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	12/19/2024

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 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 46963 Based on record review, review of facility policy, and staff interview, the facility failed to ensure the coverage of 1 of 1 surety bond provided the required coverage of all personal funds for residents who deposited money with the facility. Failure to ensure the security bond covered all funds entrusted to the facility may result in the residents suffering financial losses secondary to the facility failing to hold, safeguard, manage, and/or account for their funds. Findings included: Review of the facility policy titled Resident Trust Funds occurred on 12/19/24. This policy, dated November 2000, stated, . The facility maintains a security bond to protect the resident's funds. During an interview on 12/18/24 at 3:33 p.m., a business office staff member (#14) reported the residents' trust fund account currently contained $10,138.13. An administrative staff member (#1) showed the surveyor an insurance document, with an effective date of 03/11/23, which showed a bond limit of $10,000.00. The facility failed to implement a system ensuring they maintained a surety bond that covered all personal funds entrusted to the facility.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40488 45873 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 18 sampled residents (Resident #24 and #35) and 1 supplemental resident (Resident #40). Failure to accurately code the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION N: MEDICATIONS The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2024, page N-7 stated, . N0415G1. Diuretic: Check if a diuretic medication was taken by the resident at any time during the 7-day look-back period . - Review of Resident #24's medical record occurred on all days of survey. Medications included and identified Furosemide (a diuretic) daily. Review of the quarterly MDS, dated [DATE], showed the facility failed to code diuretic use. SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages O-3, O-4, and O-7, stated, . Coding Instructions for Column b. While a resident. Check all treatments, procedures, and programs that the resident received or performed . within the last 14 days. O0110C1, Oxygen therapy. Code continuous or intermittent oxygen administered via mask, cannula, etc. O0110K1, Hospice care. Code residents identified as being in a hospice program . - Review of Resident #24's medical record occurred on all days of survey. A physician's order, dated 03/13/24, stated, admitted to Hospice . Review of the significant change MDS, dated [DATE], showed the facility failed to code hospice services. - Review of Resident #40's medical record occurred on all days of survey. Physician's orders identified the resident admitted to hospice services on 10/21/24. Review of the significant change MDS, dated [DATE], showed the facility failed to code hospice services. - Review of Resident #35's medical record occurred on all days of survey. A physician's order, dated 05/31/24, stated, . Oxygen 2L [liters per minute] via NC [nasal cannula] PRN [as needed] to keep sats [oxygen saturation level] greater than 90% . A quarterly MDS, dated [DATE], showed the facility failed to code oxygen use. The resident's medication administration record (MAR), dated 10/30/24 to 11/13/24, identified oxygen use. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 4:25 p.m., an administrative nurse (#3) confirmed staff miscoded the MDS's.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40488 Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 2 of 18 sampled residents (Resident #1 and #35). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled Comprehensive Care Plans occurred on 12/19/24. This policy, dated 11/17/16, stated, . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment . - Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, . Potential for bleeding related to anticoagulant [medicine that increases the time for blood to clot] use. Apixaban [blood thinner] as ordered by MD [medical doctor] . Review of the October 2024 Electronic Medication Administration Record (eMAR) showed the provider discontinued Apixaban on 10/30/24. During an interview on 12/18/24 at 10:26 a.m., an administrative nurse (#2) confirmed staff failed to revise Resident #1's care plan following the discontinuation of the anticoagulant. - Review of Resident #35's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disorder (COPD) (restricted airflow in the lungs), shortness of breath, and chronic heart failure (CHF). A physician's order, dated 05/31/24, stated, Oxygen 2L [liters per minute] via NC [nasal cannula] PRN [as needed] to keep sats [oxygen saturation level] greater than 90% . A quarterly MDS, dated [DATE], identified the resident as cognitively intact and independent with activities of daily living. During an interview on 12/17/24 at 9:23 a.m., Resident #35 stated he/she uses oxygen when I feel winded. The resident confirmed he/she independently uses the oxygen concentrator and portable oxygen tank, and stated, I sometimes turn it [the meter flow] up until it pops to clear out the tube and then turn it back down. Resident #35's care plan failed to include Resident #35's independent use of oxygen and education on the risks of this practice. During an interview on 12/17/24 at 4:31 p.m., an administrative nurse (#2) confirmed Resident #35 removes and applies their own oxygen, and stated, They [facility staff] have educated [resident] on oxygen. 46963

