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 05/07/2014

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 For the complaint investigation, conducted May 5-7, 2014, the sample included (5) five current residents and (2) two closed record residents for review.	F 000		
F 221 SS=G	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from physical restraints not required to treat the resident's medical symptoms for 1 of 1 closed record resident (Resident #7), identified as having been physically restrained. Failure to assess and manage Resident #7's pain during cares/wound treatments, resulted in Resident #7 being held down against his will in an attempt to control his behavior during those cares/treatments. Due to the resident's severe resistance to cares, the process of wrapping this resident in a blanket caused avoidable psychosocial harm. Findings include: Review of the facility policy "Restraint" occurred on 05/07/14. The policy, revised July 2009, stated, ". . . The resident has the right to be free from any physical . . . restraints that are not required to treat the resident's medical	F 221	**F 221- 483.13 Freedom To Be Free From Physical Restraints**-To ensure the residents are free from any physical restraints imposed for the purpose of discipline or convenience, and not required to treat the resident's medical symptoms: The facility reviewed it's Restraint Policy (See Att. A) with Licensed Nursing staff during their monthly meeting. The policy was reviewed with all other departments during a scheduled mandatory meeting This policy will also be reviewed with new employees, flex employees, and contract employees. An assessment of each resident in the facility will be completed to ensure an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Each resident's plan of care will be reviewed to ensure they are free of unnecessary physical restraints upon admission, quarterly, annually, with a hospital return, and any significant change in status review. Monitoring of compliance of the physical restraint policy will be	5/29/14 6/12/14. 6/21/14 6/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patti Johnson	Administrator	6/13/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 05/07/2014

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 221	Continued From page 1 symptoms. Physical restraints are defined as any manual method or . . . material . . . adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. . . . [Facility] believes that any form of physical . . . restraint is an assault on the resident's dignity, physical and emotional well being. . . . Interdisciplinary team will evaluate all restraint issues . . . If restraints are used a physician order must be obtained. . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with behaviors, and aphasia. The significant change Minimum Data Set (MDS), dated 03/17/14, indicated no use of physical restraints. Resident #7's care plan, dated 02/25/14, stated, ". . . I need assist with my daily cares: . . . dementia, expressive aphasia . . . physically aggressive, Has injured staff . . . Skin: . . . pain with treatment . . . physical aggression with treatment . . . wrap in blanket during treatment to decrease hitting/injuries . . . Comfort: express discomfort nonverbally . . ." A progress note, dated 02/07/14, indicated, "Resident has been very combative with changing throughout the night. Resident would attempt to punch staff x [times] 3, kick legs, squeeze hands. Resident's hand held to chest to prevent resident from striking staff. . . . Resident has been screaming in pain when changed. . . ." A provider progress note, dated 02/18/14, indicated, ". . . With his twice daily perirectal abscess dressing changes, he needs to be	F 221	completed by the DON or appointed designee using a random sample of 20% of the facility population based on the current daily census of residents weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues that are identified and immediate corrective action will occur. The DON or designee will submit a report of the monitoring results to the QA Coordinator during the scheduled monthly QA Meeting.	

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 05/07/2014

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 221	Continued From page 2 secured with blankets so he does not strike out at nursing staff. He has been physically aggressive . . . and he is now on Seroquel for that. . . . his nursing cares [are] very difficult because of his discomfort and his dementia and his propensity to strike out at staff. . . ." Resident #7's medical record failed to include a physician's order for the use of restraints during cares/wound treatments. During an interview on the morning of 05/07/14, two administrative staff members (#2 and #10) indicated they began securing Resident #7 with a blanket during toileting cares/wound treatments to protect the staff. The facility failed to evaluate the necessity of using manual force or material adjacent to Resident #7's body to restrain him during cares/wound treatments, failed to obtain a physician's order prior to restraining him, and failed to adequately assess and manage his pain during cares/treatments. These failures resulted in the use of physical restraints for staff convenience and placed Resident #7 at risk of injury and decreased function/well-being. See F309 Care and Services, Base #1.	F 221		
F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 222	**F222-483.13 Right To Be Free From Chemical Restraints -** An Educational In-service on "Psychotropic Medications Use Guidelines" was completed by the facility's Consulting Pharmacist to Licensed Nursing Staff. Psychotropic Behavior Tracking	5/29/14

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 05/07/2014

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 222	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents are free from chemical restraints for 1 of 1 closed record resident (Resident #7) who received antipsychotic and pain medications prior to toileting cares and wound treatments. Failure to assess and manage Resident #7's pain during cares and wound treatments, resulted in Resident #7 receiving antipsychotic and pain medications in an attempt to control his behavior during cares and treatments. Findings include: Review of the facility policy "Restraint" occurred on 05/07/14. The policy, revised July 2009, stated, ". . . The resident has the right to be free from any . . . chemical restraints that are not required to treat the resident's medical symptoms. . . . Chemical restraints is [sic] defined as any drug that is used for disciplinary or convenience and not required to treat medical symptoms. . . . [Facility] believes that any form of . . . chemical restraint is an assault on the resident's dignity, physical and emotional well being. . . . Interdisciplinary team will evaluate all restraint issues . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with behaviors, and aphasia. The physician's orders identified Seroquel (anti-psychotic medication) 12.5 milligram (mg) by mouth (po) every (q) 4 hours as needed (prn) for agitation initiated on 01/30/14, and increased to 25 mg tablet po q 4 hours prn on 02/14/14.	F 222	Guidelines and documentation were reviewed. The Psychotropic Gradual Dose Reduction Guidelines, the Psychotropic Monitoring Policy, and the Informed Consent were also reviewed (See Att. B). To ensure resident's are free of chemical restraints the facility has reviewed the plan of care for any resident who is using any type of antipsychotic, anti-anxiety, and antidepressant medication to ensure these medications are used appropriately to treat a specific condition and are utilized to enhance the quality of life for those residents who need them. The individual's resident's Primary Care Physician or Psychiatrist will be involved in monitoring any psychotropic medication and make adjustments as necessary to maintain the appropriate dosage that allows residents to function at their highest level of well being. The Facility Consulting Pharmacist monitors residents based on the "Psychotropic Medication Use Guidelines" and makes recommendation for reductions based on the "Psychotropic Gradual Dose Reduction Guidelines." Monitoring of Chemical Restraints will be completed on any resident currently receiving any psychotropic medication weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year by the SSD or appointed Nurse Manager. The Administrator will be notified of any issues that are identified and immediate corrective action will occur. The SSD or	5/29/14 6/4/14 6/21/14

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 05/07/2014

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 222	Continued From page 4 Resident #7's care plan, dated 02/25/14, stated, ". . . I need assist with my daily cares: . . . dementia, expressive aphasia . . . physically aggressive, Has injured staff . . . Skin: . . . pain with treatment . . . physical aggression with treatment . . . Comfort: express discomfort nonverbally . . ." The medication administration record (MAR), dated February 2014, identified the following: * 02/13/14 at 3:53 a.m., "Percocet . . . Seroquel . . . PRN administered. agitation . . ." * 02/16/14 at 11:44 am, "Percocet . . . Seroquel . . . PRN administered . . For aggression. . . ." * 02/18/14 at 4:11 a.m., "Percocet . . . prn administered . . ." * 02/18/14 at 4:16 a.m., "Seroquel . . . prn for agitation . . ." * 02/24/14 at 1:28 a.m., "Seroquel . . . PRN administered. given for pain control for drsg [dressing] change. . . ." * 02/28/14 at 1:32 a.m., "Seroquel . . . PRN administered. PRE MEDICATED PRIOR TO DRESSING CHANGE. . . ." The nurse's progress notes identified the following: * 02/07/14 at 1:39 p.m., "Wound has had significant deterioration since this nurse assessed yesterday a.m. . . . Resident had increased pain causing increased difficulty with assessment. . . ." * 02/13/14 at 3:59 a.m., "Resident aggressive during cares. . . . PRN Percocet [pain medication] and Seroquel given 3:50 a.m. for aggitation [sic]/aggressiveness." * 02/16/14 at 11:44 am, "Percocet . . . Seroquel . . . PRN administered . . For aggression. . . ." 02/24/14 at 2:55 p.m., ". . . Pain med [medication]	F 222	appointed Nurse Manager will submit the results to the QA Coordinator during the scheduled monthly QA Meeting.	

