| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **WEDGEWOOD MANOR** | **804 MAIN ST W CAVALIER, ND 58220** |

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| L1810 | 33-07-03.2-18,1 PHARMACEUTICAL SERVICES<br><br>The facility shall obtain the services of a licensed pharmacist who shall develop policies and procedures for the provision of pharmaceutical services within the facility consistent with chapter 61-03-02, state laws, and federal laws. These policies and procedures must be approved by medical staff or medical director and governing body and must include provisions for:<br><br>This State Licensing Rule is not met as evidenced by:<br>Based on observation, policy review, and staff interview, the facility failed to follow regulations outlined in Chapter 61-03-02 Consulting Pharmacist Regulations for Long-Term Care Facilities for 1 of 1 emergency medication kit (E-kit). Failure to label the exterior of the E-kit with an accurate list of the name, strength, quantity, and the earliest expiration date of the medications limited staffs' knowledge of the medications available for use and the timeliness of the pharmacist replacing expired medication. Failure to remove expired medications may result in residents receiving ineffective medications in an emergent situation.<br><br>Findings include:<br><br>Section 61-03-02-02.2 of the Consulting Pharmacist Regulations for Long-Term Care Facilities, states, ". . . e. Labeling-Exterior. The | L1810 | To ensure State Licensing Rule is met as outlined in Chapter 61-03-02 Consulting Pharmacist Regulations for Long Term Care Facilities regarding the emergency medication kit (E-kit): the E-kit was corrected by replacing the expired medication. The Consulting Pharmacist recommended that the Pharmacy exchange the E-kit routinely during the regularly scheduled bi-weekly medication exchanges to ensure that the E-kit is labeled accurately and there are no expired medications. Nursing staff will be educated on the new exchange policy by June 10, 2024. The QA Nurse/Designee will implement QA monitoring of the E-kit by June 10, 2024. QA monitoring will be completed by the QA Nurse/Designee to ensure the E-kit is labeled accurately and the E-kit has no expired medications | 6/20/24 |

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

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| L1810 | Continued From page 1<br>exterior of an emergency kit shall be labeled to clearly and unmistakably indicate that it is an emergency drug kit and it is for use in emergencies only; such label shall also contain a listing of the name, strength, and quantity of the drugs contained therein and an expiration date. . . . i. Expiration date. The expiration date of an emergency kit shall be the earliest expiration date on any drug supplied in the kit. Upon the occurrence of the expiration date, the Provider Pharmacist shall open the kit and replace expired drugs. . . ."<br><br>Review of the facility policy titled "Emergency Pharmacy Service and Emergency Kits" occurred on 05/16/24. This policy, dated October 2022, stated, ". . . Facility staff will check the emergency medication kit(s) for the presence of an expiration date and to ensure kit is properly stored, locked and in date at least monthly. . . . Emergency kits are checked by a pharmacist or pharmacist designee at least monthly to assure each emergency kit is . . . not outdated. . . ."<br><br>Observation of the locked E-kit occurred on 05/15/24 at 4:25 p.m. with a medication aide (#3). The list of medications attached to the outside of the E-kit identified the following expired medications:<br>* morphine oral solution 20 milligrams/milliliter (mg/ml), one vial expired 10/15/23 (seven months ago)<br>* Haldol 5 mg/ml, one vial expired 04/15/24 (one month ago)<br>* Augmentin 875/125 mg, six tablets expired 04/04/24 (six weeks ago)<br>* Nitroglycerin 0.4 mg, 25 tablets expired 05/10/24 (five days ago) | L1810 | weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The QA Nurse/designee will report the results of the QA audit on the E-kit to the QA Committee during the monthly QA Meeting. Any concerns identified will be reported to the Administrator and corrected immediately. | |

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| L1810 | Continued From page 2<br><br>On 05/15/24 at 4:47 p.m., an administrative nurse (#2) opened the E-kit. Observation identified expiration dates of 10/15/24 and 07/31/24 for the morphine and Haldol, respectively, which failed to match the list on the outside of the E-kit. Observation verified the Augmentin and Nitroglycerin expired on 04/04/24 and 05/10/24, respectively. The nurse verified the expired medications and stated she planned to send the E-kit to pharmacy for replacement.<br><br>The facility failed to ensure the list of medications attached to the E-kit contained accurate expiration dates and failed to replace the expired medications. | L1810 | | |

