STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 04/10/23 and concluded 04/12/23.	F 000		
F 550 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	F 550		5/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care in a manner and environment that maintained, enhanced, and respected the resident's dignity for 1 of 2 sampled residents (Resident #17) who used a urinal. Failure to provide privacy when using a urinal does not preserve the residents' dignity or enhance their quality of life. Findings include: Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, "Uses urinal independently. . . . likes [sic] to stay in nightgown or has his pants around ankles. Provide privacy. pull [sic] curtain or close door halfway. . . ." Observation on 04/10/23 at 3:33 p.m. showed a certified nurse aide (CNA) (#1) transferred Resident #17 with a mechanical lift from the wheelchair to the resident's recliner. Prior to lowering the resident into the recliner, the CNA pulled the resident's pants down to the ankles exposing the resident's lower half of the body. The CNA failed to close the resident's door or pull the privacy curtain upon exiting the resident's room.	F 550	To ensure corrective action for Resident #17 and any other residents that may be affected by failing to provide care in a manner and environment that maintains, enhances, and respects the resident's dignity, privacy, or the quality of their lives: Education was provided during the Mandatory All Staff meeting on April 25, 2023 on the importance of providing privacy to maintain dignity and the resident's quality of life at all times for Resident #17 and any resident when they are providing cares. The importance of providing privacy by closing window blinds, privacy curtains and doors during any cares that are provided to Resident #17 or any resident was reviewed. Employees that were unable to attend the meeting will be educated by the DON/designee by May 16, 2023. Resident #17 does like to use the urinal independently throughout the day. To ensure continuous privacy, Resident #17 agreed to use a a partial privacy screen that will still allow Resident #17 the ability to see or look out over the privacy screen while maintaining appropriate privacy coverage. The privacy screen will allow	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 550	Continued From page 2 Observation on 04/11/23 at 3:28 p.m. showed two CNAs (#1 and #2) transferring Resident #17 with a mechanical lift from the wheelchair to the resident's recliner. Prior to lowering the resident into the recliner, both CNAs pulled the resident's pants down to the ankles exposing the resident's lower half of the body. The CNAs failed to close the resident's door or pull the privacy curtain upon exiting the resident's room. When asked if it is the resident's preference to have the resident's pants pulled down to the ankles while sitting in the recliner, the CNA (#2) reported the resident prefers it that way for using the urinal. Observation on 04/11/23 at 3:58 p.m. showed Resident #17 sitting in the recliner with the resident's pants down to the ankles. Staff failed to close the door half ways or pull the privacy curtain. During an interview on the evening of 04/12/23 two administrative staff members (#4 and #5) confirmed there was an issue with the privacy of the resident during urinal use and reported they have been working on implementing new measures to ensure the privacy of the resident during urinal use.	F 550	Resident #17 to maintain independence. The privacy screen was ordered and Resident #17's plan of care will be updated to include the privacy screen when it arrives at the facility. To ensure the corrective practice is achieved and maintained, QA monitoring of providing privacy to ensure resident dignity and quality of life will be completed on Resident #17 and a random sample of 20% of the resident population by the DON/designee. QA monitoring will occur weekly x 1 month, monthly x 3 months, and quarterly thereafter for 1 year. Results of the QA audit will be reported by the DON/designee to the monthly QA Committee for review. Any issues identified will be reported to the Administrator and immediately corrected.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection 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.	F 880		5/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 880	Continued From page 3 §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 §483.70(e) 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 880	Continued From page 4 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 5 sampled residents (Resident #2 and #8) observed during personal care. Failure to perform hand hygiene and remove gloves after perineal care and follow enhanced barrier precautions guidelines may result in the spread of infection to other residents. Findings include: Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 04/12/23. This policy, dated 03/20/23, stated, ". . . Enhanced barrier precautions refer to the use of gown and	F 880	Corrective action for Resident #2, Resident #8, and any resident that may be affected by the deficient practice of failing to provide hand hygiene, removing gloves after perineal care, and not following enhanced barrier precaution guidelines which may result in the spread of infection to others was completed during the Mandatory All Staff Meeting on April 25, 2023. A review of the facility policy on hand hygiene and enhanced precautions was completed during the all staff meeting. Any employee that did not attend the all staff meeting will receive this education from the Director of Nursing/designee by May 16th, 2023. To	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 880	Continued From page 5 gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug resistant organism] as well as those at increased risk of MDRO acquisition . . . High-contact resident care activities include: . . . providing hygiene . . . changing briefs or assisting with toileting . . ." - Observation on 04/11/23 at 10:48 a.m. identified