STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	**15 1ST ST NE PO BOX 669, DUNSEITH, North Dakota, 58329**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification, facility reported incidences and complaint survey started on 07/20/26 and concluded 07/23/26. During the complaint investigation the facility was found in compliance with regulatory requirements.	F0000		08/04/2026
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F0641	The MDS Coordinator completed a comprehensive review of the MDS assessments for Residents #2, #4, #5, and #23. The identified coding discrepancies were corrected and modified assessments were submitted in accordance with CMS RAI guidelines. Resident #2's MDS was corrected to accurately reflect antiplatelet medication use in Section N0415 based on the physician's order and Medication Administration Record. Resident #4's MDS was corrected to accurately code Post-Traumatic Stress Disorder (PTSD) in Section I6100 based on physician documentation and supporting clinical documentation. Resident #5's MDS coding error identified during the survey was reviewed, corrected, and the assessment modified as appropriate. Resident #23's MDS was corrected to accurately code "Yes" in Section A1500 to reflect the resident's PASRR Level II determination for serious mental illness, as supported by the PASRR documentation and medical record. The IDT team reviewed each affected resident's care plan to ensure it accurately reflected the corrected assessment information. Any necessary care plan revisions were completed to ensure the residents' current needs continued to be addressed. 2. Dunseith Community Nursing Home has determined that all residents have the potential to be affected by the deficient practice.	08/04/2026

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 reverse for further 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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F0641 SS = E	Continued from page 1 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 4 of 13 sampled residents (Residents #2, #4, #5, and #23). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2025, pages A-30 to A-32, stated, ". . . A1500: Preadmission Screening and Resident Review (PASRR) . . . Review the PASRR report provided by the State if Level II screening was required. . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . . ." Review of Resident #23's medical record occurred on all days of survey and identified a PASRR Level II completed on 04/29/25. Diagnoses included schizophrenia and bipolar disorder. Review of the annual MDS, dated 04/14/26, showed the facility failed to code "yes" on Section A1500. SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2025, pages I-1 to I-12, stated, ". . . Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring . . . I6100, post-traumatic stress disorder (PTSD) . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included PTSD. The care plan, dated 04/06/26, stated, "Resident is at risk for adverse side effects, mood instability, anxiety, and decreased quality of life related to . . . PTSD, cognitive impairment, and complex medical conditions evidenced by psychotropic medication management. . . ." Review of the quarterly MDS,	F0641	Continued from page 1 3. The MDS Coordinator or MDS interim will conduct an audit on four of the previous MDS assessments completed within the previous 90 days to determine whether additional residents were affected by inaccurate coding. The audit will include verification of MDS coding against supporting clinical documentation, physician orders, Medication Administration Records, PASRR documentation, and active diagnoses. Any discrepancies identified will be corrected through MDS modification as appropriate, and affected residents' care plans will be reviewed and revised to accurately reflect their current status. 4. The Infection Preventionist will audit two completed MDS assessments every two weeks for four weeks, then one completed MDS assessments every eight weeks for two additional months to verify accuracy of MDS coding, supporting clinical documentation, Physician orders, medication coding, and PASRR documentation. Audits results will be documented and reviewed by the QA and QAPI committee. If deficiencies or trends are identified immediate corrective action will be taken. Including staff education, reassessment of the process, and increased monitoring until sustained compliance is met. Completion date: 8/4/2026 The facility will achieve substantial compliance with this requirement by the completion date indicated above.	08/04/2026

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F0641 SS = E	Continued from page 2 dated 05/12/26, showed the facility failed to code I6100, PTSD. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2025, pages N-4 to N-9, stated, ". . . N0415: HIGH-RISK DRUG CLASSES: Uses and Indication . . . Code all high-risk drug class medications . . . Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period . . . Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. . . . N0415I2. Antiplatelet: Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation . . . N0415H1. Opioid: Check if an opioid medication was taken by the resident at any time during the 7-day look-back period . . ." - Review of Resident #2's medical record occurred on all days of survey. A physician's order, dated 11/21/24, included aspirin, an antiplatelet medication. Review of the quarterly MDS, dated 06/03/26, showed the facility failed to code antiplatelet use. - Review of Resident #4's medical record occurred on all days of survey. The quarterly MDS, dated 05/12/26, showed the facility coded for opioid use. The medical record lacked a physician's order for an opioid medication. - Review of Resident #5's medical record occurred on all days of survey. The physician's orders included trazodone, an antidepressant medication, aspirin, and Lantus (insulin), a hypoglycemic medication. Review of the quarterly MDS, dated 07/09/26, showed the facility failed to code the use of an antiplatelet, antidepressant and hypoglycemic. During an interview on 07/23/26 at 11:09 a.m., an administrative nurse (#3) confirmed staff failed to code Resident #2, #4, #5, and 23's MDSs correctly.	F0641		08/04/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection	F0880	Catheter Care 1. Following the exit interview on 07/23/2026, resident #6's urinary catheter tubing was properly repositioned and secured to prevent contact with the floor while maintaining unobstructed urine flow. Re-education was provided to nursing staff on	08/07/2026