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 05/07/2014

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 222	Continued From page 5 and Seroquel given an hour before his tx [treatment] to minimize pain/agitation. Resident tolerated well. . . ." 02/28/14 at 4:40 a.m., ". . . prn Percocet and Seroquel given 1 hour before dressing change. Resident cooperative with dressing change. No resistance. . . ." The facility failed to evaluate the necessity of administering prn Seroquel and Percocet to Resident #7 prior to cares and wound treatments in an attempt to control his behaviors, and failed to adequately assess and manage his pain during cares and treatments. These failures resulted in the use of antipsychotic and pain medications for staff convenience and placed Resident #7 at risk of injury and decreased function/well-being.	F 222		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 1 closed record resident (Resident #7), who experienced falls with head trauma. Failure to complete neurological exams per policy following a fall with head trauma has the potential for a head injury to go undetected. Findings include: The facility provided a handout titled "Neurologic	F 281	**F281-483.20 Services Provided Meet Professional Standards-** The Neurologic Vital Signs Assessment Policy was updated and reviewed with Licensed Nursing Staff during their monthly meeting (See Att. C). Nursing Staff will perform neuro-checks on any resident who has sustained or is suspected of having sustained a head injury. The DON or appointed designee will monitor that neuro-checks are performed per facility policy on any resident identified as having head injury or trauma weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year. The Administrator will be notified of any issues that are identified and immediate corrective action will occur. The DON or designee will	5/29/14 6/21/14

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 05/07/2014

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 281	Continued From page 6 Vital Signs" when the surveyor requested a copy of their policy. The undated handout was reviewed on 5/07/14, and stated, ". . . Level of consciousness . . . reflects cortical function and usually provides the first sign of central nervous system deterioration. . . . If the previously stable patient suddenly develops a change in neurologic or routine vital signs, further assess his condition, and notify the doctor immediately. . . ." Review of the "Neurological Flow Sheet" occurred on 05/07/14. This undated form indicated staff monitor vital signs every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every 1 hour for 4 hours, then every two hours for 4 hours, and then once after four hours, eight hours, and three days. Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and history of falls. The 01/29/14 nurse's notes identified the following: * 3:44 a.m., ". . . Nurse heard noise of metal hitting floor . . . Nurse saw front wheels of wheelchair up in the air. Nurse found resident [#7] laying on back in room doorway. . . . Resident has a bump on back of head. . . . Resident assited [sic] back into wheelchair and brought out to nurse's station so staff can keep and [sic] eye on him. . . . Will continue to monitor for changes in cognition." * 12:21 p.m., "Resident [#7] fell at 11:30 a.m. this shift. Was found in awing [A-Wing] lounge on right side. Glider rocker was tipped over. Resident was unable to explain situation. . . . Resident was assisted back to w/c [wheelchair] by four staff. . . . Will continue to monitor. . . ."	F 281	submit a report of the findings to the QA Coordinator during the scheduled monthly QA Meeting.	

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 05/07/2014

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 281	Continued From page 7 On the morning of 05/07/14, the survey team requested the neurological flow sheets initiated on 01/29/14. Two administrative staff members (#2 and #10) indicated they were unable to locate the flow sheets, and confirmed staff are expected to perform neuro-checks if a resident has sustained or is suspected of having sustained a head injury. Facility staff failed to perform neuro-checks per facility policy for the known and/or suspected head injuries sustained by Resident #7.	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on information provided by the complainant, medical record review, review of facility policy, and staff interview, the facility failed to assess and treat a skin condition in a timely manner and provide the necessary care and services to promote optimal well-being for 1 of 1 closed record resident (Resident #7) who experienced continued uncontrolled pain after developing a wound on his buttocks. Failure to identify the wound when it first appeared, inform the attending physician of his continued	F 309	**F 309-483.25 Provide Care/Services for the Highest Well Being-**To ensure each resident receives and the facility provides the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The Facility's Consultant Pharmacist conducted an in-service for Licensed Nursing Personnel on Pain Management and Managing Constipation. The facility reviewed it's Skin Care Policy, Pain Management Policy, and Bowel Protocol Policy with Licensed Nursing Staff and CRA's during their scheduled mandatory meeting (See Att. D, E, F). All residents will have their pain, bowel, skin programs reviewed/assessed. Nursing will notify Primary Care Physicians and they will be involved as needed to obtain appropriate physician orders/interventions to address	5/29/14 5/29/14 6/12/14 6/21/14

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 05/07/2014

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 281	Continued From page 7 On the morning of 05/07/14, the survey team requested the neurological flow sheets initiated on 01/29/14. Two administrative staff members (#2 and #10) indicated they were unable to locate the flow sheets, and confirmed staff are expected to perform neuro-checks if a resident has sustained or is suspected of having sustained a head injury. Facility staff failed to perform neuro-checks per facility policy for the known and/or suspected head injuries sustained by Resident #7.	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on information provided by the complainant, medical record review, review of facility policy, and staff interview, the facility failed to assess and treat a skin condition in a timely manner and provide the necessary care and services to promote optimal well-being for 1 of 1 closed record resident (Resident #7) who experienced continued uncontrolled pain after developing a wound on his buttocks. Failure to identify the wound when it first appeared, inform the attending physician of his continued	F 309	**F 309-483.25 Provide Care/Services for the Highest Well Being-** The facility reviewed its Skin Care Policy, Pain Management Policy, Bowel Protocol Policy, Psychotropic Policy and Behavior Tracking Guidelines with Licensed Nursing staff and CRA's during their scheduled mandatory meetings (See Att. B, D, E, F). To ensure each resident receives and the facility provides the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care: The Facility's Consultant Pharmacist conducted an in-service for Licensed Nursing Personnel on Pain Management, Managing Constipation, and Psychotropic Medication Use/Behavior Guidelines. All residents will have their pain, bowel, skin programs reviewed/assessed. Residents with behaviors will have their	5/29/14 6/12/14 5/29/14 6/21/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

