STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W , CAVALIER, North Dakota, 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
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 06/02/25 and concluded on 06/04/25.	F0000		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean and sanitary kitchen environment for 1 of 1 facility kitchen. Failure to ensure the sanitizer test strips used to measure the concentration of sanitizing solution are not expired has the potential for inadequate sanitization and may result in foodborne illness. Findings include:	F0812	To ensure food safety and sanitary food procurement, store/prepare/serve occurs in accordance with professional standards; a Policy/Procedure was developed on the use of sanitization strips titled "Oasis 146 Multi-Quat Sanitizer and Test Strips." The policy identifies to replace the sanitizing strips if the test strips are outside the expiration date. This policy will be reviewed during the monthly staff meeting on 6/30/25. Any dietary staff unable to attend the All Staff Meeting will be educated by July 9th, 2025 to train them to check the expiration date of the sanitation strips prior to use and if expired to use new strips with an appropriate expiration date. Any staff on vacation or medical leave will be trained upon their return to work. New test strips were purchased to replace the expired test strips on June 3rd, 2025. QA monitoring of the sanitizer expiration strips will occur weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year by the Dietary Manager or designee to ensure the sanitation strips expiration dates are acceptable. The Dietary Manager/Designee will give a report of the QA findings to the QAA Committee during their monthly meeting. If concerns are identified, the Administrator will be notified promptly and immediate corrective action will occur.	07/09/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W , CAVALIER, North Dakota, 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
F0812 SS = F	Continued from page 1 Observation in the kitchen on 06/03/25 at 1:35 p.m. showed a dietary staff member (#5) measured the concentration of a premixed bucket of sanitizing solution with expired test strips, dated 05/15/2021. During an interview on 06/03/25 at 4:25 p.m., a dietary staff member (#5) stated staff should not use expired test strips.	F0812		07/09/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by:	F0641	To ensure accuracy of assessments reflects the resident's status for Resident #19 and Resident #31 and any other resident that may be affected by inaccurate assessments; The MDS Coordinator and any other personnel that complete sections N and P will receive education on Sections NO415 and P0100 from the Facility Resident Assessment Instrument 3.0 Users Manual Version 1.91.1 October 2024 by July 9th, 2025. A MDS correction was completed for Resident #19 on 6/04/25 to correctly code that no antianxiety medication was given during that ARD period. Resident #31 had a new quarterly assessment due with an ARD of 5/27/25 and completed on 6/2/25 and documentation correctly identified that no side rails restraints are used. The correction for Resident #19 and the new quarterly assessment for Resident #31 were submitted to the CMS QIES Submission Processing System and the ND Department of Human Services 6/3/2025 and accepted into the system 6/4/25. To ensure accuracy of assessments for all residents that may be affected, all residents will have sections N0415 and P0100 reviewed of their most recent MDS reviewed. If any errors are identified, corrections will be made and submitted to the CMS QIES Submission Processing System and the ND Department of Human Services by July 9th, 2025. To ensure corrective action is achieved and maintained, QA monitoring for Resident #19,Resident #31 and a random sample of resident MDS's completed will be reviewed by the DON/Designee to ensure Sections N0415 and P0100 are completed correctly weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year. Results of the QA Audit will be reported to the QAA Committee by the DON/Designee during the monthly QAA meeting for review. If concerns are identified,the Administrator will be notified and immediate corrective action will occur.	07/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W , CAVALIER, North Dakota, 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
F0641 SS = D	Continued from page 2 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 12 sampled residents (Resident #19 and #31). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTIONS N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, page N-6 to N-8, stated, ". . . Code all high-risk drug class medications according to their pharmacological classification . . . N0415: High-Risk Drug Classes . . . Coding Instructions: . . . . N0415B1. Antianxiety: Check if an anxiolytic [antianxiety] medication was taken by the resident at any time during the 7-day look-back period . . ." - Review of Resident #19's medical record occurred on all days of survey. A quarterly MDS, dated 05/20/25, showed facility staff coded an antianxiety medication during the seven-day look back period. The medical record failed to identify an antianxiety medication administered in the look-back period. During an interview on the afternoon of 06/03/25, an administrative nurse (#1) confirmed staff failed to code the MDS correctly. SECTION P: RESTRAINTS AND ALARMS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages P1-P5, stated, ". . . PHYSICAL RESTRAINTS: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. . . . P0100: Physical Restraints . . . Coding Instructions: . . . After determining whether or not an item . . . is a physical restraint and was used	F0641		07/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W , CAVALIER, North Dakota, 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