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F0880 SS = E	Continued from page 3 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by	F0880	Continued from page 3 07/24/2026 regarding proper urinary catheter management and positioning, including keeping catheter tubing secured and off the floor and maintaining the urinary drainage bag below the level of the bladder and off the floor. 2. Dunseith Community Nursing Home determined that all residents with urinary catheters have the potential to be affected by the deficient practice. Resident with urinary catheter were reviewed to ensure catheter tubing was properly positioned and secured, drainage was unobstructed, and catheter tubing and drainage bags were maintained off the floor. Any concerns identified were corrected immediately. 3. The Infection Preventionist and Director of Nursing reviewed and revised the facility's urinary catheter care policy on 07/24/2026 to include requirements for proper positioning and securing of urinary catheter tubing to prevent contact with the floor. Re-education was provided to nursing staff on 07/24/2026 regarding proper urinary catheter management, including maintaining unobstructed urine flow, keeping the drainage bag below bladder level and off the floor, and positioning and securing catheter tubing to prevent contact with or dragging on the floor. 4. The Infection Preventionist will conduct audits of urinary catheter tubing and drainage-system positioning for residents with urinary catheters weekly for four weeks, then monthly for two months, or until 100% compliance is maintained for two consecutive months. Any deficient practice identified will be corrected immediately and re-education provided as indicated. Audit findings and the Plan of Correction will be reviewed and monitored through the facility's monthly Quality Assurance/QAPI process. 5. All corrective actions will be fully implemented by 08/7/2026. Wound Care/Dressings 1. Following the exit interview, resident #5's right lower-leg wound was assessed following the identified deficient practice, with no signs or symptoms of infection noted. Nurses #4 and #5 were re-educated on 07/24/2026 on proper infection-control practices during wound care, including hand hygiene, appropriate glove changes when transitioning from contaminated to clean tasks, maintaining separation of clean and contaminated	08/07/2026

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F0880 SS = E	Continued from page 4 staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of infection control and prevention for 4 of 7 sampled residents (Resident #4, #5, #6, and #27) observed during cares. Failure to practice infection control standards related to hand hygiene, glove changes, wound care/dressing change, and catheter care has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled “Hand Hygiene” occurred on 07/23/26. This policy, dated 12/10/25, stated, “All staff will perform hand hygiene procedure to prevent the spread of infection to other personnel, residents, and visitors. . . . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. . . .” - Review of Resident #6's medical record occurred on all days of survey. Diagnosis included urinary tract infection. The current care plan stated, " . . . Staff will keep catheter tubing properly positioned . . ." Observations on all days of survey showed Resident #6's urinary catheter tubing dragging on the floor throughout the facility.	F0880	Continued from page 4 supplies, avoiding contamination of clean wound-care supplies by environmental surfaces, and discarding and replacing any dressing or wound-care supply that becomes contaminated. Return demonstration/observation of wound-care technique was completed to verify appropriate infection-control practices. 2. Dunseith Community Nursing Home determined that all residents have the potential to be affected by the deficient practice. The Infection Preventionist reviewed resident receiving wound care to ensure current wound-care orders and appropriate infection-control precautions were in place. Wounds were reviewed for signs and symptoms of infection as indicated. Any concerns identified were immediately reported to the appropriate licensed nurse/provider and corrective action was initiated as indicated. 3. The Infection Preventionist and Director of Nursing reviewed the facility's Clean Dressing Change policy on 07/24/2026 to clarify infection-control expectations during wound care. Licensed nursing staff were provided education/re-education regarding appropriate infection-control practices during wound dressing changes, including: Performing hand hygiene at appropriate points during wound care; Changing gloves and performing hand hygiene when transitioning from contaminated/dirty tasks to clean tasks; Removing gloves and performing hand hygiene when gloves become contaminated by environmental surfaces before handling clean wound-care supplies; Maintaining separation of clean and contaminated wound-care supplies; Preventing clean dressings and supplies from contacting potentially contaminated surfaces; Discarding and replacing any dressing or	08/07/2026

