North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8072	A. BUILDING: _____ B. WING _____	C 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK ON WEST CENTURY LLC	1000 W CENTURY AVE BISMARCK, ND 58503

(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) COMPLETE DATE
B 000	INITIAL COMMENTS For the unannounced licensure and complaint survey, started on 11/11/25 and completed 11/17/25, the sample included 10 residents for complete review and two closed records for review. In addition, the sample included five supplemental residents to verify specific concerns during the survey. Tier I findings were identified and attested as corrected at B1320 and B1830. Tier II citations included B910, B922, B924, B928, B1220, B1240, B1320, B1540, B1700, B1800, B1940, B2305, and B2413.	B 000	**B 910 (1)** The towel was immediately removed from the courtyard doors. There are two other courtyard doors in the Memory Care neighborhoods with the potential to be impacted by this practice. A policy was developed for the courtyard doors that took effect on 1/21/2026. The policy has been added to Relias training and will be reviewed by Basic Care staff no later than 2/27/2026	
B 910	33-03-24.1-09,1 GOVERNING BODY 1. The governing body is legally responsible for the quality of resident services; for resident health, safety, and security; and to ensure the overall operation of the facility is in compliance with all applicable federal, state, and local laws. This State Licensing Rule is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to ensure the safety and well-being for all residents on 1 of 1 unit (Devonshire 1). Failure to maintain the secure closure of courtyard doors has the potential for elopement, falls, injury, and may lead to residents not feeling safe/secure in their home. Findings include:	B 910	A visual check of patio doors in MC will be conducted weekly for three months by the Executive Director or designee to ensure doors are not propped open. If results do not indicate compliance, visual checks may continue until compliance is achieved. The Executive Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Patricia J Jaster — Executive Director — 2/6/2026

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B 910	Continued From page 1 The facility failed to provide a policy on maintaining building/door safety/security. Observation on 11/11/25 at 8:30 a.m. showed residents in the dining area and the door to the courtyard held ajar with a knotted towel with part of the towel hanging outside the door. Cold air entered the dining area through the un-secured door. During an interview on 11/11/25 at 8:54 a.m., a certified nurse aide (CNA) (#4) stated, "The towel is there so when the residents go outside, they can pull on the towel to get back in." During an interview on 11/11/25 at 3:49 p.m., a managerial staff member (#12) confirmed the courtyard doors should never be propped open. During an interview on 11/13/25 at 3:30 p.m., two administrative staff (#1 and #5) confirmed the door should not be propped open. 2. Based on information received from complainants, record review, and review of facility policy, the facility failed to ensure the safety and security of the memory care for 2 of 2 closed record residents (Resident #11 and #12) who exhibited verbal and physical aggressive behaviors. Failure to ensure overall safety and security of residents by developing an effective behavior management plan resulted in injuries, anger, and anxiety to residents, family, and staff. Findings include: Information received from the complainants identified aggressive behaviors and resident to resident altercations resulting in injuries to	B 910	**B 910 (2)** Resident #12 moved out of facility on 12/08/2023. Resident #11 passed away on 9/24/2026. Any resident residing in basic care that displays aggressive behavior has the potential to be affected by this practice. Chart notes, behavior charting, and care plans of residents displaying aggressive behaviors were reviewed by a licensed nurse to ensure adequate behavior management programs are in place. Education regarding the aggressive and assaultive residents' policy was provided to all licensed nurses, resident care managers, and caregivers who work in Basic Care on 1/15/2026. All team members unable to attend the in-person training are required to complete the training in Relias by no later than 2/27/2026. To ensure ongoing compliance, the Resident Care Manager will review behavior charting weekly to identify any changes in behavior or to provide training on interventions when needed. The Clinical Care Manager or Health Services Director will audit behavior	

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B 910	Continued From page 2 residents. Review of the facility policy titled "Resident Standards" occurred on 11/13/25. This policy, reviewed 04/04/25, stated, ". . . To enhance our diverse community, we are committed to an environment in which residents are . . . Allowed to age in place with dignity ..... provide a comfortable, secure and safe home." - Review of Resident #11's medical record occurred on 11/13/25 and identified diagnoses of Alzheimer's dementia, altered mental status, agitation, anxiety, restlessness, insomnia, and pain. Resident #11's progress notes from 03/17/25 through 09/23/25 identified the following: * 03/19/25 at 10:34 a.m., " ..... care giver had to get her in the shower and resident got really agitated. Resident hit caregiver a couple times and also was punching ..... she kept going into other resident's rooms and taking their clothes out ..... both care givers grabbed all of the clothes off of the table and resident chased after caregiver into the laundry room..... Resident also kept coming over to the med [medication] cart and trying to grab things off the med cart and kept trying to open up the drawers. During all interactions with staff, resident would hit, pinch and punch caregivers .....tried to give her snacks . . . she threw the snacks on the floor and started stomping on them. Med aid attempted to give PRN [as needed] medication.....and she hit it out of med aids [sic] hand and then 15 minutes later, another med aid attempted giving the medication, resident threw it on the floor. Resident also kept pulling her pants down in the dining room and common areas to try and have a BM [bowel movement] ..... "	B 910	(continued from page 2) plans weekly for 3 months to ensure behavior charting is being conducted appropriately and identify any residents that may need changes to the behavior plan. If results do not indicate compliance, audits may continue until compliance is achieved. The Health Services Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	

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B 910	Continued From page 3 * 03/20/25 at 9:20 a.m., ". . . [Resident #11] left her apartment and went into [room A] falling asleep in that resident's chair .....Myself and the CMA [certified medication aide] tried to get her out of the room and she became extremely agitated starting to hit, punch, and push at us. Once we were finally able to get her out of [resident's room A] she tried everything [in] her power to try and get us away from the door so she could go back in there .....All [the] while she followed us [caregiver and CMA] continuing to hit, punch and push us away ..... At one point she tried to aggressively push a chair towards us. I tried to block the chair with my body ..... this only made her angrier and she started to pound her fist on my arms and chest. Then [she] ran away once I firmly told her [to] stop and went into [resident's room B].....the CMA tried to give a snack..... the resident slapped it out of her hand and ran across the neighborhood and into [resident's room C] where she tried to shut the bottom half of the door on us..... Then she went into the kitchen and tried to ripped [sic] pages out of the report book and throw it at me as well as finding my own purse on the desk and throwing that as well, she also got a hold of my cardigan and started trying to take it off of my body, the CMA was able to get her away from me only for her [to] run back to [resident's room A] and when she couldn't get there she pushed another chair down towards us ..... This whole episode probably lasted about 20-25 minutes." * 03/30/25 at 7:57 a.m., "..... she went out of her room and into another resident's room to sleep on his chair .....I went to get some of her wafer cookies in her room to offer her a snack outside of the resident's room. She came out only to grab the cookie from me, took one bite before throwing the rest on the floor and tried to walk back into [resident's room A], when I blocked her path and	B 910		

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B 910	Continued From page 4 tried [to] ask her to come with me she started to hit and push me aside ..... during this time resident from [room D] was up and trying to ask us what was going [on] and if she could help. And while not wanting resident [from room D] to get hit/hurt in anyway [sic] I gently guided [Resident #11] back to her room.....which resulted in her hitting, pinching and scratching my chest/torso and arms which broke open my skin and bruised it." * 04/02/25 at 9:35 a.m., "..... She does not sleep in her own room but goes into other residents [sic] room[s]. When I try to explain or redirect she becomes aggressive kicking and punching me. She also went into [resident's room C] and [a] family member was trying to show her the way back out....."' * 04/06/25 at 1:15 p.m., "..... as soon as she has them [medications] in her mouth she took both meds out..... she tried putting them in the water cup..... She got extremely agitated and tried to punch my chest and head. She then was hitting my arms which resulted in the water being spilt all over the floor.....She kept trying to hit me and pull at my scrubs. She then grabbed my walkie and raised it like she was going to hit me in the head with it she was scratching and hitting me then she started to try and hit my coworker. She then grabbed my left side of my neck dug her fingers in and pulled my skin. I've got a couple of deep scratches on my neck . . . and I have a deep scratch on my finger " * 04/09/25 at 10:17 a.m., " she has been touching the male residents and following them around. The first one was [resident who resides in room A], she was touching him and holding his hands. When we helped [resident from room A] to go to bed, she went to [resident E's room]. Resident in [room E] came out and told us that he wanted her to get out of his room because she	B 910		