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 05/07/2014

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 309	Continued From page 8 uncontrolled pain as a result of his deteriorating skin condition, resulted in Resident #7 experiencing avoidable pain and required hospitalization for wound debridement. Failure to notify the attending physician of the resident's continued uncontrolled pain did not allow the physician the opportunity to prescribe treatment for his pain and resulted in Resident #7 experiencing avoidable pain. Findings include: Review of the facility policy "Skin Care Protocol/Prevention" occurred on 05/07/14. The policy, revised December 2013, stated, ". . . Early intervention/prevention is our primary focus. . . . Resident assistant will do a thorough skin inspection . . . on a daily basis. . . . Skin will be cleaned at the time of soiling and at routine intervals. . . ." Review of the facility policy "Pain Management" occurred on 05/07/14. The policy, dated 06/06/06, stated, ". . . Pain in residents will be assessed and treated promptly and consistently to assure the highest level of pain relief possible. . . . Assess for possible nonpharmacological interventions . . . Assess for possible pharmacological interventions . . . Enter pain problem and interventions on the care plan . . . Assessment and interventions should continue until pain is resolved or at the acceptable level for the resident. . . ." Information provided by the complainant indicated the facility failed to assess Resident #7's skin and/or treat his buttock wound, which resulted in the progression of his wound. The complainant also indicated the facility failed to provide	F 309	behavior program reviewed. Nursing will notify Primary Care Physicians and they will be involved as needed to obtain appropriate physician orders/interventions to address individual resident needs. Adjustments will be made in their individual care plans as needed to promote their highest practicable physical, mental, and psychosocial well being. Their individual care plan's will be reviewed upon admission, quarterly, annually, with any return hospitalizations and with any significant changes in the individual resident's condition to ensure appropriate interventions are in place. The DON or appropriate RN Nurse Manager will monitor a sample of 20% of the facility population that are at risk for pain, bowel complications, and skin issues weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues and immediate corrective action will occur. The DON or RN Nurse Manager will submit a report of the findings to the QA Coordinator during the scheduled monthly QA Meeting	6/21/14

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 05/07/2014

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 309	Continued From page 8 uncontrolled pain as a result of his deteriorating skin condition, resulted in Resident #7 experiencing avoidable pain and required hospitalization for wound debridement. Failure to notify the attending physician of the resident's continued uncontrolled pain did not allow the physician the opportunity to prescribe treatment for his pain and resulted in Resident #7 experiencing avoidable pain. Findings include: Review of the facility policy "Skin Care Protocol/Prevention" occurred on 05/07/14. The policy, revised December 2013, stated, ". . . Early intervention/prevention is our primary focus. . . . Resident assistant will do a thorough skin inspection . . . on a daily basis. . . . Skin will be cleaned at the time of soiling and at routine intervals. . . ." Review of the facility policy "Pain Management" occurred on 05/07/14. The policy, dated 06/06/06, stated, ". . . Pain in residents will be assessed and treated promptly and consistently to assure the highest level of pain relief possible. . . . Assess for possible nonpharmacological interventions . . . Assess for possible pharmacological interventions . . . Enter pain problem and interventions on the care plan . . . Assessment and interventions should continue until pain is resolved or at the acceptable level for the resident. . . ." Information provided by the complainant indicated the facility failed to assess Resident #7's skin and/or treat his buttock wound, which resulted in the progression of his wound. The complainant also indicated the facility failed to provide	F 309	individual resident needs. Adjustments will be made in their individual care plans as needed to promote their highest practicable physical, mental, and psychosocial well being. Their individual care plan's will be reviewed upon admission, quarterly, annually, with any return hospitalizations and with any significant changes in the individual resident's condition to ensure appropriate interventions are in place. The DON or appropriate RN Nurse Manager will monitor a sample of 20% of the facility population that are at risk for pain, bowel complications, and skin issues weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues and immediate corrective action will occur. The DON or RN Nurse Manager will submit a report of the findings to the QA Coordinator during the scheduled monthly QA Meeting.	6/21/14

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 05/07/2014

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 309	Continued From page 9	F 309		

non-pharmacological interventions and/or medications in an effort to manage Resident #7's pain, which resulted in his experiencing uncontrolled pain.

Resident #7's medical record, reviewed on all days of survey, identified diagnoses including Alzheimer's disease, dementia with behaviors, aphasia, perianal abscess, and pain. The resident's significant change Minimum Data Set (MDS), dated 03/17/14, identified problems with memory, severely impaired daily decision making skills, decreased level of activity, moisture associated skin damage, surgical wound, daily pain, and use of scheduled and as needed (prn) pain medications. The MDS further identified Resident #7 expressed pain both non-verbally (through body/posture) and verbally.

The care plan, dated 02/25/14, identified, ". . . Skin . . . systemic skin check weekly, Reposition at least every 1-2 hours - up in chair for meals only, Encourage to shift positions in w/c [wheelchair] as able frequently, Commercial moisture barrier as ordered, 02/04 Treatments as ordered - See ETar [electronic treatment administration record]. . . . Pressure reduction mattress in place, Treatment as ordered - see etar, Nutritional supplements as needed, Monitor skin condition with cares, report any redness or other problems to nurse for further evaluation . . . Follow P [pressure] ulcer risk intervention guide, 2/4 air mattress roho cusion [sic] in wc roho or get in recliner, 2/45 [sic] Refers to LRD [licensed registered dietitian] for further interventions, wrap with blanket during treatment to decrease hitting/injuries." The care plan also identified, ". . . Comfort . . . Assess for pain, Please try other non-medication measures for comfort like: soft

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 05/07/2014

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 309	Continued From page 10	F 309		

music, turning/repositioning, massage . . . Medications as ordered . . . Monitor effectivenes [sic] document update doctor . . . [prn], Interdisciplinary team will assess/reassess [prn] . . . ."

The physician's orders identified the following pain medications:
* 01/15/14, Tylenol two 325 milligram (mg) caplets every four hours (hr) prn for general discomfort
* 01/30/14, Seroquel 12.5 mg tablet every four hrs prn for agitation, increased to 25 mg every four hrs prn on 02/14/14
* 02/06/14, Ibuprofen two 200 mg tablets every four hrs prn for pain
* 02/12/14, Percocet 5-325 mg tablet every four hrs prn for pain
* 02/16/14, Fentanyl 25 micrograms per hr (mcg/hr) patch for pain

The "ADL [Activites of Daily Living] Roster" identified staff toileted Resident #7 three times on 02/03/14, and four times on 02/04/14. They also assisted him with bathing on 02/04/14.

The progress notes identified the following:
* 02/02/14 at 4:54 a.m., ". . . Resident would not sit on toilet," and at 9:27 p.m., ". . . only gets agitated with toileting . . ."
* 02/04/14 at 10:22 a.m., "Noted with bathroom cares: area on left inner coccyx/left side of crease with full tissue loss. Approx [approximately] 4 cm [centimeters] (length) x 2.5 cm (width) - unable to measure depth at this time d/t thick yellow sloth [sic] covering: no eschar noted. No drainage at this time. Edges are asymmetrical, dark pink/red in color. Duoderm applied to wound area alone. Approx [approximately] 2-3 inches above new

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 05/07/2014

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 309	Continued From page 11	F 309		

wound area, mid-Left gluteal area noted a hard, unblanchable area beneath tissue. Resembles the shape of an egg. appox [sic] x 5 cm (length) x 5 cm (width) calmo [calmoseptamine] cream applied with egg cart [sic] cusion [sic] applied to wc for extra protection to prevent further skin break down. . . ."
* At 11:34 a.m., "Family care conference . . . Reported to [family] the concern over skin condition that has been addressed."
* At 3:00 p.m., "Assessed skin areas. Noted that general mid left gluteal is reddened, blanchable, firm to touch. No s/sx [signs/symptoms] of discomfort with palpation. No increased warmth noted. Open area on inner buttock is in close approximation to anus . . . This writer does not feel this is pressure related. Barrier cream applied. Call made to wound specialist for direction."
* At 6:02 p.m., "Reviewed with [physican] change in skin condition as previously noted. No other orders, will proceed with skin specialist recommendation. Also with the area of redness/firmness on buttock to just monitor."
* 02/05/14 at 2:43 p.m., "Wound to left buttock near anus . . . remains sloughy appearance. Resident has discomfort during cleansing. Provided Tylenol 650 mg which was effective. Area of possible cellulitis to left glute is hard with blanchable redness. No increased warmth observed at this site during a.m. assessment. Resident easily aggitated [sic] . . ."