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F0880 SS = E	Continued from page 5 - Review of Resident #5's medical record occurred on all days of survey. Diagnosis included non-pressure chronic ulcer of the right lower leg. The current care plan stated, ". . . on Enhanced Barrier Precautions [EBP] . . . Perform wound care per provider orders. Observation on 07/21/26 at 2:18 p.m. showed an EBP sign on the door of Resident #5's room. Two nurses (#4 and #5) performed hand hygiene, applied a gown and gloves and entered the room to provide wound care. The nurse (#5) removed soiled dressings from Resident #5's right lower leg, removed the soiled gloves, performed hand hygiene, and applied clean gloves. Resident #5 removed an electrical plug from the wall, the nurse (#4) removed the electrical cord from the resident's hands and plugged it back into the wall. Without removing the soiled gloves and performing hand hygiene, the nurse (#4) prepared the clean dressings, removed the soiled gloves, performed hand hygiene and applied new gloves. The nurse (#5) removed the remaining soiled dressings, and without removing the soiled gloves and performing hand hygiene, cleansed the wound bed repositioned Resident #5's leg and the Xeroform (petroleum infused gauze) dressing to the calf fell onto the bed and folded. Rather than unfolding the dressing, the nurse reapplied it to the wound bed. - Observation on 07/21/26 at 8:14 a.m. showed Resident #27 in bed and two certified nurse aides (CNAs) (#6 and #7) completed a brief change. The CNA (#7) cleansed bowel movement (BM) using wipes, removed the gloves and applied the resident's brief. Both CNAs placed the Hoyer sling under the resident and used the mechanical lift to transfer Resident #27 into the wheelchair. The CNA (#7) failed to perform hand hygiene after removing soiled gloves. - Observation on 07/22/26 at 10:30 a.m. showed two CNAs (#7 and #8) assisted Resident #4 with toileting cares. The CNA (#8) applied gloves, used wipes to cleanse the resident's perineal area, removed the soiled gloves. As the resident stood with the walker, the CNA (#7) stood next to the resident while the CNA (#8) assisted the resident with the incontinence product and adjusted the resident's pants and shirt. The CNA (#8) failed to perform hand hygiene after removing soiled gloves. During an interview on 07/23/26 at 12:45 p.m. an	F0880	Continued from page 5 wound-care supply that becomes contaminated; Using appropriate PPE and Enhanced Barrier Precautions when indicated; and Following the facility's Clean Dressing Change policy and resident-specific wound-care orders. Education and policy review were completed by the Infection Preventionist and Director of Nursing on 07/24/2026. 4. The Infection Preventionist will conduct direct observation audits of wound-care practices on two licensed nurses weekly for four weeks, then monthly for two months, or until 100% compliance is maintained for two consecutive months. Audits will include hand hygiene, appropriate glove changes, PPE/EBP use when indicated, separation of clean and contaminated supplies, appropriate clean dressing-change technique, and prevention of contamination of wound-care supplies. Any deficient practice identified during an audit will be corrected immediately, with re-education and/or competency validation provided as indicated. Audit findings will be reviewed and monitored through the facility's monthly Quality Assurance/QAPI process. The Quality Assurance/QAPI Committee will determine whether additional monitoring, education, or corrective action is necessary based on audit results and identified trends. 5. All corrective actions will be fully implemented by 08/07/2026. Ongoing auditing and monitoring will continue according to the facility's Plan of Correction. Hand Hygiene Following Incontinence/Perineal Care 1. Observation A: Resident #27 was assessed following the identified deficient practice with no signs or symptoms of infection or other adverse effects noted. CNA #7 was re-educated regarding the facility's hand hygiene policy, including the requirement to perform hand hygiene immediately after glove removal and before proceeding to subsequent resident-care activities.	08/07/2026

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F0880 SS = E	Continued from page 6 administrative staff member (#10) stated she expected staff to complete hand hygiene after removing gloves.	F0880	Continued from page 6 Observation B: Resident #4 was assessed following the identified deficient practice with no signs or symptoms of infection or other adverse effects noted. CNA #8 was re-educated regarding the facility's hand hygiene policy, including the requirement to perform hand hygiene immediately after glove removal following perineal/incontinence care and before proceeding to subsequent resident-care activities. CNA #7 was re-education on 07/24/2026 regarding the facility's Hand Hygiene policy, including performing hand hygiene immediately after glove removal, appropriate glove use, and hand hygiene when transitioning from contaminated care to clean resident-care activities. 2. Dunseith Community Nursing Home determined that all residents have the potential to be affected by the deficient practice. The Infection Preventionist completed observations of direct-care staff during resident care to evaluate compliance with hand hygiene and appropriate glove use. Any deficient practices identified were corrected immediately and staff were re-educated as indicated. 3. The Infection Preventionist and Director of Nursing reviewed the facility's Hand Hygiene policy on 07/24/2026 to ensure the policy addressed hand hygiene following glove removal and during transitions from contaminated to clean resident-care activities. Re-education was provided to direct-care staff regarding appropriate hand hygiene and glove use, with emphasis on: Gloves do not replace hand hygiene; Hand hygiene must be performed after removing gloves; Hand hygiene must be performed after completing contaminated tasks such as bowel movement cleanup, perineal care, and incontinent care; Staff must perform hand hygiene before transitioning from contaminated care to subsequent clean resident-care activities;	08/07/2026

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F0880 SS = E		F0880	Continued from page 7 Appropriate glove changes and hand hygiene must be performed when moving from a contaminated body site/task to a clean body site/task; and Hand hygiene must be performed at appropriate times during resident care according to facility policy and accepted infection-prevention practices. Education/re-education was completed by the Infection Preventionist on 07/24/2026. 4. The Infection Preventionist or designee will conduct direct observation audits of hand hygiene practices during resident care on five direct-care staff weekly for four weeks, then monthly for two months, or until 100% compliance is maintained for two consecutive months. Audits will include observation of hand hygiene following glove removal, after incontinent/perineal care, and when transitioning from contaminated to clean resident-care activities. Any deficient practice identified will be corrected immediately, with re-education and/or competency validation completed as indicated. Audit findings will be reviewed and monitored through the facility's monthly Quality Assurance/QAPI process. The Quality Assurance/QAPI Committee will determine whether additional monitoring, education, or corrective action is necessary based on audit findings and identified trends. 5. All corrective actions will be fully implemented by 08/07/2026. Ongoing auditing and monitoring will continue according to the facility's Plan of Correction.	08/07/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a	F0550	1. DON immediately re-educated staff on resident rights. For Resident #14, DON immediately educated the staff on the resident's rights to ensure privacy is maintained during all personal hygiene and incontinence care by closing the window blinds and utilizing available privacy measures prior to providing care. The resident's care plan was reviewed to ensure privacy preferences and interventions were accurately reflected. For Resident #1, the sign posted on the resident's room door identifying the resident's hearing and	08/06/2026