F0641 SS = D	Continued from page 3 during the 7-day look-back period, code the frequency of use: Code 0, not used: if the item was not used during the 7-day look-back or it was used but did not meet the definition. . . . Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period. . . ." - Review of Resident #31's medical record occurred on all days of survey. An admission MDS, dated 02/24/25, showed facility staff coded section P0100A, bed rail as "2 used daily." Observation showed no bed rails present. During an interview on 06/02/25 at 5:00 p.m., an administrative nurse (#1) confirmed Resident #31 does not have bed rails and staff failed to code the admission MDS correctly.	F0641		07/09/2025
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	To ensure that infection control standards related to enhanced barrier precautions are followed for Resident #14 and Resident #32 and that infection control practices/standards during medication pass for Resident #32 and any other resident that may be affected by the same deficient practice; the policy on enhanced barrier precautions was reviewed and revised on 6/25/25. The revised policy titled "Enhanced Barrier Precautions" will be reviewed during the All Staff Meeting on June 30th, 2025. Any staff not in attendance at the All Staff Meeting will be educated by July 9th, 2025. Staff on vacation or medical leave will be educated upon their return to work. The policy titled "Medication Administration-General Guidelines" which discusses administering medications under sanitary conditions will be reviewed with licensed nurses and med techs by July 9th, 2025. Any licensed nurses or med techs on vacation or on medical leave will receive training upon their return to work. QA monitoring of Resident #14 and Resident #32 and other residents receiving Enhanced Barrier Precautions and medication pass for Resident #32 and 20 percent of the resident census will be monitored during medication pass to ensure infection control practices for enhanced barrier precautions and sanitary medication pass are followed. QA monitoring will be completed by the QA Nurse/Designee weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. A report of the QA monitoring results will be given by the QA Nurse/Designee to the QAA Committee during their monthly meeting. Any concerns identified will be reported to the Administrator promptly and immediate corrective action will occur.	07/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W , CAVALIER, North Dakota, 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
F0880 SS = D	Continued from page 4 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 3 sampled residents (Resident #14 and #32) observed during wound care. Failure to practice infection control standards related to enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility.	F0880		07/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W , CAVALIER, North Dakota, 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
F0880 SS = D	Continued from page 5 Findings include: Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 06/04/25. This policy, dated March 2023, stated, ". . . Enhanced barrier precautions refer to the use of gown and gloves for high-contact resident care activities for residents known to be colonized or infected with a MDRO (multidrug resistant organism) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). . . . High-contact resident care activities include: . . . Wound care: any skin opening requiring a dressing . . ." - Review of Resident #14's medical record occurred on all days of survey and identified a pressure ulcer on the inner buttocks and dressing changes every three days and as needed. The resident's room failed to identify EBP. Observation on 06/03/25 at 9:08 a.m. showed a certified nurse aide (CNA) (#4) and a nurse (#3) applied gloves and assisted Resident #14 off the toilet. The nurse cleansed the pressure ulcer area and applied a dressing. The nurse (#3) and the CNA (#4) failed to wear a gown during high-contact resident care for toileting and wound care. - Review of Resident #32's medical record occurred on all days of survey. The record identified an indwelling urinary catheter, heel ulcers to both heels, and dressing changes to the heels two times a day. Observation on 06/03/25 at 12:27 p.m. showed Resident #32's room with signage for EBP and a supply cart located at the entrance of the room. Two nurses (#2 and #3) entered the room, applied gloves, removed the wound dressings, cleansed the wounds, and applied new dressings to both the right and left heels. The nurses failed to apply a gown during the high-contact resident care for wound treatment and dressing changes. During interviews on 06/04/25, an administrative	F0880		07/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W , CAVALIER, North Dakota, 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
F0880 SS = D	Continued from page 6 staff member (#1) reported she expected Resident #14 to be in EBP and staff to wear gowns when providing wound cares. 2. Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 1 of 6 sampled residents (Resident #32) observed during medication pass. Failure to practice infection control standards during medication pass has the potential to spread infection to residents. Findings include: Review of the facility policy titled "Medication Administration- General Guidelines" occurred on 06/04/25. This policy, dated October 2022, stated, ". . . If the integrity or sanitation of a medication is in question (e.g. [for example] . . . inadvertently touched by a staff member . . . The compromised medication shall be destroyed per facility policies . . ." Observation on 06/03/25 at 1:06 p.m. showed a nurse (#3) prepared Resident #32's medications for administration. The nurse dropped the Vitamin B complex capsule on the medication cart and, with a bare hand, picked up the capsule and placed it into the medication cup for administration. During an interview on 06/04/25 at 10:00 a.m., an administrative nurse (#1) reported she expected staff to discard a medication dropped on the medication cart.	F0880		07/09/2025