The prn medication administration record (MAR), dated 01/30/14-02/05/14, further identified staff administered:
* Seroquel due to the resident being "agitated" and having "increased behaviors" on two occasions.

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 05/07/2014

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 309	Continued From page 12 * Tylenol on one occasion. There was no clear indication for use identified on the MAR. The progress notes identified the following: * 02/06/14 at 5:10 a.m., identified, ". . . CRA [certified resident assistant] reported that when they had resident up to bathroom, he barely missed punching her in the jaw . . . " * At 9:34 a.m., "During tx [treatment] to inner buttock it was observed that the area of yellow slough has become [sic] to darken. Updated [administrative staff member #2] who stated that she would make contact to the wound nurse." * At 1:04 p.m., ". . . When returning to facility resident began to cry out in pain that his butt hurt. Contacted [physician] to obtain medication other than otc [over the counter] Tylenol. Order given was Ibuprofen . . . prn for pain. Resident took along with Tylenol . . ." The physician ordered Ibuprofen, another OTC pain medication. * At 2:00 p.m., "Observed wound on 02/05/14. area measurements are approximates only due to resident guarding, clenching of buttocks and constant attempts to strike staff and nurse. on 02/05/14 area was yellow slough. during this a.m. tx area was darkened and dry. . . . medicating prior moderately effective," at 2:02 p.m., ". . . hardened area is egg shaped and causes resident discomfort. . . ." * At 2:02 p.m., "Area of possible cellulitis observed 02/05/14 during A.M. cares. area does not have warmth greater than right buttock. hardened area is egg shaped and causes resident discomfort. red but blanchable." * At 5:58 p.m., "[late entry] Did contact [clinical nurse wound specialist]. Discussed current status of wound and she recommended to continue with current treatment and continue to monitor." * At 10:20 p.m., "8:30 p.m. Treatment to anal	F 309		

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 05/07/2014

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 309	Continued From page 13	F 309		

wound as ordered. Resident screams with pain when the area is touched. Has an egg-shaped Hard, warm, [and] bright red area on the left buttock that could be abscessed. Wound is dark black, hard to observe, but feels to be quarter-sized. Other open area is also hard to observe, but feels nickel-sized. Areas cleansed with saline [and] calmoseptamine cream applied."

The wound assessment report, dated 02/06/13, identified, ". . . Treatments: . . . (02/04/14) If need to fully cleanse area on left inner buttock, use minerol [sic] oil to remove calmoseptine, then cleanse with normal saline. . . . Calmoseptine - apply heavy layer of [sic] to wound on inner left buttock near anus, with cleansing after toileting do not attempt to remove all of ung [sic]. Cleanse away any soiled ung [sic] without attempting to remove all. Reapply to keep area protected. . . . (02/04/14) Arginaid . . . wound healing. . . . Pain with wound/treatment: Yes. Pain Intensity: Moaning, Grimacing, Crying, Guarding. Pain Management: Effective. . . ." This conflicts with documentation that indicated Resident #7 experienced significant pain during the dressing changes.

The prn MAR, dated 02/06/14, identified staff administered:
* Seroquel due to the resident having "struck [the] nurse twice," on one occasion.
* Tylenol due to the resident having "pain to buttock . . . with no relief," on two occasions.
* Ibuprofen due to the resident having "pain to buttock . . . with no relief," on one occasion.

The progress notes identified the following:
* On 02/07/14 at 5:42 a.m., "Resident has been very combative with changing throughout the

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 05/07/2014

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 309	Continued From page 14 night. Resident would attempt to punch staff x 3. kick legs, squeeze hands. Resident's hand held to chest to prevent resident from striking staff. . . . Resident has been screaming in pain when changed. Treatment applied as resident would allow." * At 1:39 p.m., "Wound has had significant deterioration since this nurse assessed yesterday a.m. Brought [administrative staff member #2] and [nurse practioner] to observe wound progression. Yesterday when this nurse assessed wound bed was hardened and dark. Resident had increased pain causing increased difficulty with assessment. Attempted to obtain increased pain management from [physician] [02/06/14]. During assessment this shift [administrative staff member #2] and [nurse practioner] agreed that wound progression needs to be seen by [medical doctor] . . . transferred to ER [emergency room] to immediate observation. Further intervention will be taken from [medical doctor] discretion." * At 6:24 p.m., ". . . he was transported to ER [emergency room] . . . [and returned to facility 02/12/14 at 12:47 p.m.]" * 02/12/14 at 8:49 p.m., ". . . Becomes very restless and agitated at times. Grabs at staff members arms, wrists and fingers and twists them. . . . 3 staff members assisted to keep resident turned to right side for inspection of rectal area. . . . Open area of approximately 7 cm x 6 cm with depth difficult to determine . . . Reasonable guess would be 3-5 cm depth with 4 cm tunneling . . . Inner flesh was beefy red. . . . Resident incontinent . . . Assisted with peri cares. Resident was tearful at end of dressing change . . . did try to bite CNA . . . When asked if his butt hurt, he responded yes. . . ." Throughout the above referenced period of time, the record lacked any indication of treatment	F 309		

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 05/07/2014

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 309	Continued From page 15	F 309		

changes/medications changes despite the lack of improvement, and the worsening of the abscess.

The wound assessment report, dated 02/12/14, identified, ". . . Pain with wound/treatment: Yes. Pain Intensity: Crying. Pain Management: Effective. . . ." This conflicts with the above documentation that indicated Resident #7 experienced significant pain during the dressing changes.

The prn MAR, dated 02/07/14-02/12/14, identified staff administered:
* Tylenol due to the resident having "pain to buttock" on two occasions.
* Ibuprofen due to the resident having "pain to left buttock" on one occasion.
* Percocet on one occasion. There was no clear indication for use identified on the MAR.

The progress notes identified the following:
* 02/13/14 at 3:59 a.m., identified, "Resident aggressive during cares. Swinging at staff and trying to twist fingers. . . . PRN Percocet and Seoquel [sic] given . . . for aggitation [sic]/aggressiveness . . ."
* At 11:24 a.m., "Resident incontinent of large BM [bowel movement]. PRN pain med given for peri and wound cares, only 15 min [minutes] prior to dressing change. Assistance of two aides, three RNs [registered nurses] and . . . staff nurse in room for this procedure. . . . superior edge of wound (at tunneling site) significant raise from tissue area, creating a 'flap like' structure . . . Peri wound area dark reddish/purple . . . Resident did not tolerate well with this dressing change. Grabbing at staff with attempt of hitting while yelling and moaning . . ."
* At 9:24 p.m., "Res given pain med [medication]

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 05/07/2014

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 309	Continued From page 16	F 309		

1 hr prior to dressing change with 3 people . . . wound greenish in color . . . Res clinching buttock tight and resistive hitting out at staff . . ."

The wound assessment report, dated 02/13/14, identified, ". . . Pain with wound/treatment: Yes, Pain Intensity: Crying, Pain Management: Effective. . . ." This conflicts with the above documentation that indicated Resident #7 experienced significant pain during the dressing changes.

The prn MAR, dated 02/13/14, identified staff administered:
* Percocet "before dressing change for pain" and due to the resident having "agitation" on two occasions.