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F0550 SS = D	Continued from page 8 manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care in a manner that maintained, enhanced, and respected the resident's right to dignity and privacy for 1 of 6 sampled residents (Resident #14) observed during personal hygiene cares and 1 of 1 sampled resident (Resident #1) observed with confidential information posted on the resident's door. Failure to close the resident's blinds during personal hygiene cares and posting of confidential resident information does not preserve the resident's right to dignity, privacy and does not enhance the quality of life. Findings include: Review of the facility policy titled "Personal Privacy and Confidentiality" occurred on 07/23/26. This policy, dated February 2026, stated, " . . . protect	F0550	Continued from page 8 speech impairment was immediately removed. The resident's communication needs were reviewed with the interdisciplinary team, and an alternative method (using white board) to ensure the needs of resident #1, and re-education to staff that maintained the resident's privacy and dignity was implemented in accordance with the resident's wishes. The Director of Nursing reviewed the incidents with the staff involved to ensure the immediate correction was completed and that the affected residents' rights to dignity, privacy, and confidentiality were restored. 2. Dunseith Community Nursing Home has determined that all residents have the potential to be affected by the deficient practice. 3. The Director of Nursing and IP will provide education to all licensed nurses, certified nursing assistants, and other direct care staff regarding residents' rights under 42 CFR §483.10, including maintaining resident dignity, privacy, confidentiality, and self-determination during all care and services. Education will include the facility's "Personal Privacy and Confidentiality" policy, appropriate use of privacy measures during personal care (including closing doors, curtains, and window blinds when applicable), and the protection of resident confidential information. Staff will also be educated on using alternative methods to communicate resident care needs that do not disclose confidential information or violate resident privacy. The facility reviewed and reinforced its procedures for protecting resident rights, resident privacy and confidentiality. Privacy expectations will be incorporated into new employee orientation and ongoing annual education to ensure continued compliance with resident rights requirements. 4. The Director of Nursing or IP will conduct observations of resident care to verify that staff consistently maintain resident dignity and privacy during personal care activities, including the use of appropriate privacy measures such as closing doors, curtains, and window blinds when applicable. In addition, resident room doors and other resident care areas will be monitored to ensure confidential information is not displayed in a manner that violates resident privacy. Two observations will be completed weekly for two weeks and one observations will be completed monthly for the following two months. Any concerns	08/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

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F0550 SS = D	Continued from page 9 and promote each resident's right to personal privacy . . . Residents will be treated with dignity and respect while ensuring the confidentiality of personal, medical . . . information. . . . "Personal Privacy" Respect for resident's physical body . . . The facility shall protect each resident's privacy during: a. personal care . . . d. toileting . . ." -Review of Resident #14's medical records occurred on all days of survey. The current plan stated, ". . . Urinary Incontinence . . . " Observation on 07/20/26 at 4:16 p.m. showed two certified nurse aides (CNAs) (#7 and #9) transferred Resident #14 to the bed to check and change the brief. Without closing the window blinds, the CNAs pulled down the resident's pants, checked the resident's brief, determined no brief change needed, pulled up the resident's pants, and transferred Resident #14 back to the wheelchair. -Review of Resident #1's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS) dated 05/25/26 stated, ". . . Highly impaired-absence of useful hearing . . . No speech-absence of spoken words . . . Observations on 07/20/26 - 07/22/26 showed a sign printed in bold red and black ink on Resident #1's outside door facing the hallway, which stated, "Hearing and Speech Impaired." During an interview on 07/21/26 at 2:30 p.m., when asked (in written form) if he was ok with the sign on the door, Resident #1 indicated "no" by making horizontal hand gestures. When asked if this sign upset him, the resident indicated "yes" with a thumbs up gesture. During an interview on the afternoon 07/23/26, an administrative nurse (#1) confirmed she expected staff to close the resident's blinds during cares and agreed the sign violated Resident #1's privacy.	F0550	Continued from page 9 identified during the observations will be addressed immediately through corrective action and additional staff education The Director of Nursing and IP will maintain documentation of all monitoring activities and present the findings to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will evaluate compliance, identify trends, and determine whether additional interventions or extended monitoring are necessary to ensure sustained compliance with resident rights requirements. 5. The facility will achieve substantial compliance with this requirement on 08/06/2026	08/06/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F0600	1. Residents #1, #5, #16, and #30 were evaluated by licensed nursing staff following the resident-to-resident altercations. Comprehensive assessments were completed to identify any actual or potential physical injuries, changes in behavior, or psychosocial concerns. The attending	08/17/2026

