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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	**333 EASTERN AVE , GRAFTON, North Dakota, 58237**

(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 and facility reported incident survey started 02/23/26 and concluded 02/27/26.	F0000		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels	F0584	The resident fans identified as dusty during the survey, along with all facility fans, were cleaned by maintenance staff on 2/25/26. Resident 42's room was spot painted and the drip pan that had been ripped off the wall was replaced by maintenance staff on 2/26/26. Resident 47's cabinet was repaired and painted on 2/27/26. Spot painting was done to touch up other problematic areas that same day. Resident 82's bathroom wall was repaired and cleaned up on 3/12/26. Administrator and Environmental Supervisor did a facility walkthrough on 3/12/26 to identify other resident rooms and communal areas that are in need of repair. Suggested improvements were documented and will be addressed as able. The facility has implemented a preventative maintenance program with routine inspections of resident care areas. Staff were re-educated on promptly reporting environmental concerns through the facility's blue slip system. Maintenance staff will prioritize repairs in resident care areas to ensure timely resolution. The Maintenance Director, or designee, will conduct monthly audits of resident care areas for 3 months, then quarterly audits thereafter. Audit findings will be presented on a quarterly basis at the Quality Assurance and Performance Improvement (QAPI) meetings.	03/31/2026

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

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

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F0584 SS = E	Continued from page 1 in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: 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	F0584		03/31/2026

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F0584 SS = E	Continued from page 2 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.	F0584		03/31/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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:	F0812	Hobart Sanitizer machine was disabled in the Special Care Unit on 2/27/26. Staff communication from Director of Nutrition and Certified Dietary Manager to Nutrition Services and SCU staff. Clean dishes and silverware will be sent up with the food cart to stock the cupboards. Dirty dishes will be sent with the food cart after meals to be cleaned in the main dishwasher. An empty tub will hold dirty dishes until put in the cart. The dishwasher in the main kitchen's temperature logs were reviewed for compliance. There are no other dishwashers that would be impacted by this deficient practice. Information sent via a memo to SCU from Director of Nutrition and Certified Dietary Manager. Updated nourishment request forms to include glasses, cups, silverware, given to the Special Care unit to order par level of needed dishes/silverware daily. Nutrition Services staff to send request with food cart daily at noon. Weekly check in done by CDM for the first month to identify any issues and assure that new process is going well. CDM, or designee, will ensure that the dishwasher remains out of service at that time. If the dishwashing process is going well then audits will be done monthly for the next six months, or until compliance is achieved and sustained. Results of the audits will be presented at the QAPI meetings on a quarterly basis.	03/31/2026

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F0812 SS = E	Continued from page 3 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 71ºC (160ºF) as measured by an irreversible registering temperature measuring device to affect sanitization. . . . The . . . temperature limits of (180ºF) . . .are based on the sanitizing rinse contact time required to achieve the 71ºC (160ºF) utensil surface temperature. Review of the facility policy, "Hobert 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.	F0812		03/31/2026

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F0812 SS = E	Continued from page 4 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.	F0812		03/31/2026
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 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.	F0550	On 2-26-26, the resident environment for Resident #2 and Resident #8 was immediately corrected to ensure the identified residents' dignity was maintained. Nurse on duty provided reminders through shift report of ensuring resident dignity is maintained. On 2-26-26, resident care areas were audited to ensure dignified environment standards were maintained No additional concerns were identified. Resident's rights policy reviewed on 3-2-2026 Will provide reeducation on resident's rights including policy review and maintaining a dignified environment for residents for: CNAs on 3-17-2026 Licensed nursing on 3-19-2026 Audits of care areas for resident dignity to occur weekly x 6 weeks; Once 100% compliance is achieved, then monthly x 6 months. Any noncompliance identified will result in immediate correction and reeducation of staff as needed. Audit findings will be reviewed quarterly at the Quality Assurance and Performance Improvement	03/31/2026

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F0550 SS = D	Continued from page 5 §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 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.	F0550	Continued from page 5 (QAPI) meeting.	03/31/2026

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F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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 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 #87 The 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	F0600	Resident #87 is no longer residing in the facility. Resident #40 was seen by psychiatry following alleged incident and no medication changes were made. Education was provided to resident by administrator following alleged incident. Both residents affected were immediately assessed for injuries after alleged incidents. No physical injury or mental or emotional distress identified. The IDT review residents who demonstrate behaviors determine if additional interventions or care plan updates are necessary to maintain resident safety and dignity. Any resident identified as having behaviors that may place other residents at risk have individualized interventions implemented through the care planning process. Social services department will review and investigate all resident-to-resident incidents within 5 days of occurrence Reeducation will be provided regarding prevention of resident-to-resident interaction that may compromise a resident’s safety or dignity and the responsibility to intervene when such situations occur for: CNAs on 3-17-2026 Licensed nursing staff on 3-19-2026 The DON, or designee, will monitor residents in all areas of the nursing home for inappropriate behaviors on a weekly basis x 4 weeks then monthly x 3 months. Any concerns identified will result in redirection and education. Findings to be reviewed at QAPI committee meetings on a quarterly basis.	03/31/2026