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B 910	Continued From page 5 touched him in his private part. Lastly, she kept on following [male resident's name] and became aggressive when we stopped her." * 04/13/25 at 10:54 a.m., ". . . The resident went into other resident rooms really upsetting them especially since for some of them she tried to lay in their beds with them and had tried to hit/swat at them as well as thrown items at some of them when they asked her to stop/leave .....Resident also got physically aggressive during attempts for redirection, also throwing items at me [caregiver] and trying to hit/kick and dig her nails into my arms and stomach." * 04/15/25 at 3:31 p.m., "..... resident in [room F] walked into her apartment as [sic] was followed by [Resident #11]. [Resident who resides in room F] states that [Resident #11] went into her closet and was putting on her clothes. [Resident who resides in room F] states when she was trying to get [Resident #11] to stop, [Resident #11] scratched [Resident who resides in room F] on the right upper arm..... [Resident who resides in room [F] does have a skin tear to her right upper arm ....." * 04/30/25 at 9:26 a.m., "..... resident went into [resident's room G] and started pushing the resident in [room G] ..... While staff member was attempting to separate the residents, [Resident #11] was slapped on the face by resident in room [G] and [Resident #11] began to bleed from her right eye.....Resident [#11] had a significant scratch to cornea. Scratch began to blister. . . . appears to be in pain due to scratch. The blood blister eventually spanned entire cornea. . . . resident was transported to [hospital name] ER [emergency room]." * 04/30/25 at 11:57 a.m., "..... found [Resident #11] in [room E's] bathroom, she had bm in her pants and had gotten it on [room E's] bathroom floor and toilet seat..... as I was cleaning her legs	B 910		

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B 910	Continued From page 6 she started scratching, punching, hitting and slapping me, somewhere in there I got a mark under my right eye causing some pain and burning irritation....." * 06/14/25 at 2:18 p.m., "..... Tonight at about 10:30 pm [Resident #11] decided to start undressing in the middle of the dining room and when [staff name] attempted to lead her towards the bathroom.....[Resident #11] decided to start following her [staff member] around cursing at her attempting to hit her.....[Resident #11] ended up hitting and throwing things ..... One item she decided to throw at me happened to be a large glass vase that was in the middle of the dining table. She threw it across the table at my head, which I barely dodged.....it shattered all over the floor covering the entire dining room floor with glass and water. When attempting to get [Resident #11] out of the area ..... she started hitting and kicking again, we ended up calling for back up and [two staff names] ended up coming over to help. [Resident #11] goteven more aggressive and began pinching, which drew blood and bruised [coworkers name]....." * 06/14/25 at 2:27 p.m., "..... Resident was yelling, hitting, and attempting to run away [during cares]. . . . Resident required assistance of 3 people to ensure safety of herself and caregivers at this time ....." * 07/02/25 at 6:30 a.m., "..... resident is agitated, she is hitting staff, walking around undressed refusing to put appropriate clothes on. Yelling at staff, is not redirectable ....." * 07/20/25 at 7:21 p.m., "..... resident was found on the floor of another residents [sic] home....." * 08/08/25 at 1:13 a.m., "..... had a fall in [room E]. . . . found sitting in the bathroom on the floor. . . . small skin tear to her right wrist ....." * 09/11/25 at 12:26 p.m., "..... resident was on the floor in another resident's room....."	B 910		

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B 910	Continued From page 7 The facility failed to effectively manage Resident #11's aggressive physical and verbal behaviors and ensure all residents who reside in the memory care unit and their caregivers live and work in a safe environment. - Review of Resident #12's medical record occurred on 11/13/25 and 11/17/25. Diagnoses included Alzheimer's disease with behavioral disturbance. Resident #12's progress notes stated the following: * 10/13/23 at 8:50 a.m., ". . . saw [name of provider] yesterday . . . Delusional thoughts . . . impulsive behavior, Birds in bedroom, sees people in room. Angry. . . . Yelling/screaming ....." * 10/18/23 at 9:37 p.m., "Staff spent an hour and a half in with [Resident #12] today because she kept saying that she needed help but would not tell staff what was wrong. She was screaming and crying basically the entire shift..... While staff was trying to put her shirt on, she tried biting staff's arm. During dinner she kept screaming and was working up the other residents ..... it got to the point where a private caregiver of another resident was also trying to get her to sit down and calm down. [Resident #12] spit on caregivers back when she turned away .....she was swearing throughout dinner ..... " * 10/19/23 at 6:37 a.m., "[Resident #12] is consuming so much of staff's time. She starts screaming for help even though staff have just gotten done helping ..... Her toileting can take up to 30 minutes alone. Her cares are just so time consuming that staff probably spend anywhere from 1-3 hours with her solely on a normal shift . . . tending to her in some way at least 30 times all together."	B 910		

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B 910	Continued From page 8 * 10/19/23 at 10:00 p.m., ". . . When [spouse] left, she screamed for him and it scared [name of another resident]'s family members and everyone else in the dining area. She also said she was going to kill herself in front of [spouse] so he feels bad and stops cheating on her.....[spouse] tried to kiss her, but she bit him in the face..... She cried after [spouse left] and continued to scream in her room. It was very hard to work with her because she was trying to throw her walker or leave it behind....." * 10/20/23 at 10:10 a.m., " ..... saw [name of provider] yesterday ..... Behaviors continue - anger, screaming, inappropriate behaviors, Impaired judgement, insight ..... " * 10/24/23 at 3:47 p.m., "Physician Follow-up: . . . Has had med changes recently, worsening mental status/behaviors/mood since transition from home.....husband went to appointment with her and is aware that resident was kicking dashboard and unlocked door/opened door at intersection causing it to open up while car was in motion. Transportation driver stopped vehicle immediately....." * 10/26/23 at 1:14 p.m., "Heard [Resident #12] screaming at her husband .....She was in the bathroom, on the side of the counter, trying to sit down on the floor. Husband was trying to keep her from sitting on the floor. When I walked in she was hitting him and yelling at him to leave her alone. I intervened..... She got angry and told me to shut up....." * 10/27/23 at 4:00 p.m., "CNA [certified nurse aide] reports that on 10/24/23 at 7:15 p.m., resident was resting in bed .....resident started talking to her, she told resident she did not understand what she was trying to say and resident became aggressive, kicking her caregiver in the abdomen ....." * 10/30/23 at 12:42 p.m., "Faxed [health care	B 910		

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B 910	Continued From page 9 provider] updating on verbal and physical aggression. Towards self, family, and care givers. Staff has tried redirection, approach, and different care givers and redirection has not been effective. Due to safety concern requested a PRN [as needed] medication be added at this time." * 11/19/23 at 7:24 p.m., "It took med aide and caregiver one hour forty nine minutes to get [Resident #12] in and out of the shower, dressed in PJ's, teeth brushed and in bed." * 11/26/23 at 2:05 p.m., ". . . resident has been up to [sic] her chair since 7 AM [a.m.], intermittently yelling, at noon, this nurse asked CNA to bring resident out for lunch, CNA stated that the husband was going to wait until everyone was out of the dining room because resident was yelling and restless . . ." * 11/27/23 at 10:09 a.m., ". . . [Resident #12] bit down and spit them [medications] out into her pancakes and they [sic] syrup. Then she slapped my other hand and the rest went flying ..... " * 12/04/23 at 8:44 a.m., "..... [Report] received from caregiver 12/2 [December 2nd]. Reports resident was refusing to take medication and spitting out the pills. Residents husband tried to hold resident's mouth shut in order to keep resident from spitting pills out. Resident started to get physical and attempted to hit caregiver ....." * 12/04/23 at 10:06 a.m., "Resident yelling and in distress ..... Reports that resident has been yelling all night as well. Caregivers report other residents unable to sleep due to the yelling. This nurse attempted to feed resident. Resident spitting food out and yelling ..... " * 12/12/23 at 10:35 p.m., " ..... resident is very agitated and screaming out tonight ..... " * 12/14/23 at 6:24 p.m., "..... Resident has been spiting [sic] medications out....." * 12/26/23 at 12:28 p.m., " ..... family member [of a different resident on the same unit as Resident	B 910		

