STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Sunset Home	333 Eastern Ave Grafton, ND 58237

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and review of facility policy, the facility failed to provide care in a manner that maintained, enhanced, and respected the resident's dignity for 2 of 19 sampled residents (Resident #2 and #8). Failure to provide privacy to residents while in their room has the potential to affect the residents' psychosocial wellbeing and does not enhance the residents' quality of life. Findings include: Review of the facility policy titled Resident Rights occurred on 02/26/26. This policy, dated 11/17/16, stated, . 1. Resident rights. The resident has the right to a dignified existence . -Review of Resident #2's medical record occurred on all days of survey. The care plan stated, .Total dependence with toileting hygiene, product change and clothing adjustment . Observation on 02/24/26 at 8:52 a.m. and 9:28 a.m. showed Resident #2's room door ajar and the resident lying in bed uncovered with pants pulled down under the buttocks and the brief exposed. -Review of Resident #8's medical record occurred on all days of survey. The care plan stated, Problem: Generalized pruritis [itchy skin] . sits with no clothes on in .room . fabric causes . itch. doesn't like . door to . room closed tight so a curtain was placed in . room to provide privacy when . in . room naked. Observations of Resident #8 on 02/26/26 at 8:26 a.m. and at 10:25 a.m. showed Resident #8 asleep in a recliner, naked from the waist down, and the door to the room open. Staff failed to use the privacy curtain which left the resident exposed to visitors, staff, and other residents.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, review of the facility's policy, review of facility housekeeping checklist, and resident and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 5 of 19 sampled residents (Resident #10, #13, #42, #47, and #82) Failure to maintain clean equipment and ensure a safe, clean, and sanitary environment may result in injuries, diminish the homelike living area for residents, and does not promote overall quality of life. Findings include: Review of the facility policy, Personal Fans, occurred on 02/26/26. This policy, dated February 2025, stated, . Personal fans must be cleaned and disinfected on a routine basis . Cleaning of personal fans shall be done no less than monthly by environmental services staff. Observations on February 23-24, 2026, showed the following: -Resident #10's room: Dust/debris on a small oscillating fan. The resident stated, The rooms get cleaned every week; however, the fans don't get cleaned often. -Resident #13's room: Dust/debris on a small oscillating fan. The resident stated staff clean fans when they have time. During an interview on 02/25/26 at 8:15 a.m., an environmental staff member (#6) stated staff should clean personal fans monthly. -Observation of Resident #42's room on 02/23/26 at 1:54 p.m. identified an area approximately 5-inch by 3-inch in size missing paint. -Observation of Resident #47's room on 02/23/26 at 2:03 p.m. identified missing paint and sharp/rough pieces of wood on the cabinet under the sink, and walls missing paint. -Observation of Resident #82's bathroom on 02/23/26 at 2:07 p.m. showed moisture damage to the wall and warped molding. During an interview on the afternoon of 2/26/26, an environmental staff member (#6) confirmed Resident #42, #47, and #82's rooms needed repair.

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F 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility reported incident (FRI) reports, review of facility policy, and resident and staff interviews, the facility failed to ensure residents remained free from resident-to-resident altercations for 2 of 2 sampled residents (Resident #2 and #37) subjected to physical and sexual abuse from other residents. Failure to protect residents from physical or sexual abuse placed Residents #2 and #37 and all other residents at risk for mental and emotional distress, and injury.Findings include:Review of the facility policy titled Abuse, Neglect and Exploitation occurred on 02/25/26. This policy, revised 02/13/24, stated, . Residents must not be subject to abuse by anyone, including . other residents. 'Abuse' means the willful infliction of injury . 'Sexual Abuse' in non-consensual sexual contact of any type with a resident . 'Physical Abuse' includes . hitting .Incident between Resident #37 and Resident #87The initial FRI report, dated 08/30/25, stated, . 08/30/25 at approximately 12:55 p.m. [Resident #87] was witnessed by a CNA [certified nurse aide] touching and kissing [Resident #37] in [Resident #37's] room . CNA immediately notified RN [registered nurse] and LPN [licensed practical nurse] and immediately intervened, separating [Residents #37 and #87]. The final FRI report indicated Resident #37 denied providing consent, a provider deemed Resident #37 unable to consent to sexual activity/relationship due to her cognition, and Resident #87 felt Resident #37 comes seeking attention from him and Resident #37 kissed him first.Review of Resident #37's medical record occurred on all days of survey. Diagnoses included Alzheimer's Disease, dementia with behaviors, mild intellectual disabilities, and obsessional thoughts and acts. A quarterly Minimum Data Set (MDS), dated [DATE], identified intact cognition. The care plan stated. becomes fixated [sic] things. will often times repeat the same phrase over and over again . seeks out male attention. sometimes make [sic] unsafe decisions .Review of Resident #37's progress notes identified the following:*08/30/25 at 3:16 p.m., stated, . Notified by staff that resident [Resident #37] was found in her room on her bed, with [Resident #87]. Staff reported he witnessed [Resident #87] kissing resident and feeling her breasts under her shirt. Writer and second nurse witness [sic] [Resident #87] sitting on bed next to resident. He was leaning over her with his torso and kissing her. He was also seen touching her breasts with hand under shirt. Resident did not show any signs of distress such as screaming, hitting, or moving from [Resident #87]. Staff separated residents from each other. Skin assessment completed with no apparent injuries noted.