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F0600 SS = D	Continued from page 10 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from abuse for 4 of 6 sampled residents (Resident #1, #5, #16, #30) reviewed for resident-to-resident altercations. Failure to protect residents from verbal and/or physical abuse placed all resident at risk for physical harm, pain, mental anguish, and emotional distress. Findings include: Review of the facility's policy titled "Abuse, Neglect and Exploitation" occurred on 07/23/26. This policy, dated December 2025, stated, ". . . Provide protection for the health, and welfare and rights of each resident by . . . implementing . . . policy and procedures that prohibit and prevent abuse . . . 'Abuse' willful infliction of injury . . . intimidation . . . resulting in physical harm, pain or mental anguish . . . which can include . . . resident to resident altercations. . . . 'Physical Abuse' includes, but not limited to hitting, slapping, punching, biting, and kicking. . . . 'Verbal Abuse' means the use of oral . . . communication or sounds that willfully include disparaging and derogatory terms to resident . . . within their hearing distance . . . Identification of Abuse, Neglect . . . Physical marks such as . . . patterned appearances . . . Verbal abuse of resident overheard . . . ." -Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia with agitation, unspecified psychosis and delirium. The quarterly Minimum Data Set (MDS), dated 07/20/26, identified impaired cognition. The current	F0600	Continued from page 10 practitioners and responsible parties were notified, and all required incident reporting procedures were completed. An interdisciplinary team (IDT) review was conducted for each resident to evaluate contributing factors, including cognitive status, behavioral triggers, environmental influences, and supervision needs. Individualized care plans were reviewed and revised, as appropriate, to include resident-specific interventions aimed at preventing future resident-to-resident altercations. Interventions included supervision during high-risk periods, behavioral redirection, and separation of residents when indicated. The effectiveness of the interventions will continue to be monitored and modified by the interdisciplinary team based on each resident's ongoing needs and response to interventions. 2. Dunseith Community Nursing home has determined that all residents have the potential to be affected by deficient practice. 3. The facility's Abuse Prevention policies related to resident-to-resident altercations were reviewed by the interdisciplinary team. All licensed nurses, and certified nursing assistants, will receive education on: Resident rights to be free from abuse. Recognition and prevention of resident-to-resident altercations. Identification of behavioral triggers and escalation. Appropriate interventions, supervision, and de-escalation techniques. Immediate reporting requirements for suspected abuse. Documentation and notification procedures. New employees will receive this education during orientation, and annual education will reinforce these expectations.	08/17/2026

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F0600 SS = D	Continued from page 11 care plan stated, " . . . Resident is at risk for trauma-related behaviors due to history of resident altercation . . . Staff will provide a safe area . . . redirect resident away from triggering situations . . . provide a structured, low-stimulation environment to reduce confusion and agitation. . . ." A nurse's note, dated 04/18/26 at 4:35 p.m., stated, "Resident was sitting at CNA station when they heard two other residents talking. This resident [Resident #5] then started to curse out in response to what they were saying. The other resident [Resident #30] came up to this resident and started cursing out at this resident. Both then started to swing out at each other. Then, other resident swung out and struck them on the left hand. This resident then put their hands up in response to being struck. The other resident then stated that this resident hit them when staff did not see this. The other resident then continued to curse out at staff until staff asked them to go to their room. The other resident left the CNA station. This resident was assessed for injuries and observed redness to left hand, first two knuckles with first knuckle observed to be swollen. . . ." -Review of Resident #30's medical record occurred on all days of survey. Diagnoses included altered mental status and major depressive disorder. The quarterly MDS, dated 04/28/26, identified intact cognition. The current care plan stated, ". . . at risk for mood disturbances related to cognitive impairment, history of cerebrovascular disease (CVD), and altered coping abilities. . . . approach resident in a calm . . . non-confrontational manner. . . . exhibits impaired social interactions related to cognitive impairment as evidenced by inappropriate comments, irritability and history of altered mental status. . . . redirect residents when inappropriate verbal comments occur, avoiding confrontation or argument. . . ." -Review of Resident #16's medical record occurred on all days of survey. Diagnoses included dementia with agitation, Alzheimer's disease, violent behavior with uncontrolled agitation and aggression, altered mental status, and anxiety disorder. The current care plan stated, ". . . Resident exhibits impaired mood state related to cognitive impairment and anxiety as evidenced by emotional instability . . . Separate the resident from vulnerable residents during peak	F0600	Continued from page 11 4. The Social Work Director will conduct audits of residents with behavioral concerns and resident-to-resident altercations to ensure behavioral assessments have been completed, individualized interventions have been implemented, care plans have been updated, and appropriate supervision is provided. Audits will be conducted: *Bi-weekly for four weeks, then *Monthly for two months, or until sustained compliance is achieved. Any identified concerns will be addressed immediately through corrective action, staff education, and care plan revision as indicated. 5. The Social Service Director (implementation and oversight) and MDS Coordinator(oversight) are responsible for the corrective actions mentioned in this plan of correction. Completion date will be 08/17/2026	08/17/2026