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B 910	Continued From page 10 #12] spoke to me regarding the behavior of this resident [#12] affecting her mother and her mother being unable to sleep the night before due to this resident yelling all night." The facility failed to provide a safe and secure environment for all the residents in the memory care unit, or for staff caring for the residents and family members visiting residents in the unit and failed to develop and implement an effective behavior management plan for Residents #11 and #12. These failures resulted in injuries, fear, and anxiety for other residents, staff, and visitors.	B 910	**B 922** Resident #1's provider was updated regarding change in condition. The "Skin Open Area" policy was reviewed and no changes were made. All residents residing in Basic Care with skin issues or wounds have the potential to be affected by this deficient practice. The licensed nurses were re-educated on the "Skin Open Area" and "Promotion of Skin Integrity" policies on 11/19/2025. To ensure ongoing compliance, all residents with wounds, skin open areas, or skin concerns will be reviewed weekly at the Health Services leadership meetings to ensure physicians were notified and proper documentation is present.	
B 922	33-03-24.1-09,2,b GOVERNING BODY b. Protocols developed by appropriately licensed professionals for use in the event of serious health threatening conditions, emergencies, or temporary illnesses. These protocols must include provisions for: (1) Designation of a licensed health care practitioner for each resident and arrangements to secure the services of another licensed health care practitioner if the resident's designated licensed health care practitioner is not available. (2) Notification of an appropriately licensed professional in the event of an illness or injury of a resident. This State Licensing Rule is not met as evidenced by: Based on record review and staff interview, the	B 922		

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(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) COMPLETE DATE
B 922	Continued From page 11 facility failed notify the resident's health care provider in the event of a pressure ulcer/injury for 1 of 1 sampled resident (Resident #1). Failure to notify the health care provider of a stage two pressure ulcer may result in delay of treatment and/or health complications. Findings include: The facility failed to provide a policy or procedure on provider notification. Review of Resident #1's medical record occurred on all days of survey. Progress notes reviewed from 11/11/24 through 11/13/25 identified the following: *10/01/25 at 2:45 p.m., "The resident has a stage two ulcer to her bottom . . ." *10/11/25 at 8:38 a.m., "This resident stage two pressure sore is healing well. Resident continues to have discomfort with peri care ....." The recored lacked evidence staff notified the health care provider of the stage two pressure ulcer. During an interview on 11/13/25 at 3:30 p.m., two administrative nurses (#1 and #5) confirmed the facility faiiled to notify the provider and implement standing orders.	B 922	(continued from page 11) An audit of all skin open areas, wounds, and skin concerns will be conducted by the Clinical Care Manager or designee weekly for 3 months to verify proper notification and documentation of skin issues are present. If results do not indicate compliance, audits may continue until compliance is achieved. The Health Services Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	
B 924	33-03-24.1-09,2,d GOVERNING BODY d. Infection control practices, including provision of a sanitary environment and an active program for the prevention, investigation, management, and control of infections and communicable diseases in residents and staff members.	B 924		

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	8072	A. BUILDING: _____ B. WING _____	C 11/17/2025

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B 924	Continued From page 12 This State Licensing Rule is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control on 2 of 3 units (Devonshire 1 and Pembrook). Failure to remove soiled gloves, perform hand hygiene, and sanitize the surface after a procedure puts all residents, visitors, and staff at risk for infection and adverse effects from a potential bloodborne pathogen (organism that can cause disease). Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 11/13/25. This undated policy stated, ". . . Procedure: If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: *Before direct contact with residents . . . Before moving from contaminated body site to clean body site . . . After contact with resident's intact skin . . . After contact with inanimate objects . . . After removing gloves . . . handwashing with antimicrobial or non-antimicrobial soap and water must be performed . . . After contact with . . . body fluids, secretions . . . The use of gloves does not replace handwashing . . ." Devonshire 1 - Observation on 11/11/25 at 4:28 p.m. showed two CNAs (#2 and #3) walked towards Resident #2's room with gloved hands. Both CNAs entered the resident's room without removing gloves and performing hand hygiene. The CNAs placed a	B 924	**B 924** Staff members #2, #3, and #7 were re-educated on proper glove use & hand hygiene practices during training conducted on 1/15/2026. Staff member #2 was re-educated on proper sanitation and hygiene during medication administration during training conducted on 1/15/2026. All residents receiving care have the potential to be affected by this deficient practice. Education on proper glove use and hand hygiene, and sanitation was conducted for all health services staff who work in Basic Care on 1/15/2026. All team members unable to attend the in-person training are required to complete the training in Relias by no later than 2/27/2026. To ensure ongoing compliance, an audit of care and medication administration to ensure infection control standards are being followed, including proper glove use, hand hygiene, and sanitation will be conducted by the Clinical Care Manager or designee with results reported to Health Services Director.	

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B 924	Continued From page 13 gait belt on the resident, transferred her to a wheelchair, brought her to the bathroom, and stood and transferred her to the toilet. One CNA (#3) removed and discarded the soiled brief, then exited the room wearing soiled gloves, obtained perineal wipes, and returned to Resident #2's bathroom. Both CNAs stood the resident and one CNA (#3) completed perineal cares and pulled up the resident's brief, underwear, and pants. The CNAs transferred Resident #2 to the wheelchair and wheeled her out of the bathroom. Without removing their soiled gloves and performing hand hygiene, one CNA (#2) handed the other CNA (#3) the resident's glasses to put on the resident. The CNA (#3) then combed the resident's hair and brought the resident to the dining room. The CNA (#3) removed a dining room chair from the table and placed the resident up to the table. Both CNAs removed their soiled gloves and performed hand hygiene in the dining/kitchen area. - Observation on 11/13/25 at 7:37 a.m. showed Resident #3 seated at the dining room table along with two other residents. A medication aide (MA) (#2) approached the resident and stated, "I have your nose spray, eye drops, and blood sugar check." With gloved hands, the MA (#2) administered the eye drops and nasal spray. Then the MA (#2) performed a finger stick on Resident #3, wiped blood off the resident's finger with an alcohol swab, placed the swab on the table, obtained a second drop of blood on the glucose test strip, and placed the glucose meter on the table. The MA (#2) disposed of the lancet, test strip, and alcohol swab, and placed the contaminated glucose meter back in its case. The MA gathered the remaining supplies and without removing the soiled gloves, performing hand hygiene, or sanitizing the tabletop, left the dining area. The MA placed the case (containing the	B 924	(Continued from page 13) Random (1 per week minimum) audits will be conducted weekly for 3 months. If results do not indicate compliance, immediate corrective action and re-education will occur with staff involved. Audits may continue until compliance is achieved. The Health Services Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	

