72mg/dL.</li> <li>* 05/07/2025 11:57 a.m.: 492 mg/dL</li> </ul> <p>Resident #10's medical record lacked documentation staff notified the physician regarding out-of-range blood sugars.</p> <p>(continued on next page)</p>		

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F 0658  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	During an interview on 05/09/25 at 12:52 p.m., an administrative nurse (#2) confirmed staff failed to notify the physician regarding the out-of-range blood sugars.		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>Based on staff interview, the facility failed to ensure 1 of 1 dietary manager (#1) obtained the proper qualifications to serve as the director of food and nutrition services. Failure to ensure the facility had a qualified dietary management to carry out the functions of food and nutrition services may result in foodborne illness to residents, staff, and visitors.</p> <p>Findings include:</p> <p>During an interview on the afternoon of 05/27/25, the dietary manager (#1) stated she had not completed the certified dietary manager course and received an extension to complete the course.</p> <p>The facility failed to ensure the dietary manager (#1) completed the required education for a certified dietary manager, certified food service manager, or a national certification for food service management and safety from a national certifying body.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, review of dishwasher temperature log, review of professional reference, and staff interview, the facility failed to ensure the high temperature dishwasher provided adequate heat sanitization for dishes and utensils washed in 1 of 1 kitchen (main kitchen). Failure to monitor the dish temperatures during the high temperature dishwash cycle may result in inadequate sanitation of dishware and foodborne illness.</p> <p>Findings include:</p> <p>The Food and Drug Administration (FDA) Food Code 2022, Annex 3 Public Health Reasons/Administrative Guidelines, page 169 states, 4-302.13 Temperature Measuring Devices . Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the warewashing machine meet or exceed the required . (160&amp;deg;F) [degress Fahrenheit]. Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical warewashers, the measurements displayed by these devices may not always be sufficient to determine that the surface temperatures of utensils are reaching 71&amp;deg;C [celsius] (160&amp;deg;F). The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of . (160&amp;ordm;F) .</p> <p>Observation in the main kitchen on 05/27/25 at 1:20 p.m. showed a high temperature dishwasher in use. Review of the May 2025 dishwasher temperature log showed dietary staff documented the morning and evening temperature readings of the external temperature gauge/dial for the dishwasher. When asked, dietary staff member (#5) placed the surveyor's dish thermometer in with the tray of plates to be washed. It took up to five wash/rinse cycles before the dish thermometer registered 160 degrees Fahrenheit (F) and above.</p> <p>The dietary manager (#1) reported the dietary staff do not check dishwash temperatures at the plate level during a wash/rinse cycle. When asked about the availability of a thermometer, the dietary manager retrieved the dish plate thermometer and stated it was not functioning and needed the battery replaced.</p> <p>The facility failed to have a process or a functioning dish thermometer to monitor adequate heat sanitization of dishware.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on review of the facility's Quality Assurance Performance Improvement (QAPI) program committee minutes, review of facility policy, and staff interview, the facility failed to ensure the QAA (Quality Assessment and Assurance) Committee, and all the required members met at least quarterly for 2 of 5 quarters (June 2024 and September 2024) reviewed. Failure to meet quarterly and have the medical director participate in the facility's quality assurance activities may result in an ineffective QAPI program and deprives the committee of the physician's unique contributions for analysis of quality concerns and assisting with decision making based on identified concerns.</p> <p>Findings include:</p> <p>Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) occurred on 05/29/25. This policy, dated December 2024, stated, . The QAA Committee shall be interdisciplinary and shall . a. Consist at a minimum of: The Director of Nursing Services; The Medical Director or his/her designee . b. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program.</p> <p>Review of the QAA Committee meeting minutes from March 2024 to March 2025 showed the committee failed to meet in June and September of 2024. The medical director failed to attend any of the meetings.</p> <p>During an interview on 05/29/25 at 12:10 p.m., an administrative staff member (#7) confirmed the QAA committee had not met on a quarterly basis and failed to ensure the required quarterly attendance of the medical director.</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>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 #1) observed during wound care. Failure to practice infection control standards related to dressing changes has the potential to spread infection throughout the facility.</p> <p>Findings include:</p> <p>Review of the facility policy titled Clean Dressing Change occurred on 05/29/25. This policy, dated November 2024, stated, . Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application: If the table is soiled, wipe clean. Place a disposable cloth or linen saver on the overbed table. Wash hands and put on clean gloves. Loosen the tape and remove the existing dressing . Discard into appropriate receptacle. Remove gloves . Wash hands and put on clean gloves. Cleanse the wound as ordered . pat dry with gauze. remove gloves and wash hands . put on clean gloves. Secure dressing. Discard disposable items and gloves into appropriate trash receptacle and wash hands.</p> <p>Findings include:</p> <p>Review of Resident #1's medical record occurred on all days of survey. A physician's order stated, Mepilex Transfer [a type of wound dressing] over open wound areas, apply ABD [dressing for wound drainage], and tape. Change daily and as needed. The current care plan stated, . Resident has impaired skin integrity r/t [related to] chronic posterior [back of] left thigh and bilateral [both] buttocks . Dressing changes as ordered by MD .</p> <p>Observation on 05/28/25 at 10:20 a.m. showed a nurse (#8) performed hand hygiene, applied a gown and gloves, and placed supplies for Resident #1's dressing change on the bedside table without sanitizing the table and placing a barrier between the supplies and table. The nurse (#8) removed the soiled dressings, cleansed the wounds, and applied clean dressings without changing gloves or performing hand hygiene between steps. The nurse (#8) removed her gown and gloves, performed hand hygiene, and exited the room.</p> <p>During an interview on 05/29/25 at 10:20 a.m., an administrative nurse (#2) confirmed staff failed to follow infection control practices when completing Resident #1's dressing change.</p>		