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F0600 SS = D	Continued from page 12 agitation periods and periods of distress . . ." Resident #16's progress notes identified the following: *06/03/26 at 9:30 p.m., "Client [Resident #16] was sitting by nurse's station trying to get up. Med [medication] nurse assisted client back into his wheelchair. Client attempted to hit nurse; swing out at staff. Another resident [Resident #1] attempted to get client to sit down and [Resident #16] hit other resident on the arm. Staff immediately intervened. . . ." *06/03/26 at 9:35 p.m., "Notified [provider] client hit another resident. New orders to administer Haldol [antipsychotic medication] . . . now and if continues to be aggressive." -Review of Resident #1's medical record occurred on 07/23/26. A quarterly MDS, dated 04/14/26, identified intact cognition. Resident #1's progress notes identified the following: *06/03/26 at 9:30 p.m., "CNA notified this writer that [Resident #1] has been hit by another resident. . . . [Resident #1] was attempting to get the other resident to sit down in his wheelchair as he was trying to stand up. [Resident #1] reached towards [Resident #16] and [Resident #16] struck [Resident #1] on the right arm. . . ." During an interview on 07/23/26 at 1:00 p.m., an administrative nurse (#1) confirmed all residents have the right to a safe living space.	F0600		08/17/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care	F0656	Resident #7's comprehensive care plan was reviewed and revised by the interdisciplinary team to address the resident's diagnosis of Post-Traumatic Stress Disorder (PTSD). A trauma-informed assessment was completed to identify the resident's history, known triggers, preferences, coping strategies, and individualized interventions to reduce the risk of re-traumatization. The resident and/or resident representative, will participate in the care planning process. The revised care plan was communicated to direct care staff, and interventions were implemented.	08/17/2026

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F0656 SS = D	Continued from page 13 plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 2 sampled resident (Resident #7) reviewed for post-traumatic stress disorder (PTSD). Failure to develop a comprehensive care plan limits staffs' ability to communicate, ensure the continuity of care, and avoid triggers that may result in re-traumatization. The facility failed to provide a policy related to PTSD.	F0656	Continued from page 13 Dunseith Community Nursing Home has determined that all residents have the potential to be affected by this deficient practice. The facility developed and implemented a policy addressing trauma-informed care for residents with PTSD. The policy includes expectations for assessment, care planning, interdisciplinary team involvement, and individualized interventions, documentation requirements, and ongoing review of care plans following significant changes in condition. Director of Nursing (DON) or designee will audit the medical records of all residents admitted with a diagnosis of PTSD or a documented trauma history to ensure a trauma-informed assessment has been completed and that the comprehensive care plan includes individualized trauma-informed interventions, identified triggers, resident preferences, and measurable goals. Two resident records will be audited weekly for two weeks, then monthly for two months or until 100% compliance is met. Any identified concerns will be corrected immediately, including updating the comprehensive care plan and providing additional staff education as needed. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action if indicated. Completion date will be 08/17/2026	08/17/2026

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F0656 SS = D	Continued from page 14 Review of Resident #7's medical record occurred on all days of survey. Diagnoses included post-traumatic stress disorder. The medical record failed to include an assessment addressing the history and triggers for PTSD. The current care plan failed to identify PTSD, known triggers, or personalized interventions to prevent re-traumatization. During an interview on 07/22/26 at 2:35 p.m., two administrative staff members (#1 and #3) stated, "we knew she was coming in with a diagnosis of PTSD."	F0656		08/17/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and	F0657	1. Resident #30's smoking status was reviewed, and a smoking safety assessment was completed on 07/22/2026. The resident's comprehensive person-centered care plan was revised to reflect her current smoking status and individualized smoking-safety interventions. Resident #30 was educated regarding the facility's smoking policy and applicable smoking-safety measures. Staff were informed of the updated care-plan interventions. 2. Dunseith Community Nursing Home determined that all residents have the potential to be affected by the deficient practice. 3. The Director of Nursing reviewed and revised the facility's Smoke Free Facility Policy on 07/22/2026 to clarify assessment and care-planning requirements for residents who currently smoke, have a history of smoking, or use tobacco products. Licensed nursing, MDS, and SSD staff were re-educated on the revised policy, including completion of smoking safety/risk assessments and incorporation of current smoking status and individualized interventions into the comprehensive person-centered care plan. SSD/Nurse Management completed a facility-wide review of residents with current or historical smoking/tobacco use to ensure smoking safety/risk assessments were completed, and care plans were updated as indicated. Smoking status and related safety needs will be reviewed during comprehensive and quarterly assessments and care plans revised as indicated. 4. The SSD will conduct audits on two residents who currently smoke, have a history of smoking, or use tobacco products to ensure smoking safety/risk assessments are completed and current. For residents who currently smoke or use tobacco	08/19/2026