*09/02/25 at 10:45 a.m., stated, . LATE ENTRY . A comprehensive interview was conducted with resident . Resident [Resident #37] did concede that a male resident had entered her room and touched her inappropriately and stated, 'I did not like it.' .-Review of Resident #87's medical record occurred on all days of survey. Diagnoses included dementia with behaviors. An annual MDS, dated [DATE], identified intact cognition. The care plan stated, . has a behavior problem r/t [related to] making inappropriate touching, kissing, and comments towards females at times. Resident did have an episode of touching a female resident on 8/30/2025.A progress note, dated 08/30/25 at 3:44 p.m., stated, . Resident was seen in [Resident #37's] room. He was sitting next to her on her bed while she was lying down. Resident had his hand under her shirt and was kissing her face. Resident was escorted out of [Resident #37's] room back to his room by nursing staff. Incident between Resident #2 and Resident #40During an interview on 02/23/26 at 1:33 p.m., Resident #40 stated there is too much noise outside his room and indicated he had hit other residents.-Review of Resident #40's medical record occurred on all days of survey and identified diagnoses of psychosis, delusions, intermittent explosive disorder, traumatic brain injury, and mild intellectual disabilities. A quarterly MDS, dated [DATE], identified moderately impaired cognition. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan stated, . He is not orientated to time and has difficulty with recall. 'explodes' . if there is a lot of noise. He has hit other residents in the fact [sic] and pushed them with his 4WW [wheeled walker]. When it gets too loud outside his room, he may start yelling to 'Shut up!' .A progress note, dated 08/24/25 at 7:00 p.m., stated, . Dietary aide reported to writer that this resident [Resident #40] had struck another resident [Resident #2] on the cheek. no injury noted but the resident was confused. Writer spoke with this resident [Resident #40], and he stated that he did it because she [Resident #2] is always making noise out by the nurse station and it bothers him in his room. Writer told resident that it is never okay to be physically aggressive with another resident. He then stated that she deserved it because she never gets in trouble for making noise.-Review of Resident #2's medical record occurred on all days of survey and identified diagnoses of Alzheimer's Disease, dementia with psychotic disturbance, hallucinations, and anxiety. A quarterly MDS, dated [DATE], identified severely impaired cognition. A progress note, dated 08/24/25 at 7:11 p.m., stated, . Dietary aide reported that this resident [Resident #2] had been struck on the cheek by another resident [Resident #40] when he was going to the dining room. She stated that the male resident stopped and said something to this resident and when she made a noise, he had struck her, hard, on the cheek. Writer assessed resident and found no injury present. Writer asked resident if she was okay and she said yes but she doesn't think he likes her very much.During an interview on 02/25/25 at 2:55 p.m., an administrative staff member (#11) confirmed the facility investigated incidents that occurred on 08/24/25 and 08/30/25. The facility failed to protect Resident #2 from physical abuse and Resident #37 from sexual abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to report potential abuse for 1 of 2 sampled residents (Resident #2) and 1 supplemental resident (Resident #40) reviewed for resident-to-resident altercations. Failure to report potential abuse to the State Survey Agency (SSA) placed Resident #2 and all other residents at risk for possible abuse and/or physical injury.Findings include:Review of the facility policy titled Abuse, Neglect and Exploitation occurred on 02/25/26. This policy, dated 02/13/24, stated, . Ensure that all alleged violations involving abuse . are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the advents [sic] that cause the allegation do not involve abuse and do not result in serious bodily injury to the . State Survey Agency . Report the results of all investigation to the . State Survey Agency, within 5 working days of the incident .-Review of Resident #2's medical record occurred on all days of survey and identified diagnoses of Alzheimer's Disease, dementia with psychotic disturbance, hallucinations, and anxiety. A quarterly MDS, dated [DATE], identified severely impaired cognition. A progress note, dated 08/24/25 at 7:11 p.m., stated, . Dietary aide reported that this resident [Resident #2] had been struck on the cheek by another resident [Resident #40] when he was going to the dining room. She stated that the male resident stopped and said something to this resident and when she made a noise, he had struck her, hard, on the cheek. Writer assessed resident and found no injury present. Writer asked resident if she was okay and she said yes but she doesn't think he likes her very much.-Review of Resident #40's medical record occurred on all days of survey and identified diagnoses of psychosis, delusions, intermittent explosive disorder, traumatic brain injury, and mild intellectual disabilities. A quarterly MDS, dated [DATE], identified moderately impaired cognition. The care plan stated, . He is not orientated to time and has difficulty with recall. 'explodes' . if there is a lot of noise. He has hit other residents in the fact [sic] and pushed them with his 4WW [wheeled walker]. When it gets too loud outside his room, he may start yelling to 'Shut up!' .During an interview on 02/25/25 at 2:55 p.m., an administrative staff member (#11) confirmed the facility failed to report the above incident to the SSA. See F600