enhanced barrier precautions for Resident #8, including the use of gowns and gloves during high-contact resident care activities. Observation showed two certified nurse aides (CNAs) (#1 and #3) donned gloves but failed to put on gowns. A CNA (#3) changed Resident #8's brief and performed perineal care while the resident was in bed. Without removing her gloves, the CNA (#3) placed a new brief, pulled up the resident's pants, placed a mechanical lift sling under the resident, and transferred the resident into the wheelchair. The CNA (#3) then combed the resident's hair, made the bed, and placed the resident's call light and overbed table within reach before removing her gloves and performing hand hygiene. - Observation on 04/11/23 at 11:07 a.m. identified enhanced barrier precautions for Resident #2, including the use of gowns and gloves during high-contact resident care activities. Observation showed two CNAs (#1 and #3) donned gloves but failed to put on gowns. A CNA (#3) changed Resident #2's brief and performed perineal care while the resident was in bed. Without removing her gloves, the CNA (#3) placed a new brief, pulled up the resident's pants, placed a mechanical lift sling under the resident, and transferred the resident into the wheelchair. The CNA (#3) then placed a pillow between the	F 880	ensure the deficient practice does not recur, QA monitoring of hand hygiene and enhanced precautions on Resident #2, Resident #8, and a random sample of 20% of the resident population will be completed. QA monitoring will be completed weekly x 1 month, monthly x 3 months, and quarterly thereafter for a year by the Infection Control Nurse/designee. Results of the QA audit will be reported to the QA committee by the Infection Control nurse/designee. Any issues identified will be reported to the Administrator and immediately corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 880	Continued From page 6 resident's knees, combed the resident's hair, and assisted her with applying lipstick before removing her gloves and performing hand hygiene. During an interview on 04/12/23 at 4:39 p.m., an infection control nurse (#4) stated she expected staff to wear gowns when providing care to Resident #2 and #8 and remove their gloves after perineal care, use hand sanitizer, and put on new gloves.	F 880		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.	F 888		5/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 888	Continued From page 7 §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 888	Continued From page 8 (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 888	Continued From page 9 CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on review of facility policy, and staff interview, the facility failed to include the required elements intended to mitigate the transmission and spread of Covid-19 for all staff who are not fully vaccinated for Covid-19. Failure to implement additional precautions for staff who are not fully vaccinated may lead to increased transmission and spread of Covid-19 among residents, staff, and visitors. Findings include: Review of the policy titled "Covid-19 Vaccination" occurred on 04/13/23. This policy, dated 09/29/22, stated, ". . . It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from Covid-19	F 888	Corrective action to ensure the facility COVID-19 policy includes the elements to mitigate the transmission, spread, and additional precautions of unvaccinated staff are met was completed by updating the facility COVID-19 Policy Plan on April 25, 2023. The facility COVID-19 Plan was updated to include the mitigation requirement for any staff member that is unvaccinated to screen prior to their shift for any signs or symptoms of COVID-19 such as an elevated temp, shortness of breath, cough, runny nose, sore throat, loss of taste/smell, or any gastrointestinal illness. The updated COVID-19 Policy Plan regarding mitigation for unvaccinated staff was reviewed during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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
F 888	Continued From page 10 (SARS-CoV-2) by educating and offering our residents and staff the Covid-19 vaccine . . . " This policy lacked the required elements to mitigate the transmission, spread, and additional precautions of Covid-19, for staff who are not fully vaccinated. During an interview on 04/13/23 at 3:20 p.m., an administrative staff member (#5) confirmed the policy for Covid-19 vaccination lacked the mitigation strategies for transmission, spread, and additional precautions of unvaccinated staff.	F 888	the Mandatory All Staff Monthly Meeting on April 25, 2023. Any employee that was not at the meeting will receive the education on the revisions to the COVID-19 plan by the Director of Nursing/designee by May 16, 2023. The unvaccinated staff will self monitor and document their findings on a screening sheet prior to their shift. If the unvaccinated staff have any signs or symptoms of COVID-19 or identify as a close contact to someone positive with COVID-19 they will report this information to the Infection Control Nurse or Charge Nurse and test for COVID-19 immediately. The unvaccinated staff will turn in their self monitoring documentation sheets weekly to the Infection Control Nurse/designee for review. To ensure the deficient practice does not recur the Infection Control Nurse/Designee will complete QA monitoring that unvaccinated staff are following the mitigation guidance in the COVID-19 Policy Plan. QA monitoring will occur weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The results of the QA Audit will be reported to the QA Committee during the monthly QA meeting by the Infection Control Nurse/designee. Any issues identified will be reported to the Administrator and immediately corrected.	
F9999	FINAL OBSERVATIONS The complaints investigated in conjunction with the standard Medicare/Medicaid survey were not substantiated.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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