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B 924	Continued From page 14 contaminated glucose meter) back into the medication cart and removed the soiled gloves. This surveyor intervened and had MA remove the glucometer for disinfection. The MA (#2) entered the kitchen to do meal service and started to grab a new set of gloves. This surveyor intervened and informed the MA of required hand hygiene before applying new gloves and assisting with meal service. Pembrook 1 Observation on the Pembrook unit on 11/11/25 at 5:27 p.m. showed a CNA (#7) picked up two residents' supper plates from the dining room table with gloved hands, scraped the remains into the garbage, and placed the plates on the dirty dish rack. Without removing the soiled gloves and performing hand hygiene, the CNA (#7) picked up Resident #7's metal water bottle, unscrewed the cover, filled the bottle from the water dispenser, and gave the bottle back to the resident. Wearing the same soiled gloves, the CNA continued to pick up, scrape, and place dirty plates on the rack. The CNA (#7) then removed her gloves and without performing hand hygiene, touched and moved items on the top of the medication cart, grabbed a disposable cup and filled it from the coffee dispenser for Resident #8, and then applied gloves, without performing hand hygiene first. During an interview on 11/13/25 at 3:30 p.m. two administrative staff (#1 and #5) confirmed staff should follow policy and procedures for infection control practices.	B 924		
B 928	33-03-24.1-09,2,h GOVERNING BODY	B 928		

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B 928	Continued From page 15 h. Resident rights which comply with North Dakota Century Code chapter 50-10.2. This State Licensing Rule is not met as evidenced by: Based on observation, record review, review of the North Dakota Century Code, review of facility policy, and staff interview, the facility failed to comply with resident rights for 2 of 10 sampled residents (Residents #3 and #9). Failure to provide Resident #3 and/or his/her representative with a written notice of transfer/discharge upon transfer to the hospital is an infringement on the resident's rights and limits their ability to make informed decisions regarding medical care. Failure to ensure privacy for Resident #3 and other residents seated near the resident during blood sugar testing and administration of nasal spray and eye drops is an infringement on the residents' rights and can result in emotional distress, loss of dignity, and a diminished quality of life. Findings include: Review of the North Dakota Century Code, chapter 50-10.2: Rights of Health Care Facility Residents, stated, ". . . Residents' rights - Implementation . . . The right to receive at least a thirty-day written advance notice of any transfer or discharge when the resident is being discharged to another facility . . . because of a change in the resident's level of care; however, advance notice of transfer or discharge may be	B 928	**B 928** Resident #3 moved out of facility on 1/22/2026. All residents receiving medications or treatments or who are transferring from our facility have the potential to be impacted by this practice. A Notice of Transfer form has been initiated and will include transfers for: • Medical reasons • The resident's welfare or that of other residents • Nonpayment of one's rent or fees: or • A temporary transfer during times of remodeling. Education for the licensed nurses and all Basic Care staff responsible for completing a Notice of Transfer form has been completed. Medications and treatments should be administered in a private setting according to our "Medication Service" policy. All medication aides and licensed nurses working in Basic Care have received further training on our policy on 1/15/2026. All team members unable to attend the in-person training are required to complete the training in Relias by no later than 2/27/2026.	

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B 928	Continued From page 16 less than thirty days if the resident has urgent medical needs that require a more immediate transfer or discharge . . ." Review of the facility policy, titled "Resident Rights" occurred on 11/13/25. This policy, dated April 2025, stated, ". . . The right to have privacy in treatment and in caring for personal needs . . . The right to be treated . . . with the fullest measure of dignity....." Review of the facility policy/procedure titled, "Medication Service" occurred on 11/13/25. This policy, dated April 2025, stated, "".....trained or licensed team member administering or assisting with medications shall follow ..... The administration/assistance of medications or treatments should occur outside of the Dining Room area ..... " -Review of Resident #9's medical record occurred on all days of survey. The nurses' notes stated the following: * 04/22/25 at 11:36 a.m., "The resident brought to [hospital name] ER [emergency room]....." * 04/23/25 at 7:54 a.m., "Resident is being admitted to [name] hospital..... " * 04/28/25 at 2:59 p.m., "..... the resident will be discharged from the hospital tomorrow and will be going to [name of skilled nursing facility] for short term rehab." The record lacked evidence the facility provided the resident/representative with a Notice of Transfer upon transfer to the hospital. During an interview on 11/13/25 at 12:40 p.m., an administrative nurse (#1) stated, "We don't have a notice of transfer" for Resident #9's transfer to the hospital in April, and stated, "We were not	B 928	(continued from page 16) To ensure ongoing compliance, an audit of resident transfers to verify appropriate transfer paperwork was sent when transferring will be conducted by the Clinical Care Manager or Health Services Director during the weekly Health Services leadership meetings. Audits will be conducted weekly for 3 months. If results do not indicate compliance, immediate corrective action and re-education will occur with involved staff. Audits may continue until compliance is achieved. An audit of randomly selected medication administration will be conducted weekly by the Clinical Care Manager or designee. Audits will be conducted weekly for 3 months. If results do not indicate compliance, immediate corrective action and re-education will occur with staff involved. Audits may continue until compliance is achieved. The Health Services Director is responsible for ensuring compliance. The deficiency will be corrected on 2/27/2026.	

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B 928	Continued From page 17 aware of this process [to provide notice of transfer/discharge forms]." -Observation on 11/13/25 at 7:37 a.m. showed Resident #3 seated at the dining room table along with two other residents. A medication aide (MA) (#2) approached the resident and stated, "I have your nose spray, eye drops, and blood sugar check." With gloved hands the MA (#2) administered the eye drops, and nasal spray, and performed a blood sugar check on Resident #3. The MA (#2) failed to honor Resident #3's and the other residents seated in the dining room rights to privacy and dignity. During an interview on 11/13/25 at 3:30 p.m. two administrative staff (#1 and #5) stated they expected staff to follow the policy and procedures for medication administration and resident rights.	B 928		
B1220	33-03-24.1-12,2 RESIDENT ASSESSMENTS/CARE PLANS 2. The assessment must be completed in writing by an appropriately licensed professional. The assessment must include: a. A review of health, psychosocial, functional, nutritional, and activity status. b. Personal care and other needs. c. Health needs. d. The capability of self-preservation. e. Specific social and activity interests.	B1220		

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B1220	Continued From page 18 This State Licensing Rule is not met as evidenced by: Based on record review, policy review, observation, and staff interview, the facility failed to adequately assess the individual needs/problems for 1 supplemental resident (Resident #13) with nutritional concerns.Failure to assess and implement interventions to address resident needs placed the resident at risk for impairment of nutrition intake and alteration in over-all health status. Findings include: Review of the facility policy titled: "Resident Assessment" occurred on 11/13/25. This policy, revised April 2025, stated, ". . . On-going assessments shall be reviewed and updated every 90-180 days or upon a significant change of condition that changes the resident's care and services . . . the resident, family and/or legal designee will be contacted on the date provided in the electronic assessment to schedule a care conference regarding the assessment and services or changes for the resident . . . monitor and document significant changes in the resident's physical, mental or emotional functioning . . . the services plan shall be reviewed and updated . . . based on current assessment of the resident . . ." Review of Resident #13's medical record occurred on all days of survey and included diagnoses of Alzheimer's dementia and right sided flaccidity. Observations showed the following: *11/11/25 at 9:00 a.m. and 12:12 p.m. and 11/12/25 at 8:30 a.m. and 5:15 p.m. showed	B1220	**B1220** Resident #13 was reassessed to evaluate nutritional status and ability for adaptive interventions. The resident's care plan was updated to account for resident's needs. Any resident who have weight loss or nutritional concerns could be affected by this deficient practice. Licensed nurses were re-educated on the weight loss policy on 11/17/2026. Residents with weight loss or nutritional concerns will be reviewed weekly at the Health Services leadership meeting to ensure care plans have been adjusted accordingly and to assess if further interventions are needed. To ensure ongoing compliance, an audit of resident assessments and care plans regarding nutritional status and weight loss will be conducted by the Clinical Care Manager or designee. Dining room observations of resident nutritional status and ability to eat independently will be conducted by the Clinical Care Manager or designee in order to observe any changes to resident nutritional status.	