The progress notes identified the following:
* 02/14/14 at 4:57 a.m., "Resident has been very combative and agressive [sic] with staff when changing/repositioning. Resident has squeezed and twisted CRAs hands . . . Has struck one CRA in chest and the other CRA in stomach. Resident has also tried to kick staff. . . . Uncooperative during changing," and at 10:45 a.m., "[Physician] called due to increase in behaviors. Orders recieved [sic] to increase Seroquel [an anti-psychotic]," and at 10:50 p.m., ". . . Medicated for pain 1 hr prior to dressing change. Buttock wound is bright red granulation tissue with loose white-colored slough that loosened with irrigation . . ."
* 02/15/14 at 10:43 a.m., ". . . Pain noted and prn medication given 1 hour before dressing change. . . . Wound bed was cleaned it is beefy red . . ."
* 02/16/14 at 9:13 a.m., ". . . Resident was very combative this a.m. so we left [him] in a safe way in his room and checked on him often. Pain

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 05/07/2014

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 309	Continued From page 17	F 309		

medications given at 7:30 a.m. and dressing done at 9:00 a.m., and he was more cooperative at this time," and at 1:54 p.m., ". . . [Family] felt that pain management was inadequate. Call placed to [physician] and updated on condition over past few weeks while she was gone on vacation. Orders for Fentanyl . . . Patch placed on resident. He is resting comfortably. . . ."
* 02/17/14 at 3:00 p.m., "Dressing change complete during this shift with assist of staff x 4. . . . Resident showed signs of improved toleration to procedure with new orders for pain management . . . min [minimal] moaning with no attempt to hit or yell at this time. Resident rested well through this shift. . . ."

The prn MAR, dated 02/14/14-02/16/14, identified staff administered:
* Percocet due to the resident having "pain" and "hitting with repositioning" on eight occasions.

A provider progress note, dated 02/18/14, identified, ". . . This past week, [Resident #7] had an irrigation and debridement of a rectal abscess by [physician] . . . [Resident #7] was admitted on February 7, 2014, and discharged on February 12, 2014. . . ."

The wound assessment report, dated 03/14/13, identified, ". . . Wound Type: open debriedment [sic]. Wound Location: Coccyx; left buttock near rectum. . . . Measurements: Length - 5.50 cm, Width - 5.7 cm, Depth 2.1 cm . . ."

A progress note, dated 03/19/14, indicated Resident #7 expired while in the facility.

The death certificate, dated 03/21/14, indicated his rectal abscess was a significant condition

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 05/07/2014

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 309	Continued From page 18 contributing to his death. During an interview on the morning of 05/07/14, two administrative staff members (#2 and #10) stated they had contacted Resident #7's physician on 02/06/14, and confirmed they failed to contact her again regarding Resident #7's continued uncontrolled buttock pain. The facility failed to: * Identify Resident #7's buttock wound until it had progressed to 4 cm x 2.5 cm in size with necrotic tissue. * Notify physician of Resident #7's deteriorating condition until he required hospitalization and wound debridement. * Although the facility contacted the physician on 02/06/14, they failed to inform him/her of Resident #7's continued uncontrolled buttock pain during toileting cares as evidenced by: * his increasing anxiety * his increasing agitatation/combativeness: attempts to bite, grab, squeeze or twist fingers, hands, wrists, and arms, hit, punch or swing at staff, and kick staff * his nonverbal indications of discomfort: grimacing and clenching his buttocks * his verbal indications of discomfort: moaning, crying, and yelling or screaming in pain when the area was touched, and his confirming he was in pain when asked by staff Documentation indicated staff were aware he was not tolerating his dressing changes well, and his medications were ineffective. They increased the numberof staff to provide cares to six, and held his hands to his chest to prevent him from striking out at staff during cares. The facility's failure to notify the attending	F 309		

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 05/07/2014

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 309	Continued From page 19 physician of Resident #7's continued uncontrolled pain, did not allow him the opportunity to prescribe treatment and resulted in Resident #7 experiencing avoidable pain. 2. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavioral and/or pain symptoms for 1 of 1 closed record resident (Resident #7) who received as needed (PRN) medications for behaviors and/or pain prior to attempting non-pharmacological interventions. Failure to identify target behaviors, assess the reason/causative factor(s) for behaviors, and establish accurate on-going monitoring of the behaviors had prevented the resident from obtaining his highest practicable physical, mental, and psychosocial well-being. Findings include: Review of the facility policy "Psychotropic medications" occurred on 05/07/14. The undated policy stated, ". . . Psychotropic medications will not be used unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's behavioral disturbances (ie: target behaviors). Resident will not receive psychotropic medications unless such medication is needed to treat a specific condition and each psychotropic medication will be given to treat clearly defined target behaviors. . . . Antianxiety [medications] . . . are to be monitored for effectiveness and continued need for the medication. . . ." Resident #7's medical record, reviewed on all days of survey, identified diagnoses including	F 309		

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 05/07/2014

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 309	Continued From page 20	F 309		

Alzheimer's disease, dementia with behaviors, aphasia, and pain. The resident's significant change Minimum Data Set (MDS), dated 03/17/14, identified problems with memory, severely impaired daily decision making skills, altered level of consciousness, decreased level of activity, and use of scheduled and prn pain medications.

The care plan, dated 02/25/14, identified, ". . . Mood/sleep: . . . Medications as ordered, monitor for effectiveness and adverse effects . . . Take time to visit with and listen to concerns, Use family as a resource, like to have familiar objects brought from home, Encourage participation in activities . . . aroamatherapy [sic] as needed, music therapy. . ."

The physician's orders identified the following psychotropic and pain medications:
* 01/27/14, Ativan 1 milligram (mg) every four hours prn for aggression/agitation, decreased to .5 mg every four hours prn on 01/28/14, and discontinued on 01/30/14
* 01/30/14, Seroquel 12.5 mg tablet every four hours prn for agitation, increased to 25 mg every four hours prn on 02/14/14
* 02/12/14, Percocet 5-325 mg tablet every four hours prn for pain
* 02/16/14, Fentanyl 25 micrograms per hour (mcg/hr) patch for pain

The medication administration record (MAR) and progress notes identified the following:
* 01/27/14, ". . . Became resistive when CRA [certified resident assistant] wanted to do cares. PRN Ativan given task completed 45 minutes later. . . ."
* 01/28/14, ". . . he was pinching, hitting, and

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 05/07/2014

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 309	Continued From page 21	F 309		

twisting CRA's arms when ever [sic] toileted. PRN Ativan given, no relief noted. . . ."
* 01/30/14, ". . . Seroquel . . . prn administered. Agitated. . . ."
* 01/31/14, ". . . When staff was assisting, was trying to kick staff with his feet. . . . Resident given prn Seroquel at 11:20 p.m. . . ."
* 02/01/14, "PRN Seroquil 12.5 mg given [at] 11:25 p.m. for aggitation. . . . Has been sleeping in recliner since. . . ."
* 02/05/14, ". . . Seroquel . . . PRN administered. Profolactic [sic] due to frequency of increased behaviors after noon meal. . . ."
* 02/06/14, ". . . During transfer resident struck nurse x [times] 2. Once in clavicle and once in face. After transfer Seroquel 12.5 mg was administered to resident. . . ."
* 02/07/14, ". . . Seroquel . . . PRN administered. . . ."
* 02/13/14, "Resident aggressive during cares. Swinging at staff and trying to twist fingers. . . . PRN Percocet and Seoquel [sic] given 3:50 a.m. for agitation/aggressiveness."
* 02/16/14, ". . . Seroquel . . . PRN administered. For aggression. . . ."
* 02/18/14, ". . . Seroquel . . . PRN administered. . . ."
* 02/24/14, ". . . Pain med and Seroquel given an hour before his tx [treatment] to minimize pain/agitation. Resident tolerated well . . ."
* 02/28/14, ". . . PRN Percocet and Seroquel given 1 hour before dressing change. Resident cooperative with dressing change. No resistance. . . ."