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F0657 SS = D	Continued from page 15 resident and staff interviews, the facility failed to revise the comprehensive person-centered care plan to reflect the resident's smoking status and related interventions for 1 of 2 residents (Resident #30) reviewed for smoking. Failure to address the resident's smoking status in the care plan may result in inconsistent care and compromised smoking safety. Findings include: Review of facility policy titled "Smoke Free Facility Policy" occurred on 07/23/26. This policy, dated 04/06/23, stated, " . . . applies to all residents . . . both smokers and non-smokers. . . . Smoking is prohibited in all areas of the facility. . . . Residents with a history of smoking will be further assessed . . . If a resident does not abide by the smoking policy, care plan revisions shall be documented and implemented to promote safety. . . ." Review of Resident #30's medical record occurred on all days of survey. Review of Resident #30's smoking status identified light tobacco smoker. Review of the quarterly Minimum Data Set (MDS), dated 07/20/26, identified the resident as cognitively intact. The care plan failed to address Resident #30's smoking habits. A progress note, dated 11/29/25 at 11:44 a.m., stated, ". . . observed resident outside smoking a cigarette. . . ." During an interview on 07/22/26 at 10:07 a.m., Resident #30 confirmed she smokes and stores the cigarettes and lighter in her purse. The resident stated, "I smoke on the patio area outside in front of the building and only go to the sidewalk if another resident comes and asks me for a smoke." During an interview on the morning of 07/22/26, an administrative staff member (#1) confirmed Resident #30's smokes and her care plan failed to include smoking.	F0657	Continued from page 15 products, audits will also verify that smoking status and individualized smoking-safety interventions are accurately reflected in the comprehensive person-centered care plan. Audits will be completed weekly for four weeks, then monthly for two months, or until 100% compliance is maintained for two consecutive months. Any deficient practice identified will be corrected immediately, and staff re-education will be provided as necessary. Audit findings will be reviewed through the facility's monthly Quality Assurance/QAPI process to identify trends and determine whether additional corrective actions are necessary. 5. All corrective actions will be fully implemented by 08/19/2026. Ongoing monitoring and auditing will continue in accordance with the facility's Plan of Correction.	08/19/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	1. Resident #23 received a smoking safety assessment and care plan review to address smoking-related safety risks. A secured lock box was provided for storage of smoking materials, and the resident was educated regarding the safe handling and storage of cigarettes and lighters.	08/17/2026

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F0689 SS = D	Continued from page 16 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to ensure residents remain free from accident/hazards for 2 of 2 sampled residents (Resident #23, and #30) reviewed for smoking. Failure to safeguard fire starting devices from resident access placed all residents, staff, and visitors at risk for injury or fires. Findings include: Review of the facility policy titled "Smoke Free Facility Policy" occurred on 07/23/26. This policy, dated 04/06/23, stated, " . . . applies to all residents . . . both smokers and non-smokers. . . . Smoking is prohibited in all areas of the facility. . . . to promote safety. . . ." - Review of Resident #23's medical record occurred on all days of survey. The care plan stated, ". . . Resident exhibits nicotine dependence as evidence by choosing to smoke against facility policy. . . ." The record lacked a smoking assessment to identify safety issues/concerns related to Resident #23's smoking habit. Observations on all days of survey showed Resident #23 seated on a bench located outside on facility grounds multiple times each day smoking cigarettes. During an interview on 07/21/26 at 8:35 a.m., Resident #23 reported he smokes every few hours and keeps his cigarette lighter in his possession. During an interview on 07/22/26 at 3:00 p.m., two administrative staff members (#1 and #3) confirmed Resident #23 keeps his cigarette lighter in his possession. - Review of Resident #30's medical record occurred on all days of survey and identified the resident as light tobacco smoker. A behavior and mood event assessment, dated 07/17/26, stated, ". . . observed smoking outside . . . offered . . . nicotine patch,	F0689	Continued from page 16 Resident #30 received a smoking safety assessment and care plan review. A secured lock box was provided for storage of smoking materials, and the resident was educated regarding the safe handling and storage of cigarettes and lighters. Resident #5's environmental safety concern was immediately corrected. Protective outlet covers were installed on the electrical outlet located by the resident's bed, and the resident's care plan was reviewed and revised to include interventions to prevent access to electrical outlets and cords. These corrective actions were completed prior to the survey team's exit. 2. Dunseith Community Nursing Home has determined that all residents have the potential to be affected by the deficient practice. 3. The facility has reinforced its Accident Prevention Program and Smoking Safety procedures. Smoking safety assessments be completed: Upon admission. With a significant change in condition (current smoker). Whenever smoking behaviors change. Smoking materials are maintained in secured lock boxes when indicated by the resident assessment and facility policy. Environmental safety rounds will include inspection of resident rooms for potential hazards, including electrical outlets, exposed cords, and other accident risks. The Director of Nursing or designee has educated licensed nurses and direct care staff regarding: Smoking Safety Policy. Environmental safety expectations.	08/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 17 resident refused. . . ." Review of the quarterly Minimum Data Set (MDS), dated 07/20/26, identified the resident as cognitively intact. Review of Resident #30's progress note, dated 11/29/25 at 11:44 a.m., stated, ". . . observed resident outside smoking a cigarette. . . ." During an interview on 07/22/26 at 10:07 a.m., Resident #30 confirmed she smokes and stores the cigarettes and lighter in her purse. The resident stated, "I smoke on the patio area outside in front of the building . . ." During an interview on the morning of 07/22/26, an administrative staff member (#1) stated staff were unaware Resident #30 had a cigarette lighter in her possession. 2. Based on observation, record review, review of professional reference and staff interviews, the facility failed to ensure a safe environment for 1 of 1 sampled resident (Resident #5) observed during wound cares. Failure to ensure the safety of residents with access to electrical equipment places all residents at risk for adverse events and/or serious injury. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice, " 11th ed., Pearson Education Inc., New Jersey, chapter 29, stated, ". . . Alterations in mobility . . . place clients at risk for injury . . . Remove unsafe objects . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia with agitation, delirium, and unspecified psychosis. The current care plan stated, ". . . Resident exhibits altered mood and emotional dysregulation related to dementia with agitation, psychosis, delirium . . . as evidenced by agitation . . . impaired reality perception. . . ." Observation on 07/21/26 at 2:23 p.m. two nurses (#4 and #5) entered Resident #5's room to provide wound care treatment. Resident #5 unplugged the bed's electrical cord from the wall outlet, handled the plug, and attempted to reinsert it into the outlet while his fingers were in contact with the metal prong. The surveyor asked the nurse (#4) whether the resident should be attempting to plug the bed back into the outlet. The nurse (#4) responded, "no, he shouldn't," immediately removed the electrical cord from the resident's hands, and plugged the	F0689	Continued from page 17 Prompt identification and correction of hazards. Resident-specific accident prevention interventions. 4. The Director of Nursing or designee will monitor smoking safety assessments and the appropriate storage of smoking materials for all identified residents who smoke The Director of Nursing or designee will conduct audits weekly for one month, then monthly for one month or until 100% compliance. Results of the audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee at each scheduled meeting. If concerns are identified, immediate corrective action, additional staff education, and continued monitoring will be implemented. 5. Completion date will be implemented by 08/17/2026	08/17/2026