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B1220	Continued From page 19 Resident #13 at the dining room table attempting to eat with her left hand/fingers. Foods included scrambled eggs, meat, oatmeal/cereal, mixed vegetables, and mashed potatoes. Resident #13's care plan, dated 10/30/25, stated ". . . meal tracking . . . regular texture/thin liquids . . . staff to notify the Resident Care Manger (RCM) or Registered Nurse (RN) if change in eating or drinking . . . has a hard time with regular silverware . . . which can impact her intake . . ." During an interview on 11/13/25 at 12:30 p.m., two administrative staff members (#1 and #5) confirmed Resident #13 has difficulty feeding herself with regular eating utensils. The facility failed to assess for and provide food in a consistency (finger foods) and/or provide self-feeding equipment to meet Resident #13's needs.	B1220	(continued from page 19) Audits will be conducted weekly for the next 3 months. Audits may continue until compliance is achieved. The Health Services Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	
B1240	33-03-24.1-12,4 RESIDENT ASSESSMENTS/CARE PLANS 4. The care plan must be updated as needed, but no less than quarterly. This State Licensing Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the care plan (service plan) reflected each resident's current status for 2 of 10 sampled residents (Resident #1 and #9) reviewed. Failure to review and revise the care plan limits staff's ability to meet the residents' current care needs. Findings include:	B1240	**B1240** Resident #1's care plan was updated to include the problem and interventions related to treatment and prevention of pressure ulcers. Resident #9's care plan was updated to include the problem and interventions related to treatment and prevention of skin issues. All residents who have skin concerns could be affected by this deficient practice.	

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B1240	Continued From page 20 -Review of Resident #1's medical record occurred on all days of survey. Progress notes identified the following: *10/01/25 at 2:45 p.m., "The resident has a stage two ulcer to her bottom . . ." *10/11/25 at 8:38 a.m., "This resident [sic] stage two pressure sore is healing well. Resident continues to have discomfort with peri [perineal] care ..... " Review of Resident #1's care plan lacked a problem and interventions related to treatment and prevention of pressure ulcers. - Review of Resident #9's medical record occurred on all days of survey. The progress notes stated the following: * 10/09/25 at 12:27 p.m., "Resident obtained left lower leg hematoma during transfer out of bed this morning ..... " * 10/10/25 at 10:03 a.m., "Resident obtained a right leg hematoma last evening 10/9/25 during cares ..... " Review of Resident #9's care plan lacked a problem and interventions related to treatment and prevention of skin issues.	B1240	(continued from page 20) Education regarding proper assessment of skin concerns and the necessary care plan inclusions was conducted with the licensed nurses on 11/19/2025. To ensure ongoing compliance, all residents with wounds, skin open areas, or skin concerns will be reviewed weekly at the Health Services leadership meetings. An audit of all skin open areas, wounds, and skin concerns will be conducted by the Clinical Care Manager or designee weekly for 3 months, to ensure that care plans have been updated to include the problem and interventions related to treatment and prevention of skin concerns. If results do not indicate compliance, audits may continue until compliance is achieved. The Health Services Director is responsible for ensuring compliance.	
B1320	33-03-24.1-13,2 RESIDENT RECORDS 2. Resident records must include: a. The resident's name, social security number, marital status, age, sex, previous address, religion, personal licensed health care practitioner, dentist, and designated representative or other responsible person. b. The licensed health care practitioner's	B1320	Deficiency will be corrected on 2/27/2026.	

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B1320	Continued From page 21 orders and report of an examination of the resident's current health status. c. An admission note. d. A copy of an initial and current assessment and care plan. e. Documentation of resident observations by authorized staff. f. Documentation of death, including cause and disposition of the resident's personal effects, money, or valuables deposited with the facility. g. A quarterly progress note documenting the resident's current health condition, level of functioning, activity involvement, nutritional status, psychosocial interactions, and needs. h. Documentation of review of prescribed diets. i. Transfer forms that are completed, signed, and sent with the resident when transferred to another facility. j. A medication administration record documenting medication administration consistent with applicable state laws, rules, and practice acts. k. Documentation of an annual medication regimen review. l. A written report of any funds kept at a	B1320	**B1320** Resident Care Manager conducted and documented fire drill walk-throughs for residents #1, #4, #5, #6, #7, #8, #9, and #10. Resident #3 moved out of our facility on 1/22/2026. All residents who have not received a fire drill walk-through are affected by this deficient practice. Resident Care Manager will audit all other resident records and conduct fire drill walk-throughs with any resident that does not have one documented. Resident #11 passed away on 9/24/2025. Any basic care resident who passes away has the potential to be impacted by this deficient practice. Licensed nurses will be re-educated on the proper documentation of a resident's personal affects upon death on 2/4/2026. Any nurses not able to attend in person will be re-educated no later than 2/27/2026. To ensure ongoing compliance, the Fire Drill Walk-through has been added to the new move-in checklist. The Clinical Care Manager or designee will audit new move-ins monthly for the next 3 months to ensure proper fire drill walk-through documentation.	

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B1320	Continued From page 22 resident's request. Such record shall show deposits to and withdrawals from the fund. m. Documentation of a fire drill walk-through within five days of admission. n. All agreements or contracts entered into between the facility and the resident or legal representative. o. A discharge note. This State Licensing Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure complete medical records for 9 of 10 sampled residents (Resident #1, #3, #4, #5, #6, #7, #8, #9, and #10) and one closed record resident (Resident #11) reviewed. Failure to take newly-admitted residents on a fire drill walk-through of the facility may affect the safety of each resident. Failure to document the disposition of a resident's personal effects, money, or valuables following a resident's death does not ensure the resident's personal possessions are returned to the family or resident representative. Findings include: Medical record reviews occurred during all days of survey. - The medical records for Resident #1, #3, #4, #5, #6, #7, #8, #9, and #10 lacked documentation of a fire drill walk-through within five days of admission. During an interview on 11/13/25 at 9:00 a.m., an	B1320	(continued from page 22) The Health Services Director or designee will audit the resident record before closing the residents' chart to ensure it includes disposition of the residents effects, money, or valuables deposited with the facility. Audits will be conducted upon resident death to ensure compliance and will continue weekly for 3 months. The Health Services Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	

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B1320	Continued From page 23 administrative staff member (#5) stated during pre-admission or on the day of admission, the facility staff completed a "verbal" walk-through of the fire emergency plan with the resident's family. The administrative staff member denied facility staff walked each newly-admitted resident to the fire exits and evacuation area. - Resident #11's record identified the resident passed away at the facility on 09/23/25. The record failed to include disposition of the resident's personal effects, money, or valuables deposited with the facility. During an interview on 11/13/25, an administrative staff member (#1) confirmed staff failed to document disposition of belongings in Resident #11's medical record.	B1320		
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered. This State Licensing Rule is not met as evidenced by: Based on observation, record review, review of the facility policy, and staff interview, the facility	B1540	**B1540** MA #6 was educated on the proper technique to prime and administer insulin using and insulin pen. Re-education occurred on 1/15/2026. All residents receiving insulin injections could be affected by this deficient practice. The medication administration policy was updated to reflect the proper priming and administration practices.	