During an interview on the morning of 05/07/14, two administrative staff members (#2 and #10) confirmed staff failed to:
* identify the non-pharmacological interventions

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 05/07/2014

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 309	Continued From page 22	F 309		

they attempted prior to administering Resident #7's prn Ativan and Seroquel.
* assess Resident #7's signs/symptoms of pain, resulting in the concurrent administration of Percocet and Seroquel.

Failure to attempt non-pharmacological interventions, administer one medication at a time, and monitor the effectiveness of those interventions/medications prior to administering an anti-anxiety/anti-psychotic medication did not allow staff to evaluate what interventions were most effective to manage Resident #7's behavior.

3. Based on information provided by the complainant, record review, review of professional literature, review of facility policy and procedure, and staff interview, the facility failed to provide interventions to promote regular bowel elimination for 1 of 1 closed record resident (Resident #7) who required as needed (PRN) interventions for constipation. The facility failed to schedule and administer stool softeners/laxatives to Resident #7 in a manner that stimulated bowel activity and prevented constipation and hemorrhoids.

Findings include:

Review of the facility policy "Bowel Protocol" occurred on 05/07/14. The undated policy stated, ". . . All residents will have bowel movements monitored and recorded for the purpose of evaluating bowel habits and the need for possible nursing interventions. . . . Complications such as . . . hemorrhoids are prevented. . . . Nurse will: . . . Review the BM [bowel movement] record daily. . . . Determine which residents need intervention. . . . Prune juice and/or prune mixture may be given

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 05/07/2014

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 309	Continued From page 23 as often as necessary to promote . . . stools . . . If prune juice and/or Prune mixture is unsuccessful . . . the Dietitian recommends nursing incorporates Benefiber . . . If all of the above are unsuccessful, Standing orders for bowel management will be followed on the evening of the second day without a BM. . . . If standing orders is [sic] unsuccessful, the night nurse will insert a suppository rectally on the early morning of the third day . . . Stool softening medications on residents who are receiving narcotics or who are felt to be high risk of constipation. . . ." Information provided by the complainant indicated the facility failed to provide interventions to promote regular bowel elimination, which resulted in Resident #7 experiencing constipation. Resident #7's medical record, reviewed on all days of survey, identified diagnoses including Alzheimer's disease, dementia with behaviors, aphasia, pain, and constipation. The resident's significant change Minimum Data Set (MDS), dated 03/17/14, identified problems with memory, severely impaired daily decision making skills, extensive assistance of two persons for toileting, bowel incontinence, no constipation present, and use of scheduled and prn pain medications. The care plan, dated 02/25/14, identified, "Elimination: . . . Meds [medications] as ordered . . . Nutrition: . . . 02/01/14 prune juice 4 oz [ounces] . . . stewed prunes at dinner . . ." The physician's orders identified the following constipation medications: * 01/15/14, Milk of Magnesia (MOM) 30 cubic centimeters (cc) every eight hours prn * 01/31/14, Senna S two tablets daily, Mirilax 17	F 309		

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 05/07/2014

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 309	Continued From page 24	F 309		

grams (gm) twice daily (bid), and Hemmorrhoidal suppository twice daily prn
* 02/01/14, Fleets enema daily prn
* 02/12/14, Bisacodyl 10 milligram (mg) suppository daily prn
The orders for Senna S, Fleets enemas, and Bisacodyl, were obtained after the resident failed to have a bowel movement for three days, four days, and six days each on one occasion.

A bowel assessment, dated 01/14/14, identified elimination occurred every three days.

The progress notes identified the following:
* 01/15/14, "Wife reports last BM was on Monday so PRN MOM given tonight."
* 02/01/14, "Spoke with [physician] regarding current problems with bowels and hemorrhoids [after six days with no bm]. Informed [physician] of last BM. Orders obtained to give Senna S 2 tabs orally daily. If no BM by Monday to give a full bottle of mag [magnesium] citrate. . . . Resident straining to pass bowel movement. . . . Fleet emema [sic] provided with no results. Observed large external hemorrhoids with bright red bleeding. Provided hemorrhoidal suppository. Resident started on Mirilax 17 gms BID. Dietary notified to start resident on pureed prunes with meals and prune juice with nourishments. . . . He is anxious at times and stops being anxious after toileting. Resident is constipated. Warm prune juice and MOM given to resident. He stated he liked that very much. CNA [certified nursing assistant] noted scant amount of blood in brief. Nurse summoned and there are hemmoroids [sic] present. Hemmoroid [sic] supp prn given to help reduce inflamation of hemmoroids [sic]. Then an enema was given after supp to see if this will help him have a BM. Resident does pass a lot of gas

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 05/07/2014

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 309	Continued From page 25	F 309		

when toileted but no BM. . . . Dietary notified of trouble with having BM's [after six days with no bm]. They are going to look at his diet and see if we can add dietary things to help resident have BM naturally without medications. . . ." Dietary was only contacted after the resident failed to have a bowel movement for three days on one occasion, four days on one occasion, and six days on one occasion.
* 02/16/14, ". . . [Family] felt that pain management was inadequate. Call placed to [physician] . . . Orders for Fentanyl 25 mcg/hr [micrograms per hour] [pain medication] . . ."
* 02/18/14, ". . . Increase to Fentanyl 50 mcg/hr . . ."
* 02/20/14, "BS [bowel sounds] heard x 4 HYPERactive, however, no BM larger than a small since 02/13/14. No results from suppository this AM. Given another one. . . . Residents eyes appeared glazed and out of focus when not ingaged [sic]. Thick dry mucus in mouth with dry membranes note[d], mouth swabs put in room with staff informed of s/s [signs/symptoms] of dehydration and need for oral cares and increased fluid intake. . . ."
* 02/26/14, ". . . Educated direct care staff to increase fluids . . ."

A bowel assessment, dated 02/21/14, identified daily elimination, presence of fecal/oozing/straining, rectal abscess affecting bowel function, use of narcotic analgesics, and current bowel regime: laxative.

Documentation of Resident #7's eliminations ("BM Roster"), dated January 14, 2014-March 19, 2014, identified the resident failed to have a bowel movement for three days, four days, five days, seven days, and eight days each on one

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 05/07/2014

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 309	Continued From page 26 occasion. During an interview on the morning of 05/07/14, two administrative staff members (#2 and #10) confirmed staff failed to administer stool softeners/laxatives in a manner that stimulated bowel activity. The facility failed to assess and implement an individualized/specific plan of care for managment of Resident #7's problem with constipation, including any revisions (ie: nutritional, fluids, physician directed changes to the resident's pain medications, etc.) following the episodes of constipation, and lacked evidence of monitoring the effectiveness of the established plan to promote normal bowel patterns/habits for Resident #7.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of manufacturer's recommendations, review of facility policy, and staff interview, the facility failed to ensure staff used mechanical lifts appropriately for 2 of 3 sampled residents (Resident #1 and #2) observed during sit-to-stand lift transfers. Failure	F 323	**F323-483.25 (h) Free of Accident Hazards/Supervision/Devices-** To ensure that the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents: The Policy on Safe Resident Lifting and Repositioning was revised to include notification of Nursing Personnel if a resident is having any pain with a transfer and also the importance of securing residents according to manufacturer's guidelines (See Att. G). The updated policy was reviewed with Licensed Nursing Staff during their meeting. This policy will be reviewed with CRA's at their mandatory meeting. PT reviewed Resident #1 and Resident	5/29/14 6/12/14 5/8/14