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F0689 SS = D	Continued from page 18 bed's cord into the wall outlet. Observation on 07/21/26 at 3:27 p.m. showed Resident #5 reached out and touched the wall outlet next to the head of the bed. During an interview on 07/21/26 at 5:15 p.m., an administrative nurse (#1) confirmed the resident should not have access to the electrical outlet. Observation on 07/22/26 at 8:00 a.m. showed outlet covers placed in the electrical outlet by the head of Resident #5's bed.	F0689		08/17/2026
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 7 residents (Resident #14 and #22) observed during medication administration. Five medication errors occurred during staff administration of 26 medications, resulting in a 19% error rate. Failure to properly prepare and administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: The facility failed to provide a policy on medication administration, crushing medications, and obtaining/clarifying physician orders. Review of Mayo Clinic at https://www.mayoclinic.org/drugs-supplements/meloxicam-oral-route/description/drg-20066928, dated July 01, 2026, titled “Meloxicam (oral route)” stated, “. . . Proper Use . . . Swallow the . . . tablet whole. Do not crush, break, or chew it. . . .” Observation on 07/22/26 at 8:01 a.m. showed a medication aide (MA) (#11) placed a crushed Tylenol and the contacts of a Gabapentin capsule in pudding	F0759	Corrective Action for Residents Found Affected Resident #14 and Resident #22 were immediately assessed by the licensed nurse for any adverse effects related to the medication administration errors. No adverse outcomes were identified. The attending physician and responsible party were notified of the medication administration errors in accordance with facility policy. Physician orders were reviewed and clarified regarding medications that may or may not be crushed. Medication administration records (MARs) were updated as applicable to reflect current physician orders. Medication Aide #11 received immediate re-education regarding proper medication administration, physician order verification, medications that must not be crushed, and adherence to facility medication administration procedures. 2. Identification of Other Residents Who May Be Affected All residents receiving medications have the potential to be affected by the deficient practice. A 100% audit of all residents receiving crushed medications will be completed by the Director of Nursing or designee to verify: Physician orders accurately reflect whether medications may be crushed. Medications identified as "Do Not Crush" are administered according to manufacturer recommendations or verified by MD/ or Pharmacy for crush order. State reason in the documentation.	08/17/2026

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F0759 SS = D	Continued from page 19 and administered to Resident #14. The medical record lacked a physician's order to crush medication. Observation on 07/22/26 at 12:23 p.m. showed a MA (#11) placed crushed Tylenol, Meloxicam and Sertraline in pudding and administered to Resident #22. The medical record lacked a physician's order to crush medications.	F0759	Continued from page 19 Medication administration records contain complete and accurate physician orders. Any discrepancies identified will be immediately corrected through physician clarification and MAR updates. 3. Systemic Changes to Prevent Recurrence The facility's policies and procedures for medication administration, medication crushing, physician order clarification, and medication error prevention have been reviewed and revised as necessary. Licensed nurses and medication aides will receive mandatory in-service education on: Safe medication administration practices. Verification of physician orders before medication administration. Identification of medications that must not be crushed unless MD/ or pharmacy approve. Appropriate documentation and clarification of physician orders. Compliance with CMS medication administration regulations. Medication administration competency validations will be completed for all licensed nurses and medication aides before independent medication administration. 4. Monitoring to Ensure Continued Compliance The Director of Nursing or designee will be responsible for monitoring compliance. Quality assurance audits will include direct observation of medication passes and review of medication administration documentation to ensure: Physician orders are followed.	08/17/2026

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F0759 SS = D		F0759	Continued from page 20 Medications are prepared and administered appropriately. Medications that should not be crushed are administered correctly or have documentation from MD/ or pharmacy for crush order. Physician order clarifications are obtained before medication administration when needed. Audits will be conducted: Once weekly on two random resident medication passes for two (2) weeks; Monthly for two (2) month; or until 100% compliance. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and follow-up monitoring. 5. Completion date: 08/17/2026	08/17/2026