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B1540	Continued From page 24 failed to ensure proper administration of medications for 1 of 1 resident (Resident #3) observed during insulin administration. Failure to properly prime an insulin pen may result in adverse consequences for the residents. Findings include: Review of the facility policy/procedure titled, "Medication Service" occurred on 11/13/25. This policy, dated April 2025, stated, ". . . trained or licensed team member administering or assisting with medications shall follow: . . . manufacturer directions for each individual treatments before administration . . . The administration/assistance of medications or treatments should occur outside of the Dining Room area . . ." Review of the facility policy/procedure titled, "Assessment for Skill Proficiency with Insulin Injection Using a Pen" occurred on 11/13/25. This undated policy/procedure stated, ". . . prime the insulin pen . . . have pen turned upwards and push the knob all the way . . . leave the needle inserted for about 5 seconds . . ." Review of administration instructions for Lantus (a long-acting insulin) found at https://www.lantus.com/dam/jcr:817aed9c-a677-4cd6-a6b3-d93d8aba629a/lantus-solostar-pen-guide.pdf, stated, ". . . How to Use Your Lantus Solostar Pen . . . Dial a test dose of 2 Units. Hold pen with the needle pointing up . . . Use your thumb to press the injection button all the way down ..... slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose.) Release the button and remove the needle from your skin." Review of Resident #3's medication	B1540	(continued from page 24) Re-education on insulin administration occurred with all med aides and licensed nurses on 1/15/2026. Licensed nurses and med aides who were unable to attend the in-person training are required to complete competency sign offs no later than 2/27/2026. The Clinical Care Manager or designee will conduct random (1 per week minimum) audits of insulin priming and administration by observing med-techs as they prime and administer to ensure proper administration. Audits will be conducted weekly for 3 months. . If results do not indicate compliance, immediate corrective action and re-education will occur with staff involved. Audits may continue until compliance is achieved. The Health Services Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	

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B1540	Continued From page 25 administration record (MAR) occurred on 11/13/25. A physician's order included Lantus 15 units under the skin one time per day. Observation on 11/13/25 at 7:37 a.m. showed a medication aide (MA) (#6) prepared insulin for Resident #3. The MA applied a needle to the resident's Lantus insulin pen, dialed the pen to two units and held the pen horizontally to prime. The MA then injected the insulin into the Resident's abdomen and immediately removed the needle/pen. The MA failed to prime the insulin pen with the needle pointing up and failed to hold the needle/pen in place and slowly count to 10 before removing. During an interview on 11/13/25 at 3:30 p.m., two administrative staff members (#1 and #5) confirmed the MA failed to prime and administer the insulin properly.	B1540	**B1700** Resident #1's provider was notified and the residents' care plan was updated to include physician standing orders and appropriate nursing services were implemented to meet resident's condition. The facility policy "Physician Orders" was reviewed and no changes were made. All residents residing in Basic Care with skin issues or wounds have the potential to be affected by this deficient practice.	
B1700	33-03-24.1-17 NURSING SERVICES 33-03-24.1-17. Nursing services. Nursing services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate individual or agency providing nursing services. This State Licensing Rule is not met as evidenced by: Based on record review the facility failed to provide nursing services to meet resident's needs for 1 of 1 sampled resident (Resident #1) with a pressure ulcer. Failure to transcribe and implement physician standing orders may result	B1700		

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B1700	Continued From page 26 in delayed treatment, longer treatment times, and negative health outcome. Findings include: The facility failed to provide a policy on transcribing and implementing physician orders. Review of Resident #1's medical record occurred on all days of survey. Notes identified: *10/01/25 at 2:45 p.m., "The resident has a stage two ulcer to her bottom . . ." *10/11/25 at 8:38 a.m., "This resident stage two pressure sore is healing well. Resident continues to have discomfort with peri care ....." Review of signed physician Standing Orders identified the following orders for a Stage 2 Pressure Injury: *Implement repositioning scheduled and pressure relief on affected area(s). *Vitamin C 500 mg (milligrams) PO (by mouth) BID (twice a day) until healed. *Multivitamin with minerals QD (daily) until healed. *Zinc 200 mg PO TID (three times a day) times 3 days. *Nutritional protein supplement 4 ounces BID until healed. *Draw albumin and prealbumin levels (lab work). *Cleanse with warm, soapy water (no peroxide), lightly pat dry, apply duoderm (hydrocolloid dressing to promote healing) or foam dressing and change every 3 days and as needed (PRN). Review of the October and November 2025 medication administration record (MAR) failed to show staff transcribed and implemented the orders.	B1700	(continued from page 26) The licensed nurses were re-educated on the "Physician Orders," "Skin Open Area" and "Promotion of Skin Integrity" policies on 11/19/2025. To ensure ongoing compliance, all residents with wounds, skin open areas, or skin concerns will be reviewed weekly at the Health Services leadership meetings to ensure physicians were notified and physician orders have been transcribed and implemented. An audit of all skin open areas, wounds, and skin concerns will be conducted by the Clinical Care Manager or designee to verify physician orders have been transcribed and implemented. Audits will be conducted weekly for 3 months. If results do not indicate compliance, audits may continue until compliance is achieved. The Health Services Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	

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B1800	Continued From page 27 33-03-24.1-18 DIETARY SERVICES 33-03-24.1-18. Dietary services. The facility must meet the dietary needs of the residents and provide dietary services in conformance with the North Dakota sanitary requirements for food establishments. Dietary services must include: This State Licensing Rule is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide dietary services in conformance with the North Dakota sanitary requirements for food establishments on 2 of 3 days of survey (November 11-12, 2025). Failure to properly label and date opened food, prepare and serve food in a sanitary manner, and ensure clean fans/floors in food prep and storage areas and proper cold storage in a walk-in freezer may result in foodborne illness for residents, staff, and visitors. Findings include: Review of the facility policy titled "Food Storage and Labeling" occurred on 11/13/25. This undated policy stated, ". . . Label and date food with the product name, the date it was opened or prepared, the name of the person who opened/prepped it, the use-by date or shelf life and the Manager's signature . . . do not take risks: When in doubt, throw it out!". Review of the facility policy titled "Handwashing and Hand Maintenance and Wearing gloves for food safety" occurred on 11/13/25. This undated policy stated, ". . . all team members must wash	B1800 B1800	**B1800** All basic care residents have the potential to be affected by this deficient practice. All unlabeled, undated, or improperly stored food items identified in the refrigerators and freezers were discarded on 11/11/2025. The fan in the food prep area was permanently removed on 11/12/2025. The freezer was defrosted and thoroughly cleaned on 11/18/2025. The daily sanitation checklist was revised to include freezer frost and foreign objects in the kitchen. Re-education on proper food labeling (product name, date opened/prepared, use by date), hand washing and glove use, and sanitation was conducted in-person with all dining staff on 1/27/2026. Any staff unable to attend the in-person training must complete the required Relias training no later than 2/27/2026. The Executive Chef or designee will audit the coolers, refrigerators, and freezers to ensure proper food labeling and dating and food prep and storage area cleanliness. Audits will be conducted weekly for 3 months. Any identified issues will result in immediate corrective action and re-education of staff involved. If results do not indicate compliance, audits may continue until compliance is achieved.	

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B1800	Continued From page 28 their hands before and after the following . . . performing any food service tasks . . . change your gloves often . . . change them in all the following situations . . . if they become contaminated . . . when switching tasks . . . you should always wash your hands before putting on new pair of gloves . . ." The 2022 Food Code U.S.(United States) Food and Drug Administration, Chapter 3, pages 61-62, stated, ". . . 3-304.15 . . . SINGLE-USE gloves shall be used for only one task . . . used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation ....." - Initial observation of the main kitchen on 11/11/25 at 8:25 a.m. with the culinary manager (#13) showed the following: * Two large containers of cooked chicken and pork chops and one large container of cooked potatoes and vegetables in the walk-in fridge were unlabeled and undated. * One unsealed, unlabeled, and undated corned beef container in the main refrigerator. * One unsealed, unlabeled, and undated bag of sliced cheese in the main refrigerator. * A fan on the floor in the clean food preparation area with accumulated dust clumps blowing towards the preparation area. * One walk-in freezer with frost accumulation around the fan and boxes and containers of food with frost on them. A sticky substance and food debris were found on the freezer floor. - Additional observations on 11/11/25 showed the following: * 9:45 a.m., A dietary staff member (#14) wore gloves, stirred a pot of food, and then opened a freezer door, removed a box of food, removed	B1800	(Continued from page 28) Re-education on food handling, glove use, and sanitation occurred for the health services team on 1/15/2026. Basic Care staff who were unable to attend the in-person training will complete the Relias training no later than 2/27/2026. The Resident Care Manager or designee will conduct an audit of a meal weekly to ensure hand hygiene and glove use policies are being followed, and surfaces are being sanitized properly. Audits will be conducted weekly for 3 months. Any identified issues will result in immediate corrective action and re-education of staff involved. If results do not indicate compliance, audits may continue until compliance is achieved. The Dining Services Director is responsible for compliance. Deficiency will be corrected on 2/27/2026.	