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 05/07/2014

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 323	Continued From page 27 to ensure staff used a mechanical lift appropriately placed the residents at risk for a fall and/or injury during transfers. Findings include: Review of the facility policy "Safe Resident Lifting, Repositioning, Transporting" occurred on 05/07/14. The policy, revised 05/09/12, stated, ". . . Sling[s] . . . will be tightened appropriately and adjusted as needed with position changes to ensure safety. . . ." Review of the manufacturer's guideline "Sara 3000" occurred on 05/07/14. The instructions, dated 2003, stated, ". . . lean forward slightly to enable the sling to be placed around his/her lower back. Position the sling around the patient's back so that the bottom of the sling lies horizontally about two inches above the patient's waistline . . . The [support] strap should be tight . . ." - Review of Resident #2's chart occurred on all days of survey. Diagnoses included history of hip fracture, spinal stenosis and lower extremity neuropathy. Observation on 05/06/14 at 1:10 p.m. showed a certified nursing assistant (CNA) (#1) used the sit to stand lift to assist Resident #2 onto the toilet. During the transfer, the sling slid up touching the back of the resident's neck with the support strap under Resident #2's chin. The CNA failed to position the sling around the lower back and tighten the support strap. During an interview on the morning of 05/07/14, an administrative staff member (#2) confirmed the sling should not slide up during a transfer.	F 323	# 2's transfer abilities. Resident #1 and # 2's care plan was updated to reflect the Physical Therapist's recommendations. Each resident's plan of care will be reviewed by the Interdisciplinary Team upon their admission, quarterly, annually, or with any significant change to ensure their environment is as safe as possible and they are receiving appropriate supervision and use of assistive devices to maintain their highest level of function. Monitoring of Resident # 1 and # 2 and a sample of resident transfers will occur weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year by the Rehab Coordinator or designee. The Administrator will be notified of any issues that are identified and immediate corrective action will occur. The Rehab Coordinator or Designee will submit a report to the QA Committee during their regular scheduled monthly QA Meeting.	5/13/14 6/21/14

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 05/07/2014

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 323	Continued From page 28	F 323		

Review of the manufacturer's guideline "Medcare Lifts" occurred on 05/07/14. The instructions, dated 02/24/06, stated, ". . . The Medcare Stand was designed specificaly for assisting your residents/patients to a standing position. . . . Because the Stand is an assistive device, it should only be used with residents/patients [who] can bear the requisite amount of weight . . ."

- Resident #1's medical record, reviewed on all days of survey, identified diagnoses included dementia, obesity, degenerative joint disease, osteoarthrosis, and leg cellulitis.

Observations on 05/06/14 showed the following:
* 10:40 a.m., two CNAs (#3 and #7) transferred Resident #1 from his wheelchair to the toilet using the sit-to-stand lift. The resident did not bear weight and was in a seated position as he hung from the harness. As the harness straps pulled upward into Resident #1's axillae (armpits), his shoulders raised to ear level.
* 10:55 a.m., two CNAs (#3 and #7) transferred Resident #1 from the toilet to his wheelchair using the sit-to-stand lift. The resident did not bear weight and was in a seated position as he hung from the harness. As the harness straps pulled upward into Resident #1's axillae, his shoulders raised to ear level.
* 2:30 p.m., two CNAs (#8 and #9) transferred Resident #1 from the recliner to his wheelchair using the sit-to-stand lift. The resident did not bear weight and was in a seated position as he hung from the harness. As the harness straps pulled upward into Resident #1's axillae, his shoulders raised to ear level. He began moaning and stated, "Let me down." The CNAs (#8 and #9) ignored Resident #1's request, and focused

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 05/07/2014

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 323	Continued From page 29 on positioning his wheelchair for the transfer. As the CNAs (#8 and #9) transferred him into his wheelchair, he buttocks/legs slid horizontally onto the seat and his shoulders relaxed as the sling was lowered. During an interview on the morning of 05/07/14, two administrative staff members (#2 and #10) confirmed a resident should be able to bear his/her own weight if a sit-to-stand lift is used.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, record review, review of professional literature, review of facility policy, and staff interview, the facility staff failed to offer fluids to 2 of 2 sampled residents (Resident #1 and #5) and one closed record resident (Resident #7) dependent on staff for fluid intake. Failure to offer fluids during cares increased Resident #1 and #5's risk of dehydration, urinary tract infections, and constipation, and may have contributed to Resident #7 being hospitalized. Findings include: Review of the facility policy "Hydration" occurred on 05/07/14. The policy, revised April 2013, stated, ". . . It is the responsibility of the dietitian . . . to determine the fluid requirement for each	F 327	**F327-483.25 (j) Sufficient Fluid To Maintain Hydration**-To ensure each resident is provided with sufficient fluid intake to maintain proper hydration and health, the facility revised it's Hydration Policy (See Att. H). The Hydration Policy which included a review of documentation of fluid intake and identifying risk factors for insufficient fluid intake such as: coma/decreased sensorium, fluid loss related to diarrhea, vomiting, fever, uncontrolled diabetes, fluid restriction secondary to renal dialysis, functional impairments that make it difficult to drink, reach fluids, or communicate needs, dementia residents who may forget to drink, or any resident who refuses fluids was reviewed with Nursing Staff at their monthly meeting and will be reviewed with other direct care staff at the scheduled mandatory meeting. Upon admission, quarterly, annually, with any significant changes, or hospital returns the fluid intake needs of individual residents are assessed by the LRD or Interdisciplinary Team to ensure	5/28/14 5/29/14 6/12/14

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 05/07/2014

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 327	Continued From page 30 resident. . . . To promote adequate hydration, water is provided at bedside daily . . . Offer and encourage fluids as a part of daily interaction with the residents . . . Clinical Symptoms of dehydration include . . . Dry mouth . . . Constipation . . . Dark urine and/or decreased urine output . . . Abnormal lab values. . . . There are several short-term physical symptoms that increase the resident's fluid needs, including . . . infection . . . diarrhea . . . dementia . . . functional impairment . . . aphasia. The nursing staff is responsible to provide additional fluids and encourage residents to consume fluids while these conditions are present. . . ." Berman, Snyder, Kozier, Erb, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 9th Edition, Pearson - Prentice Hall, New Jersey, pages 1463-1464, states, ". . . Hypernatremia [elevated sodium level] . . . Clients at highest risk for hypernatremia are those who are unable to access water, such as clients who . . . are unable to request fluids such as . . . older adults with dementia . . . clinical manifestations: . . . dry, sticky mucous membranes . . . weakness . . . Severe hypernatremia: fatigue . . . Laboratory findings: Serum sodium above 145 mEq/L [milliequivalents per liter]. . . ." Information provided by the complainant indicated the facility failed to encourage fluids as part of daily interaction with Resident #7, which resulted the resident being hospitalized for dehydration. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, expressive aphasia, and constipation.	F 327	that each resident's individual needs are identified. Intakes of Resident #1 and # 5 and any resident with inadequate fluid intake are being monitored by Nursing Management. For resident's identified at high risk alternatives treatment approaches will be developed such as attempting to increase fluid intake by the use of popsicles, gelatin, and other similar non liquid foods. For residents that are unable to assimilate oral intake, these residents will receive artificial means of hydrations such as IV or g-tube as per their Primary Care Physician's recommendations, and as they so desire, as per their advanced directive, or their legal representatives allows. Nursing Management are addressing interventions that can be initiated to their plan of care to increase fluid intake and promote adequate hydration as individual resident's condition allows The Nursing Manager or appointed designee will monitor Resident # 1 and # 5 and a 20% sample of the facility population they feel may be at risk for inadequate hydration weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues and immediate corrective action will occur. A Nurse Manager or appropriate designee will submit a report of the monitoring results to the QA Coordinator during the scheduled monthly QA meeting.	6/21/14 6/21/14 6/21/14 6/21/14

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 05/07/2014

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 327	Continued From page 31	F 327		

The care plan, dated 02/25/14, identified, ". . . feeds self, may need cues to eat or how to use utensils . . . daily fluid needs: 2265-2490 ml [milliliters or cc] daily . . . Offer fluids in conjunction with turning schedule . . ."