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F0600 SS = D	Continued from page 7 #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 07/14/25, 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 07/24/25, 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	F0600		03/31/2026

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F0600 SS = D	Continued from page 8 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 #40 During 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 07/05/25, 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!' . . .” 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 08/20/25, 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. . . ."	F0600		03/31/2026

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F0600 SS = D	Continued from page 9 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.	F0600		03/31/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, 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 events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: 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:	F0609	On 2-25-2026, the identified incident was reviewed, and the initial report was made to the State Survey Agency (SSA) upon identification of the oversight. A thorough investigation was completed, including interviews and record review. No additional resident harm was identified. Final report submitted to the SSA on 2-26-2026. The DON reviewed incident reports from the previous 30 days to ensure any reportable events were properly reported to the SSA. No additional unreported incidents were identified. Licensed nurses will be reeducated on abuse reporting requirements including immediate reporting requirements to administration and reporting timelines to the SSA on 3-19-2026 An Abuse Reporting Quick Reference Tool was provided to licensed nursing staff outlining: What must be reported When it must be reported Abuse Prohibition Plan policy reviewed on 3-13-2026 and remains current. The DON or designee will review incident reports daily x 4 weeks to ensure timely reporting to the State Survey Agency. If 100% compliance is achieved, then monitoring will occur weekly x 6 weeks, then monthly x 6 months. Any noncompliance identified will result in immediate correction and reeducation of staff as needed. Audit findings will be reviewed quarterly at the Quality Assurance and Performance Improvement (QAPI) meeting.	03/31/2026

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	**333 EASTERN AVE , GRAFTON, North Dakota, 58237**

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F0609 SS = D	Continued from page 10 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 08/20/25, 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 07/05/25, 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	F0609		03/31/2026

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F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical,	F0849	On 2-26-2026, HIA contacted to obtain missing hospice election documents. Hospice election form obtained and filed in the resident electronic record The resident identified is deceased; no adverse outcome related to hospice services was identified. On 2-27-26, an audit was conducted of all current residents receiving hospice services verifying that the hospice election documents were filed in the residents' electronic record. Any missing documents were obtained and filed in the resident electronic record. Assigned responsibility to Medical Records to confirm hospice election form documentation upon initiation of hospice services. On 2/27/2026, Medical Records staff were educated on ensuring hospice election forms are obtained and maintained in the resident's medical record. On 3/19/2026, licensed nursing staff will be educated on ensuring hospice election forms are obtained and maintained in the resident medical record. Documentation of education will be maintained. DON reviewed the process with HIA to ensure hospice election forms are shared with the facility upon hospice admission. DON or designee will review all new hospice enrollments weekly x 6 weeks until 100% compliance is achieved then monthly for 6 months to verify required documentation is present. Any noncompliance identified will result in immediate correction and reeducation of staff as needed. Audit findings will be reviewed quarterly at the Quality Assurance and Performance Improvement (QAPI) meeting.	03/31/2026

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F0849 SS = D	Continued from page 12 mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.	F0849		03/31/2026

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F0849 SS = D	Continued from page 13 §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if	F0849		03/31/2026

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F0849 SS = D	Continued from page 14 any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: 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.	F0849		03/31/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	On 2-26-2026, nebulizer mask and tubing were immediately discarded, and new nebulizer mask and tubing were provided. Nurse manager provided education to affected residents to avoid placing	03/31/2026

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F0880 SS = D	Continued from page 15 §483.80 Infection Control The facility must establish and maintain an infection 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	F0880	Continued from page 15 nebulizer machine and components on the floor and provided a clean storage container within reach to promote appropriate placement after use. Resident assessed for signs and symptoms of respiratory infection. No adverse effects were identified related to nebulizer storage. On 2-27-26, a DON conducted audits of all residents receiving nebulizer treatments verifying nebulizer machines and components were properly stored in a clean storage container and not on the floor. No additional concerns have been identified. Will provide reeducation on infection prevention related to respiratory equipment and the expectation that nursing staff are responsible to rinse nebulizer mask and components and ensure equipment is stored in a clean, designated location after each treatment per policy on 3-19-2026. On 2-27-2026, administration notes for nebulizers updated to include reminder of rinsing of nebulizer equipment and proper storage after each use. Policy for the care of nebulizer and compressor was reviewed to ensure compliance with infection control standards. The updated policy clarifies nebulizer cleaning procedures, equipment replacement, and standard precautions. DON or designee will conduct weekly audits for 6 weeks once 100% compliance is maintained; monitoring will transition to monthly audits for 6 months. Any noncompliance will result in immediate correction and re-education. Audit findings will be reviewed quarterly at the Quality Assurance and Performance Improvement (QAPI) meeting.	03/31/2026

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F0880 SS = D	Continued from page 16 the disease; and (vi)The hand hygiene procedures to be followed by 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 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.	F0880		03/31/2026