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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification survey started on 05/13/24 and concluded 05/16/24. | F 000 | | |
| F 641 SS=E | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 5 of 12 sampled residents (#3, #10, #15, #28, and #30). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the development of a comprehensive care plan and the care provided to the residents.<br><br>Findings include:<br><br>SECTION J: FALLS<br><br>The Long-Term Care Facility RAI Manual, revised October 2023, page J-37, states, ". . . If this is not the first assessment . . . the review period is from the day after the ARD [assessment reference date] of the last MDS assessment to the ARD of the current assessment. . . . Determine the number of falls that occurred since . . . prior assessment . . . and code the level of fall-related injury for each. . . ." | F 641 | To ensure corrective action for Resident #3,#10,#15,#28,#30 and any other resident that may be affected by assessments not accurately reflecting the resident's status: the MDS Coordinator and DON will receive education by June 6, 2024 from CMS's RAI Version 3.0 Manual on Sect J1700 Fall History, Sect J1800 Any Falls Since Admission/ Entry or Reentry of Prior Assessment, Sect J1900 Number of Falls Since Admission,/Entry/or Reentry or Prior Assessment, and Sect P0200 Alarms. MDS Corrections for Resident #3,#10,#15,#28, and #30 regarding their use of the roam alert and Resident #30's MDS regarding a fall not coded will be corrected to accurately reflect the resident status by June 10, 2024. Other residents with roam alerts and fall histories will be reviewed and if any resident is affected by this practice the most recent MDS assessment will be corrected and submitted to CMS QIES submission Processing system and the North Dakota Department of Human Services by June | 6/20/24 |

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| F 641 | Continued From page 1<br><br>- Review of Resident #30's medical record occurred all days of survey. The record identified a fall with injury (bruising) on 02/28/24 and falls without injury on 02/24/24, 03/18/24, and 03/23/24. Resident #30's annual MDS, dated 04/04/24, identified no falls since the previous assessment on 01/04/24.<br><br>During an interview on 05/16/24 at 09:30 a.m., an administrative nurse (#1) agreed Resident #30's 04/04/24 MDS lacked documentation of his falls.<br><br>SECTION P: RESTRAINTS AND ALARMS<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2023, pages P-9 through P-11, stated, "An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected. . . . Code 2, used daily: if the device was used daily during the look-back period [seven days]. . . . Other alarm includes devices, such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms or seatbelt alarms. . . ."<br><br>- Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated 04/25/24, showed the facility coded "other" alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as "other."<br><br>- Record review for Resident #10 occurred on all days of survey. The quarterly MDS, dated 02/26/24, showed the facility coded "other" alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined | F 641 | 20, 2024. To ensure corrective action is achieved and maintained, QA monitoring by the DON/Designee will be implemented by June 10, 2024 and will occur weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. Results of the QA audit will be reported to the QA Committee by the DON/Designee during the monthly QA Committee Meeting for review.<br><br>Any concerns identified will be reported to the Administrator and immediately corrected. | |

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| F 641 | Continued From page 2<br>as "other alarm" during the MDS assessment.<br><br>- Review of Resident #15's medical record occurred on all days of survey. The annual MDS, dated 05/09/24, showed the facility coded "other" alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as "other" during the look-back period.<br><br>- Record review for Resident #28 occurred on all days of survey. The quarterly MDS, dated 02/20/24, showed the facility coded "other" alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as "other alarm" during the MDS assessment.<br><br>- Review of Resident #30's medical record occurred all days of survey. The annual MDS, dated 04/04/24, showed the facility coded "other" alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as "other."<br><br>During an interview on 05/16/24 at 09:49 a.m., an administrative nurse (#1) stated staff coded "other" alarm for the alarm triggered on an exit door when a resident with a wander guard got too close to the exit. The nurse (#1) agreed the exit alarm did not meet the definition of an "other" alarm. | F 641 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment. | F 657 | | 6/20/24 |

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| F 657 | Continued From page 3<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 2 of 12 sampled residents (Resident #15 and #28). Failure to review and revise the care plan limited staff's ability to communicate needs and ensure continuity of care.<br><br>Findings include:<br><br>Review of the facility policy titled "Wedgewood Manor Comprehensive Care Plans" occurred on 05/16/24. This policy, dated 10/05/22, stated, "It | F 657 | To ensure corrective action for Resident #15, Resident #28, and any other resident that may be affected by failure to revise the care plan: Resident # 15's care plan will be updated to include interventions to address wandering and elopement risk and interventions by June 6, 2024, Resident #28's care plan will be updated to address side effects and interventions related to anticoagulant and diuretic medications by June 6, 2024. Isolation will be removed from Resident #28's care plan regarding a disease process from December 2023 which the resident has | |