The "intake and output register," dated February 20, 2014-March 4, 2014, identified fluid intakes as low as 620 cc/day. Resident #7 failed to reach the goal of 2,265 cc/day on any of 13 days monitored.

The progress notes identified the following:
* 02/20/14, ". . . Residents eyes appeared glazed and out of focus when not ingaged [sic]. Thick dry mucus in mouth with dry membranes note[d], mouth swabs put in room with staff informed of s/s [signs/symptoms] of dehydration and need for oral cares and increased fluid intake. . . ."
* 02/26/14, ". . . Educated direct care staff to increase fluids . . ."
* 03/03/14, ". . . Has a diagnosis of Alzheimer's disease and meal acceptance likely affected by this. . . . Resident sleepy today. . . . Liquids offered . . . but would only drink a small swallow. . . ."
* 03/04/14, ". . . Resident lethargic most of the day. . . . s/sx [signs/symptoms] dysphagia. Will trial pudding thick liquids . . . Resident has been drowsy today, intake has been poor . . . wet x [times] 1 lg [large] amt [amount] amber color . . ."
* 03/05/14, ". . . Res has been resting quietly all shift, no meal, no meds [medications] . . . Lab notified this nurse of the urgent lab values. . . . [Physician] was informed that resident is on pudding thick liquids. . . . Family informed about hospitalization."

The hospital progress note, dated 03/08/14, identified, ". . . admitted with severe

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 05/07/2014

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 327	Continued From page 32	F 327		

hypernatremia . . . Sodium is 162 . . . improving with IV [intravenous] fluids . . . volume depletion . . ."

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included cerebral vascular accident (CVA).

The current care plan stated, "Res [resident] needs assist with daily care . . . have been provided built up silverware to increase independence . . . likes drinks in bowls so can spoon self drinks . . . pudding thickened liquids . . . Nutrition . . . problems swallowing due to stoke . . . daily fluid needs 6-8 glasses daily . . . decreased mobility r/t [related to] stroke . . . Offer fluids with turning schedule . . . Encourage nutrition/hydration . . ."

Observation of Resident #5 identified the following:
* 05/06/14 at 10:45 a.m. - Two certified nursing assistants (CNAs) (#3 and #4) assisted Resident #5 in his room to reposition in the wheelchair. The CNAs failed to offer thickened fluids to the resident.
* 05/06/14 at 3:15 p.m. - Two CNAs (#5 and #6) assisted Resident #5 out of bed and into the wheelchair. The CNAs failed to offer the resident thickened liquids during cares.

Observation on 05/06/14 showed a covered bowl of pudding thickened water at Resident #5's bedside, but no spoon available to consume the thickened water.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, recent CVA, inability 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 05/07/2014

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 327	Continued From page 33	F 327		

communicate needs, swallowing problems, diarrhea, and an infection.

A nutrition risk assessment, dated 05/07/14, identified, ". . . Total fluid requirement . . . 2,500 [cubic centimeter (cc)/day] . . . Resident acceptance of dietary needs . . . consistently . . . intake: fluids, Consumes 1,500 cc/day. . . ."

The current care plan identified, ". . . able to feed self after set up-cues [and] assist as needed . . . Offer fluids in conjunction with turning schedule . . . Encourage . . . hydration as allows . . . Encourage fluids . . ."

The "intake and output register," dated April 1, 2014-May 6, 2014, identified fluid intakes as low as 1100 cc/day. Resident #1 reached the goal of 2,500 cc/day on one of 36 days monitored.

Observations on 05/06/14 showed the following:
* 10:40 a.m., Two CNAs (#3 and #7) provided Resident #1's toileting cares, and transported him to the lounge. The CNAs failed to offer the resident liquids following cares.
* 2:30 p.m., Two CNAs (#8 and #9) repositioned/transferred Resident #1 back into his wheelchair. The CNAs failed to offer the resident liquids following cares.

Observation on 05/06/14 showed the CNAs failed to encourage fluids as a part of daily interaction with Resident #1.

During an interview on the morning of 05/07/14, two administrative staff members (#2 and #10) confirmed staff are expected to offer and encourage fluids as a part of their daily interactions with the residents.

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 05/07/2014

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 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F441-483.65 Infection Control, Prevent Spread of, Linens-** To ensure the facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and prevent the spread of disease and infection to Resident #2 and any other residents in the facility: The facility reviewed it's "Hand Washing Hygiene Policy" (See Att. I) with Licensed Nursing Staff during their monthly meeting and will review this policy with all other employees during the Mandatory Meeting. Any employees unable to attend the meeting will review this policy with their Manager. This policy is also included in the orientation of new employees, contract employees, and annually with the electronic training program and throughout the year as needed. Monitoring of hand washing and infection control practices for Resident # 2 and a random sample of other residents will occur weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year by the DON or designee. The Administrator will be notified of any issues that are identified and immediate corrective action will occur. The DON or designee will submit a report of the finding s to the QA Coordinator during the scheduled monthly QA meetings.	5/29/14 6/12/14 6/21/14 6/21/14

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 05/07/2014

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 441	Continued From page 35 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/18/13. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow infection control practices for 1 of 3 sampled residents (Resident #2) in contact isolation who received perineal care. Failure to follow infection control practices has the potential to spread infection to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Methicillin-Resistant Staphylococcus aureus (MRSA)" occurred on 05/07/14. This policy, dated 2009, stated ". . . In healthcare facilities, the main mode of transmission to others patients is through human hands, especially healthcare workers' hands. Hands may become contaminated with MRSA by contact with infected or colonized patients. If appropriate hand hygiene such as washing with soap and water or using an alcohol -based hand sanitizer is not performed, MRSA can be spread when healthcare worker touches other patients." Review of the facility policy titled "Perineal Care-Male" occurred on 05/07/14. This policy, undated, stated, ". . . 21. Remove soiled linen and dispose of properly. Remove gloves [and] wash hands. . . ." Review of Resident #2's medical record occurred on May 05-06, 2014. Diagnoses included bullous pemphigoid (skin condition that causes blisters).	F 441		

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 05/07/2014

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 441	Continued From page 36	F 441		

The current care plan stated, ". . . Infection: MRSA-skin blisters . . . Educate res [resident] and family regarding handwashing . . . Contact precautions . . ." The certified nursing assistant (CNA) care plan stated, " . . . FYI [for your information] - special instructions contact precautions"

Observation on 05/06/14 at 11:00 a.m. showed a CNA (#1) donned gloves and gown and assisted Resident #2 in the bathroom. The resident had a bowel movement and the CNA (#1) performed perineal care. After completing perineal care the CNA removed her gloves, donned another pair, and used the sit to stand lift to assisted Resident #2 into the wheelchair. The CNA removed the upper body sling, applied bilateral leg rests to the wheelchair, wiped the lift with a cavi wipe (disinfectant wipe), went into the bathroom, removed her gown and gloves, collected the trash, and left the room. The CNA (#1) failed to perform hand hygiene when her gloves were removed after perineal care and before leaving the resident's room.

During an interview on the morning of 05/07/14, an administrative staff member (#2) stated staff are expected to wash hands after removing gloves when providing perineal care, and before leaving a resident's room when contact precautions are in place.