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B1800	Continued From page 29 packages of meat, and cut the meat up. While wearing the same gloves, the staff member touched pieces of bread and cheese, cut up an onion, touched the pan and cooking utensils, and continued to cook. The staff member failed to remove their gloves or perform hand hygiene between tasks. * 11:30 a.m., At the end of meal service, an unidentified certified nurse aide (CNA) cleaned the food service area counter with hand sanitizing wipes. The CNA failed to use an appropriate cleaner/disinfectant to clean the surface/counter. * 12:00 p.m., A staff member (#8) opened a refrigerator door, cupboards, and drawers with gloved hands. Without changing gloves, the staff member (#8) reached into a container of shredded lettuce and placed the lettuce onto residents' lunch plates. During an interview on 11/13/25 at 3:30 p.m., the culinary manager (#13) stated she expected staff to follow food handling and safety practices.	B1800	**B1940**	
B1940	33-03-24.1-19,4 ACTIVITY SERVICES 4. Assist residents with arrangements to participate in social, recreational, religious, or other activities within the facility and the community in accordance with individual interests and capabilities. This State Licensing Rule is not met as evidenced by: Based on observation, review of facility policy, and family, resident, and staff interviews, the facility failed to provide individualized activities in 1 of 2 secured memory care units (Devonshire 2). Failure to educate caregivers who work in the	B1940	Resident #14's care plan was updated to include individual activity interests. All resident care plans are being audited to ensure they include a detailed activity profile. Resident care plans that did not have a detailed activity profile will be updated to reflect resident's interest by no later than 2/27/2026.	

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B1940	Continued From page 30 memory care unit on each resident's individual activity interests and provide those activities based on the interests and capabilities when unable to attend/participate in scheduled activities inside/outside the unit or in between activities may result in boredom, increased behaviors, and decreased quality of life. Findings include: Review of the facility policy titled "Memory Care & Pembrook Life Enrichment" occurred on 11/13/25. This policy, reviewed 04/04/25, stated, ". . . It is the policy of Touchmark to have life enrichment opportunities available for residents on a scheduled and unscheduled basis..... The life enrichment calendar will be based on the interests of residents who are currently living in our memory care communities. We encourage families of all new residents who are moving in to complete a social history/personal interest form. Items identified in this social history will be weaved into Touchmark's monthly memory care life enrichment calendar..... The monthly life enrichment calendar will have 5-8 daily activities going on per day..... Spontaneous or 1:1 activities will be introduced into daily routine as staff time allows and/or residents needs change or require it due to behaviors....." Confidential family interviews on the morning of 11/11/25 identified the following: * Family member A stated, "I question the programming. They [residents] sit and do nothing a lot. Staff are not engaging with the residents" and "The unit is not very homey [noisy]. Activities are not individualized." * Family member B stated, "Too much stimulation in here [Devonshire 2]. Like the TV [in the dining room] playing music all day long" and "They	B1940	(Continued from page 30) Training was conducted with all Basic Care caregivers on the caregiver role in providing resident activity based on resident preference, knowing where to access resident interest information, and updating Health Services leadership team when interests change. Training occurred on 1/15/2026. Basic Care staff who were unable to attend the in-person training must complete the Relias training no later than 2/27/2026. Resident Care Manager or designee will conduct audits of the Memory Care Neighborhoods to ensure that Basic Care Caregivers provide activities to residents unable to attend/participate in scheduled activities, and that they know each resident's activity interest or where to access that information. Audits will be conducted weekly for 3 months (1 per week minimum). If results do not indicate compliance, immediate corrective action and re-education will occur with staff involved. Audits may continue until compliance is achieved. The Health Services Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	

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B1940	Continued From page 31 [activity staff] plan an event calendar for all residents and it's not appropriate for all." - Observation on 11/11/25 at 8:25 a.m. until 11:55 a.m. (3.5 hours) showed Resident #14 seated at a table in the dining area, head hanging down towards chest, and back faced to a television screen mounted on the wall playing music. The only staff engagement during this time occurred when staff gave the resident a mid morning snack. The resident remained seated in the same place with head hanging down. At 11:55 a.m., when this surveyor asked if he/she had enough to do, the resident stated, "Not really." - Observation on 11/12/25 at 9:00 a.m. identified a whiteboard setting on a kitchenette counter listed the day's activities as follows: * 9:30 a.m., Polka Spotlight Channel 12 (on unit) * 10:30 a.m., Snack Time (on unit) * 2:00 p.m., Chapel Service (off unit) * 3:00 p.m., Catholic Mass (off unit) * 6:00 p.m., Puzzle Past Time with Caregivers (on unit) - Observation on 11/12/25 at 9:45 a.m. showed three residents seated in a lounge area in front of a television viewing the polka spotlight, while at the same time a television in the adjacent dining room played different music (competing televisions). During this time, one resident sat at a dining room table with nothing in front of them and another resident continuously walked the hallway. - Observation on 11/12/25 at 2:21 p.m. showed two residents continuously walked the hallways and another resident seated at a dining room table staring out the window while three staff members (#9, #10, and #11) conversed by the	B1940		

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B1940	Continued From page 32 kitchenette counter. When asked how many residents left the unit to attend the chapel service, a staff member (#9) stated, "About three." When asked what activity was being offered for those residents who did not go to church, the staff member (#9) stated, "Well, some will go to Catholic Mass later." When asked what activities are provided for residents who do not or are not able to participate in activities outside the unit or in between scheduled activities in the unit, the staff member (#9) stated, "Just a minute, let me turn this [television in the dining room] down," walked to the television, and turned down the volume. The staff (#9) then opened a locked closet door and stated the items in the closet are used for the residents' activities. When asked if the caregivers in the unit knew what each resident's individual interests were, the staff members (#9, #10, and #11) all stated "No" and staff member #9 stated, "Most like manicures." The facility failed to provide/educate the memory care unit caregivers on resident's individual activity interests and provide those activities based on the resident's capabilities when unable to attend/participate in scheduled activities inside/outside the unit or in between activities held within the unit.	B1940	**B2305** Resident #11 passed away on 9/24/2025. Resident #4's care plan was updated to include the resident's condition requiring treatment, services provided, hospice contact information with the criteria for contacting the agency between visits or after hours, hospice care interventions, and cares provided by each entity. All basic care residents receiving hospice care could be affected by this deficient practice.	
B2305	33-03-24.1-23,5 End-of-Life Services 5. The facility, in consultation with the resident or resident's designee, shall develop and implement an interdisciplinary care plan that identifies how the resident's needs are met and includes delineation of the roles of facility staff and others in the provision of care and services for the resident in need of end-of-life care and a list of medications the resident receives related to	B2305		

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B2305	Continued From page 33 end-of-life care and who is authorized to administer the medications. This State Licensing Rule is not met as evidenced by: Based on record review, the facility failed to develop and implement an interdisciplinary care plan that identified how the resident's needs are met and include delineation of the roles of the facility staff and others in the provision of care and services for 1 of 2 sampled residents (Resident #4) and 1 of 2 closed records (Resident #11) reviewed for end-of-life services. Lack of interdisciplinary care plans and delineation of specific roles may result in unmet needs for residents receiving end-of-life services. Findings include: Review of Resident #4's medical record occurred on all days of survey and identified admission to hospice on 09/29/25. The care plan failed to include the resident's condition requiring treatment, services provided, hospice contact information with the criteria for contacting the agency between visits or after hours, hospice care interventions, and cares provided by each entity. Review of Resident #11's medical record occurred on 11/13/25 and identified admission to hospice on 06/10/25. The care plan failed to include the resident's condition requiring treatment, services provided, hospice contact information with the criteria for contacting the agency between visits or after hours, hospice care interventions, and cares provided by each	B2305	(Continued from page 33) Care plans of all basic care residents receiving hospice care were reviewed to ensure an interdisciplinary care plan was developed and implemented. Licensed nurses were re-educated on ensuring an interdisciplinary care plan is developed and implemented and that it includes delineation of roles and provision of care and services. Re-education took place on 1/28/2026. The Health Services Director will audit all new hospice admissions within one week to ensure a complete interdisciplinary care plan is developed and implemented. Audits will be conducted upon a resident's admission to hospice and will continue weekly for 3 months. An audit of residents receiving hospice care will be conducted by the Health Services Director or designee to ensure an interdisciplinary care plan has been developed and implemented. Audits will be conducted weekly for 3 months. If results do not indicate compliance, immediate corrective action and re-education will occur with staff involved. Audits may continue until compliance is achieved.	