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| F 657 | Continued From page 4<br>is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. . . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment. . . ."<br><br>- Observation throughout the survey showed Resident #15 with a wanderguard (roam alert device) on his leg and wheelchair frame and frequently wandering throughout the building.<br><br>Review of Resident #15's medical record occurred on all days of survey. Diagnoses included dementia with behavior disturbance.<br><br>Resident #15's Elopement Risk Assessment, dated 11/13/19, identified the resident at risk for elopement/wandering with interventions of personal safety alarms, frequent monitoring, music, personalization of room, staff aware of wander risk, and initiation of roam alert.<br><br>Resident #15's nurses' notes included episodes of exit seeking and/or elopement on at least nine occasions from 01/27/24 to 05/16/24.<br><br>The facility failed to update the care plan to include interventions to address wandering/elopement.<br><br>During an interview on 05/16/24 at 10:06 a.m., an | F 657 | recovered from by June 6, 2024. All other resident care plans will be reviewed and updated as needed to ensure continuity of care by June 20, 2024. A Care Plan Revision Policy was developed on June 3, 2024 and will be reviewed with the Interdisciplinary Team and the Nursing Department by June 10, 2024. To ensure corrective action of revision of care plans is achieved and maintained, QA monitoring of care plan revision will be completed by the DON/Designee weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. QA monitoring to ensure revision of care plans will be implemented by June 10, 2024 on Resident #15, Resident #18, and a random sample of 20 percent of the resident census. Results of the QA audit will be reported by the DON/Designee to the QA Committee during the monthly QA Meeting. Any concerns identified will be be reported to the Administrator and immediately corrected. | |

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| F 657 | Continued From page 5<br>administrative nurse (#2) agreed Resident #15's care plan lacked interventions related to wandering/elopement.<br><br>- Review of Resident #28's medical record occurred on all days of survey. The quarterly MDS, dated 02/20/24, identified the resident received anticoagulant and diuretic medications, and failed to identify the resident was in isolation for an active infection. The current care plan identified the resident was in isolation related to a communicable disease.<br><br>The facility failed to update Resident #28's care plan to include side effects and/or interventions related to anticoagulant and diuretic medications and failed to remove isolation after the resident recovered from the disease in December 2023. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>1. Based on record review, facility policy review, and staff interview, the facility failed to follow professional standards of care regarding physician orders for 1 of 5 sampled residents (Resident #17) selected for medication review. Failure to follow professional standards and contact the physician when blood glucose levels are higher than the practitioner's parameter has the potential to prevent the provider from altering medications to control residents blood sugar | F 658 | 1.To ensure services provided meet professional standards of quality for Resident #17 and any other resident that may be affected by not meeting the professional standards of quality: Policy Revision for Physician Notification was completed on June 3, 2024. Education to Licensed Nursing Staff on notifying physicians of blood sugars outside of ordered blood sugar parameters will be | 6/20/24 |