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40489 Based on observation, record review, review of manufacturer's instructions for use, and staff interview the facility failed to ensure staff followed standards of practice for 2 of 2 residents (Resident #33, and #235) who required rapid acting insulin. Failure to administer rapid acting insulin within the time specified by the manufacturer may result in a hypoglycemic (low blood sugar) reaction. Findings include: Prescribing information for Humalog insulin (a raid acting insulin), found at https://www.humalog.com, stated, Administer HUMALOG . within 15 minutes before a meal or immediately after a meal. Prescribing information for Novolog insulin, found at https://www.novolog.com, stated, Novolog is a rapid-acting insulin . Novolog starts acting fast. Eat a meal within 5-10 minutes after taking it. - Review of Resident #235's medical record occurred on 12/18/24. Current physician's order included Humalog insulin 50 units three times a day. During an interview on 12/18/24 at 5:16 p.m., a nurse (#15) stated she checked Resident #235's blood sugar at 4:45 p.m., obtained a blood glucose reading of 125 milligrams/deciliter (mg/dl), and administered 50 units of Humalog. Observation on 12/18/24 of Resident #235 showed the following: * 5:17 p.m., at a table in the dining room. * 5:37 p.m., received two glasses of juice at the table. (52 minutes later) * 5:48 p.m., received the evening meal (one hour and 3 minutes after receiving a rapid acting insulin). - Review of Resident #33's medical record occurred on all days of survey. Current physician's order included, Aspart (Novolog Insulin) 30 units in the evening and hold if resident does not eat. Observations on 12/18/24 showed the following: * 5:00 p.m., a nurse (#15) administered 30 units of Novolog to Resident #33. * 5:28 p.m., Resident #33 received her evening meal. (28 minutes after receiving a rapid acting insulin). During an interview on 12/19/24 at 10:26 a.m., an administrative nurse (#2) stated she expected staff to serve a meal within 15 minutes of administering a rapid acting insulin.

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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. 46963 Based on observation, record review, and review of facility policy, the facility failed to properly utilize assistive devices necessary to prevent accidents and/or injury for 1 of 3 sampled residents (Resident #75) observed during transfers. Failure to utilize a gait belt during transfers placed the resident at risk for falls and/or injury. Findings include: Review of the policy titled Gait belt For Transfers occurred on 12/19/24. This policy, dated September 2002, stated, . Gait belts are provided to assist staff to safely transfer or ambulate residents. Observation on 12/18/24 at 8:44 a.m., showed a certified nurse aide (CNA) (#11) provided personal cares to Resident #75. After personal cares were provided, the CNA (#11) placed both hands on the resident's buttocks to assist the resident to sit in the wheelchair. The CNA failed to utilize a gait belt during the transfers. Review of Resident #75's medical record occurred on all days of survey. The care plan, dated 11/16/24, stated, . Assist of 1 with gait belt for transfers. The facility failed to ensure staff followed Resident #75's plan of care and use a gait belt during transfers.

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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. 40488 Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure food is served and stored in accordance with professional standards for food service sanitation in 1 of 1 kitchen (main kitchen). Failure to ensure a reach-in freezer remains free of frozen water/condensation and ensure proper glove usage when serving ready-to-eat foods has the potential to result in foodborne illness and may result in adverse consequences for residents, visitors, and staff. Findings include: Review of the facility policy titled USE OF PLASTIC GLOVES occurred on 12/19/24. This policy, dated 2005, stated, . If used, single use gloves shall be used for only one task . used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. ANYTIME A CONTAMINATED SURFACE IS TOUCHED, THE GLOVES MUST BE CHANGED. The 2022 Food and Drug Administration (FDA) Food Code, page 81, stated, . 3-305.11 Food Storage. FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . Annex 3 Page 384, stated, . 3-305.12 Food Storage, Prohibited Areas. Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate . can be sources of microbial contamination for stored food. Observation on 12/16/24 at 1:37 p.m. showed a large amount of ice build-up on the back wall of a reach in freezer extending from the top to the bottom floor of the freezer, ice accumulation on top of a box containing ice cream bars and several closed boxes placed on top of the ice build-up on the bottom of the freezer. When asked about the ice accumulation, a dietary manager (#12) stated, I am not sure why this happens. Maintenance takes care of this for us. I guess it's that time again. Observation of the tray line in the main kitchen on 12/17/24 at 12:00 p.m. showed a dietary staff member (#13) wore gloves while using utensils to dish food onto residents' plates. The staff member removed a food item from a warming oven, pushed a plate