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure dishware and eating utensils are properly cleaned and sanitized in 1 of 1 kitchenette (Special Care Unit) utilizing a mechanical dish-washing machine. Failure to ensure the mechanical dishwashing machine reaches the proper temperatures for the wash and final rinse cycles may result in unclean and unsanitized dishware and eating utensils. Findings include:The 2022 FDA (Food and Drug Administration) Food Code, Public Health Reasons, pages 172 - 153, stated . 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature. The wash solution temperature in mechanical warewashing equipment is critical to proper operation. The chemicals used may not adequately perform their function if the temperature is too low. Therefore, the manufacturer's instructions must be followed. The temperatures vary according to the specific equipment being used. 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multiuse utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least 71 C (160 F) as measured by an irreversible registering temperature measuring device to affect sanitization. The . temperature limits of (180 F) .are based on the sanitizing rinse contact time required to achieve the 71 C (160 F) utensil surface temperature.Review of the facility policy, [NAME] SR24 Dish Sanitizer (SCU) [Special Care Unit] occurred on 02/26/26. This policy, dated January 2025, stated, Purpose: Sanitize dishes that have been handwashed in the Special Care Unit. Procedure: 1. Wash all dishes in the sink with hot soapy water to remove all food debris. Rinse and put on a rack in the dish sanitizer in a single layer. 4. Sanitation accomplished by means of a built-in . electric booster .designed to raise the water to 180 [degrees] F [Fahrenheit] . 5. Minimum Water Temperature - Wash Cycle 150 [degrees] F Rinse Cycle 180 [degrees] F .Observation of the Special Care Unit kitchenette occurred on 02/26/06 at 11:55 a.m. with a supervisory dietary staff member (#4). Observation showed a mechanical dish-washing machine, which is used three times a day for washing dishware and utensils. The dietary staff member identified the dishwasher uses heat to sanitize the dishware and utensils. When asked to see the temperature log of wash and rinse temperatures, an unidentified staff member on the unit stated they do not check the temperature gauges on the dish machine and they have never kept a log. The surveyor placed an irreversible temperature measuring device in the dish machine and the dietary staff member (#4) started the dish machine. The temperature of the wash cycle and the rinse cycle did not reach the minimum temperatures per policy. The dietary staff member started the dishwasher for a second cycle and the wash gauge reached 155 degrees F, the rinse temperature reached 195 degrees, and the irreversible temperature measuring device reached 165 F. The dietary staff member (#4) confirmed staff should monitor the dish machine to ensure the proper temperature is reached to wash and sanitize the dishware and utensils.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure resident records contained the hospice election form for 1 of 1 closed record (Resident #85) who received hospice services. Failure to obtain the election form may have limited staff's ability to ensure coordination of care between the facility and the hospice. Findings include: Review of Resident #85's medical record occurred on 02/26/26 and identified the following:* A nurse's note dated 01/02/26 at 2:46 p.m., stated, . Phone call made to [physician's name] office regarding decline in [name] condition change. Hospice referral given by [provider's name] .* A nurse's note dated 01/07/26 at 1:32 p.m., stated, Hospice nurse visit completed to assess patient status. The medical record lacked the hospice election form. During an interview on 02/26/26 at 10:03 a.m., a facility staff member (#2) confirmed the medical record for Resident #85 lacked the hospice election form.

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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 observations, review of the Resident Council minutes, and resident interview, the facility failed to follow standards of practice for infection control for 1 of 1 sampled resident (Resident #82) who received nebulizer treatments. Failure to ensure nebulizer masks and tubing are on a clean surface may result in contamination of the items and lead to respiratory infections. Findings include: Review of Resident Council Meeting minutes occurred on 02/25/26. The meeting minutes, dated 10/17/25, identified two residents had concerns regarding nebulizer tubing left lying on the floor. -Observations on 02/23/26 at 2:07 p.m. and 3:25 p.m., on 02/24/26 at 8:37 a.m., and on 02/26/26 at 12:56 p.m. showed a nebulizer mask and tubing on the floor next to Resident's #82's recliner. During an interview on 02/26/26 at 12:56 p.m., Resident #82 stated the nebulizer machine, mask, and tubing are always on the floor.