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| F 658 | Continued From page 6<br>and/or result in adverse events.<br><br>Findings include:<br><br>Review of the facility policy title "Notification of Changes" occurred on 05/16/24. This policy, dated 12/11/23, stated, "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician . . . when there is a change requiring notification. . . . Potential to require physician intervention. . . . Circumstances that require a need to alter treatment. . . ."<br><br>Record review for Resident #17 occurred on all days of survey. A physician's order, dated 04/09/24, stated, "Accucheck [a test for blood sugar] - Obtain accucheck three times daily. Update physician if blood sugar is greater than 400 and if less than 70."<br><br>Review of Resident #17's blood sugar levels from 05/01/24 to 05/15/24 showed the following:<br>* 05/03/24 at 11:46 a.m. blood sugar 454 milligrams per deciliter (mg/dl)<br>* 05/04/24 at 11:25 a.m. blood sugar 408 mg/dl<br>* 05/04/24 at 4:39 p.m. blood sugar 501 mg/dl<br>* 05/05/24 at 4:00 p.m. blood sugar 401 mg/dl<br>* 05/07/24 at 12:00 p.m. blood sugar 412 mg/dl<br>* 05/08/24 at 11:30 a.m. blood sugar 401 mg/dl<br>* 05/08/24 at 4:38 p.m. blood sugar "High"<br>* 05/11/24 at 5:04 p.m. blood sugar 430 mg/dl<br>The medical record lacked documentation facility staff notified the provider of blood sugar results over 400 mg/dl.<br><br>During an interview on the morning of 05/16/24, an administrative nurse (#1) identified the policy | F 658 | completed by June 10, 2024. Resident #17's blood sugar parameters were changed on May 30, 2024 by his PCP to report any blood sugars below 70 mg/dl or blood sugars above 450 mg/dl. Resident #17's physician orders and care plan were updated with these changes on May 30, 2024. To ensure services meet the professional standards of quality for Resident #17 and any other resident that has blood sugar parameters monitored, QA will be implemented by June 10, 2024 by the QA Nurse/Designee. The QA Nurse/Designee will report their QA audit findings to the QA Committee during the monthly QA meeting. Any concerns identified will be reported to the Administrator and corrected immediately.<br>2.To ensure services provided meet professional standards of quality for Resident #30 and any other resident that may be affected by not meeting the professional standards of quality: A new policy on Head Injury and a revised Neuro Assessment was completed on June 3, 2024. Nursing staff will receive education by June 10, 2024 regarding the policy revision for Head Injury and the new Neuro Check Assessment Form. Resident #30's care plan will be revised by June 6, 2024 to include initiation of neuro checks after any head trauma or suspected head trauma. To ensure services meet the professional standards of quality, QA will be completed by the QA Nurse/Designee on Resident #30 or any resident that experiences a head injury or suspected head injury to ensure neuro checks are | |

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| F 658 | Continued From page 7<br>provided is the one the administrator expected nursing staff to follow regarding blood sugar levels outside the provider's parameters.<br><br>2. Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 4 sampled residents (Resident #30) who experienced a fall. Failure to perform neurological assessments following a fall with actual or suspected head injury may result in delayed identification and treatment of a resident's medical condition.<br><br>Findings include:<br><br>Review of the facility policy titled "Neurochecks" occurred on 05/16/24. This policy, dated 05/29/14, stated, "Neurochecks will be initiated in case of actual or suspected head injury to assess changes in vitals, level of consciousness, pupil response and motor function to help identify any nervous system damage. Neurological flow sheet will be completed . . ." The attached "Neurological Flow Sheet" identified the timeframe for staff to complete vital signs and neurological checks as follows:<br>"- q [every] 15 min [minutes] X [times] (1) hr [hour]<br>- q 30 min X (1) hr<br>- q 1 hr X (4) hr<br>- q 2 hr X (4) hr<br>- q 4 hr X (4) hr<br>- q 8 hr X (8) hr<br>- 3 days after occ. [occurrence]"<br><br>Review of Resident #30's medical record occurred on all days of survey. Diagnoses | F 658 | completed. The QA Nurse/Designee will implement QA monitoring by June 10, 2024. QA will be completed by the QA Nurse/Designee weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. Results of the QA Audit will be reported by the QA Nurse/Designee to the QA Committee during the monthly QA Meeting. Any concerns identified will be reported to the Administrator and corrected immediately. | |

| 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 05/16/2024 |

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

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|---|---|---|---|---|
| F 658 | Continued From page 8 | F 658 | | |

included dementia, other abnormalities of gait and mobility, and repeated falls.

Resident #30's nurses' notes showed the following:

* 02/28/24 at 8:12 p.m., "Resident found on his back in his room. . . . VS [vital signs] taken. Neuros [neurological checks] completed. States he did remember if he hit his head. . . . On left upper buttock a red area had formed with a bruise starting . . ."

* 03/01/24 at 7:11 p.m., "Resident is alert and orient to person. . . . Able to follow commands. Neuros WNL [within normal limits]. Able to move all extremities." The record lacked documentation of the results of the initial [02/28/24] and subsequent neurological checks except the entry on 03/01/24 above.

* 03/20/24 at 4:40 a.m., "Fall notes 3/19/24 [03/18/24 per the incident report]: Resident was found in the bathroom of another resident. . . . Suspected head trauma from position after fall. Resident also claims to have hit his head. . . ." The neurological flow sheet, started 03/18/24 at 8:30 p.m., identified staff failed to complete eight of the required neurological checks.

During an interview on 05/16/24 at 10:05 a.m., an administrative nurse (#2) stated Resident #30's record lacked a neurological flow sheet for the resident's fall on 02/28/24. The nurse verified staff failed to complete all the required neurological checks for the resident's fall on 03/18/24.