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	8072	A. BUILDING: _____ B. WING _____	C 11/17/2025

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B2305	Continued From page 34 entity.	B2305	(Continued from page 34) The Health Services Director is responsible for ensuring compliance.	
B2413	33-03-24.1-24,13 Optional Alzheimer's, Dementia, Special Mem If the facility or unit is unable to meet the needs of the resident, or the resident no longer meets the criteria for retention, the facility promptly shall make arrangements to discharge or transfer the resident to a safe and appropriate placement consistent with the level of care required to meet the resident's needs. This State Licensing Rule is not met as evidenced by: Based on record review, review of facility policy, review of the facility's criteria for residents to reside in the memory care unit, and family interview, the facility failed to meet the criteria for retention for 1 of 2 closed records (Resident #11) reviewed. Failure to meet the physical, mental, and psychosocial needs of the resident did not allow the resident to maintain the highest level of functioning and contributed to a disruptive and chaotic living environment which caused anger, fear, and anxiety in other residents, visitors, and staff on the units. Findings include: A facility document titled "Criteria for Residency in Memory Care" stated, " ..... 3. Resident is not a risk of injury to self or others and accepts staff assistance or redirection through gentle care approach. 4. Resident's health is stable and predictable. 'Stable and predictable' means . . .	B2413	Deficiency will be corrected on 2/27/2026. **B2413** Resident #11 passed away on 9/24/2025. Any resident residing in basic care that displays aggressive behavior has the potential to be affected by this practice. Chart notes, behavior charting, and care plans of residents displaying aggressive behaviors were reviewed by a licensed nurse to determine whether the resident continues to meet the criteria for retention. Residents that did not meet the criteria were discharged to a facility that can meet their needs. Education regarding the aggressive and assaultive residents' policy was provided to all licensed nurses, resident care managers, and caregivers who work in Basic Care on 1/15/2026. All team members unable to attend the in-person training are required to complete the training in Relias by no later than 2/27/2026.	

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B2413	Continued From page 35 behavioral status . . . does not require frequent presence and evaluation of a registered nurse. 5. Resident does not require a chemical . . . restraint. 6. Resident can recognize and respond to danger and evacuate the building independently with verbal cueing, or with one person assisting ..... 10. Resident is able to participate with cueing and direction as necessary, with medication administration and activities of daily living such as dressing, bathing, grooming, etc., with or without assistance of one person. 11. Resident is able to care for some of their own toileting needs, and/or allow staff to assist or give reminder for incontinence management and personal hygiene .....15. If a resident exceeds one (1) or more of the criteria, he/she will be reassessed for proper level of care or discharged to an appropriate setting ..... " During a family interview on the morning of 11/11/25, family member C stated they were aware of a resident-to-resident altercation involving Resident #11 and stated Resident #11 "was quite violent at times and debilitated." - Review of Resident #11's medical record occurred on 11/13/25. Diagnoses included Alzheimer's dementia, altered mental status, agitation, anxiety, restlessness, insomnia, and pain. The record identified several medication classifications (antipsychotic, antianxiety, and antidepressant) with adjustments to dose and times given to attempt to control the resident's behaviors. Resident #11's individualized service plan, dated 07/15/25, included the following: * ".....LN [licensed nurse] will setup and monitor behavior monitoring plan based on residents' medication profile and behavioral tendencies. . . .	B2413	(Continued from page 35) To ensure ongoing compliance, the Resident Care Manager will review behavior charting weekly to identify any changes in behavior or to provide training on interventions when needed. Concerning behaviors or changes in condition that are identified will be brought to the attention of the Health Services Director and Executive Director. The Health Services Director and Executive Director will determine, based on the "Aggressive & Assaultive Residents" policy and the criteria for Basic Care, if the facility is able to meet the needs of the resident. If it is determined that it is unsafe or the resident no longer meets criteria, the facility will make arrangements to discharge or transfer resident to appropriate placement. The Clinical Care Manager or Health Services Director will conduct audits weekly for 3 months to ensure that residents who are inappropriate for basic care are being transferred to a facility that can meet their needs. If results do not indicate compliance, audits may continue until compliance is achieved.	

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B2413	Continued From page 36 Agitation/aggression Triggers: telling her to leave a room that is not hers, Change in environment, routine, and new staff .....talk to her a little bit and ask her to come with you to go have a snack and visit. Do not tell her this is not your room or you need to leave [sic] that may trigger aggression because she doesn't [sic] understand that ..... " * "..... MA [medication aide] or caregiver will record VS [vital signs] and weight monthly....." * "..... requires reminders to perform grooming tasks. Expected result: Maintains independence with grooming and is neat and clean..... Remind [Resident #11] to groom in the morning and evening....." * "..... requires assistance for all shower/bathing needs .....Try to get [Resident #11] in the shower or whirlpool daily, if she refuses make sure to chart that ....." * "..... requires assistance with clothes selection and/or help with dressing/in dressing. [Expected Result] Maintains independent and dignity and is dressed according to Resident's preferences. Clothing is neat and clean....." * "..... has own teeth and needs help with oral care .....Remind [Resident #11] to perform oral cares ....." * "..... requires standby assistance toileting. [Expected Result] Maintains dignity/independence with toileting ..... Wake [Resident #11] up, take her to the bathroom and assist her with getting cleaned up when she is finished....." * "..... Wanders through public spaces within residence..... has a history of wandering and exit seeking, staff will help and redirect as needed. . . ." Review of Resident #11's March through September 2025 progress and behavioral notes identified the facility was unable to implement the	B2413	(Continued from page 36) The Executive Director is responsible for ensuring compliance. Deficiency will be corrected on 2/27/2026.	

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B2413	Continued From page 37 interventions listed in the above service plan due to Resident #11's unmanageable behaviors (see B910). The record identified documented behavioral incidents on 109 of the 191 days reviewed. These behaviors included the following: * Frequent refusal of personal care (toileting, bathing, oral, dressing/undressing). * Frequent aggression towards staff (swatting, punching, scratching, pulling hair, pushing, kicking, slapping, cussing, swinging, pinching, name calling, yelling, chasing, throwing items, smacking, and grabbing on/towards staff) during personal cares and/or redirection attempts from entering/exiting resident rooms or non-resident areas (i.e., in laundry room, in kitchenette area cupboards, pulling on cord to food warmer, throwing glass items). This aggression caused injuries to staff at times. * Frequent entering in other resident rooms (sleeping in their chairs, laying on their beds, using and/or falling in their bathrooms). * Upsetting residents when entered their rooms (rummaged through their personal belongings, wearing their clothes, throwing their personal belongings around, and unwanted touching). One episode resulted in a skin tear to another resident and another episode resulted in an eye injury to Resident #11. * Disrobed in common and/or dining areas. * Refused/spit out medications. * Refused monthly and post fall vital signs. The record lacked evidence the facility discussed with Resident's #11's representative about placement in a facility equipped to meet the behavioral, emotional, and physical needs of the resident.	B2413		