warmer cart out of his/her way, and without changing gloves, reached into a bag and placed bread onto a resident plate. The staff member (#13) failed to change gloves after touching non-food areas and before handling ready-to-eat food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40489 45873 Based on observation, record review, policy review, and staff interview, the facility failed to follow standards of infection control and prevention for 4 of 18 sampled residents (Resident #2, #33, #75, and #236) and 2 supplemental residents (#9 and #43) observed. Failure to practice infection control standards related to enhanced barrier precautions (EBP), transmission-based precautions (TBP), and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Enhanced Droplet Precautions occurred on 12/19/24. This policy, dated July 2022, stated, Residents suspected of or confirmed to have COVID-19 will be placed on Enhanced Droplet Precautions . Doffing [removing] PPE [personal protective equipment] . Remove gloves immediately outside the room. Take care to not touch the contaminated surface of the glove. Perform hand hygiene. Remove gown . Remove goggles. Remove N95 mask. Perform hand hygiene . Review of the facility policy titled Enhanced Barrier Precautions occurred on 12/19/24. This policy, dated April 2024, stated, . PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact resident care activities include: . dressing . transferring . changing briefs . Review of the facility policy titled Standard Precautions occurred on 12/19/24. This policy, dated December 1996, stated, Standard Precautions incorporates previous CDC [Centers for Disease Control] recommendations for universal precautions, patient care equipment . The major emphasis is on the use of gloves and other protective equipment, devices, and controls to prevent or reduce hand, skin, and mucous membrane contact with blood and other potentially infectious materials. Standard Precautions should be used for all residents at all times . The precautions apply to . feces .Gloves should be worn for . handling items or surfaces soiled with these substances . Hands should be washed immediately after gloves are removed. Gowns should be worn during procedures . when soiling with these substances is likely . -Review of Resident #2, #43, and #236's medical records occurred on all days of survey and identified diagnoses of Covid-19 infection. Observation on 12/16/24 at 2:30 p.m., showed a certified nurse aide (CNA) (#9) exited Resident #43 and #236's shared room wearing PPE and carrying two used drinking glasses. The CNA (#9) set the two glasses on a table outside of the residents' room, removed her PPE and placed the glasses in the container with the dirty dishes. The CNA applied PPE and returned to the resident's room. The CNA failed to perform hand hygiene after removing PPE and before re-entering the resident's room. Observation on 12/18/24 at 10:20 a.m., showed a CNA (#10) exited Resident #2's room wearing PPE, and carried a meal tray down the hall, past the nurse's station and another resident, and placed the tray on a cart designated for dirty dishware. The CNA returned to the bin located outside the resident's room, removed her PPE and completed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/24 at 10:55 a.m., an administrative staff member (#2) confirmed she expected staff to remove PPE and perform hand hygiene after leaving a Covid-19 positive room and before completing other tasks. - Review of Resident #75's medical records occurred on all days of survey. The care plan stated, Potential for UTI [urinary tract infection] related to indwelling foley catheter. Enhanced Barrier Precautions in place. Observation on 12/18/24 at 8:44 a.m., showed a CNA (#11) providing high-contact resident cares including changing the resident's brief, dressing, and transferring Resident #75. The CNA failed to wear a gown during the high-contact resident care. - Review of Resident #9's medical record occurred on 12/17/24 and identified EBP. Observation on 12/17/24 at 2:35 p.m. showed two CNAs (#10 and #11) performed hand hygiene, applied gowns and gloves, and changed Resident #9's brief soiled with bowel movement (BM). The CNA (#10) removed the resident's brief, cleansed the perineal area, removed her gloves and without performing hand hygiene, applied clean gloves. The CNA (#11) cleansed the resident's hands of BM, removed her gloves and without performing hand hygiene, applied clean gloves. Both CNAs applied a clean brief and clean linens to the resident's bed. The CNAs (#10 and #11) failed to perform hand hygiene after removing soiled gloves and before performing other tasks. - Observation on 12/19/24 at 5:00 p.m. showed a nurse (#15) entered Resident #33's room and without performing hand hygiene, donned gloves, checked the resident's blood sugar, removed the gloves, and again without performing hand hygiene, exited the resident's room. At the nurses' station, the nurse (#15) placed the glucometer on top of the medication cart, obtained an alcohol wipe and gloves from the cart, and returned to Resident #33's room. The nurse donned gloves without performing hand hygiene, administered insulin, exited the room and threw the gloves in the trash can. The nurse failed to perform hand hygiene throughout the observation. During an interview on 12/19/24 at 10:55 a.m., an administrative staff member (#2) confirmed staff should perform hand hygiene between glove changes. 46963