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 _____	10/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid survey started on 10/15/18 and concluded on 10/18/18.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		11/22/18

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

Electronically Signed | 11/08/2018

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident interview, the facility failed to provide care for 4 of 12 sampled residents (Resident #5, #19, #31, and #35) and a supplemental resident (Resident #37) in a manner and environment that maintained, enhanced, and respected each resident's dignity on 3 of 4 days of survey (October 15-17, 2018). Failure to knock, announce themselves, and wait for permission prior to entering residents' rooms, cover a commode, and serve all residents seated at a dining room table at one time does not preserve the residents' personal dignity or enhance their quality of life and placed them at risk of embarrassment and/or emotional harm. Findings include: Review of the facility policy titled, "Routine Care," occurred on 10/18/18. This policy, revised June 2014, stated, ". . . Knock and identify yourself upon entering the room. Give resident time to respond. . . ." Resident interviews identified the following: * 10/16/18 at 10:13 a.m., Resident #5 reported staff do not consistently wait for permission prior to entering his room. * 10/16/18 at 2:55 p.m., Resident #35 indicated	F 550	F-550 Resident Rights/Exercise of Rights: To ensure Resident #5, 19, 31, 35, and 37 and all other residents have the right to a dignified existence, self- determination and communication with access to persons and services inside and outside the facility; the facility has reeducated employees at monthly All Staff meeting 10/30/2018 regarding knocking on doors, announcing themselves, and waiting for permission to entering the room, covering commodes, and serving all residents seated at a dining room table at one time. Staff that were not at the meeting will be educated on these topics by 11/22/2018. A Resident committee met on 11/01/2018 and elected to have tables served on a rotating basis with all residents at one table served at the same time using rotating table system. QA monitoring will be completed by QA Nurse/Designee to ensure correction is achieved and sustained weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. Results of QA audit will be reported to monthly QA committee	

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F 550	Continued From page 2 staff "come on in." Care observations showed the following: * 10/15/18 at 2:23 p.m., A certified nursing assistant (CNA) (#5) transferred Resident #31 into the bathroom, when a second CNA (#7) opened the door to Resident #31's room, knocked once she was in the room, looked about for the resident, and then exited the room. The staff member failed to announce herself and/or wait for permission to enter the room. * 10/15/18 at 2:44 p.m., A CNA (#9) just finished toileting Resident #5, when a second CNA (#7) entered the room to remove the mechanical lift. An uncovered commode sat in the corner of his room. Both CNAs (#7 and #9) failed to cover the commode, and one of the CNAs (#7) failed to knock, announce herself and/or wait for permission to enter the room. * 10/16/18 at 9:34 a.m., An unidentified registered nurse (RN) entered Resident #31's room to "do vitals." She entered her room a second time twenty-six minutes later. The staff member failed to knock, announce herself and/or wait for permission to enter the room. * 10/16/18 at 10:33 a.m., An unidentified staff member entered Resident #5's room with a can of soda, and knocked on the door once she was in the room. An uncovered commode sat in the corner of his room. The staff member failed to announce herself and/or wait for permission to enter the room, and failed to cover the commode. * 10/16/18 at 4:05 p.m., A CNA (#7) entered Resident #19's room to speak to her roommate. A few minutes later, a second CNA (#8) entered, and knocked on the door once she was in the room. One CNA (#7) failed to knock, and both CNAs (#7 and #8) failed to announce themselves	F 550	meeting for review. Any issues identified will be reported to the Administrator and will be immediately corrected.	

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F 550	Continued From page 3 and/or wait for permission to enter the room. * 10/17/18 at 1:28 p.m., An uncovered commode sat in the corner of Resident #5's room. Facility staff failed to cover the commode. Dining observations showed the following: * 10/15/18 at 4:50 p.m., Resident #37 sat at a table with two other residents, who had started eating their food. Staff served Resident #37 sixteen minutes later. * 10/16/18 at 11:47 a.m., Resident #19 sat at a table with four other residents, when staff served her. Staff served the last resident at her table at 12:12 p.m., twenty-five minutes later. Resident #19 had already finished eating. * 10/17/18 at 11:48 a.m., Resident #5 sat at a table with two other residents, when staff served him. Staff served the last resident at his table at 12:13 p.m., twenty minutes later. Facility staff failed to serve all residents seated at the same dining room table at one time.	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F 565		11/22/18

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F 565	Continued From page 4 requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of monthly Resident Council meeting minutes, and Resident Council group interview, the facility failed to act upon grievances expressed by 10 of 10 residents (A, B, C, D, E, F, G, H, I, and J) during the Resident Council group interview and 3 sampled residents observed during dining (#5, #19, and #37). Failure to act upon the grievances regarding staffs' failure to serve meals in a timely manner resulted in the residents continued dissatisfaction. Findings include: Review of the July-October 2018 Resident Council Minutes identified the following:	F 565	F-565 Resident/Family Group and Response: To ensure corrective action of meals being delivered in a timely manner for group grievance expressed by Resident A - J and any other resident that may be affected. During the All Staff Meeting on 10/30/2018 staff were re-educated on the importance of meal delivery in a timely fashion and educated on the changes made in the delivery process and the new menu system. Any staff not in attendance will be re-educated by 11/22/2018. Dietary Department revised their tray line	

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F 565	Continued From page 5 * 08/13/18, ". . . there has been a long wait for some meals to be served . . . to switch to restaurant style service . . . first come/first serve . . . " * 09/10/18, ". . . often there are long waits to be served supper . . ." During the Resident Council group interview on 10/16/18 at 3:22 p.m., Residents A, B, C, D, E, F, G, H, I, and J agreed the facility failed to follow up on meal service concerns expressed at the August-September, 2018 Resident Council meetings. The residents reported having repeated concerns regarding excessive wait times for food trays at meals, and the possibility it was related to insufficient staffing. They stated this had been a resident concern for some time and has been discussed during previous resident council meetings. The residents stated the wait time for staff to serve meals varied from fifteen to forty-five minutes. The residents made the following statements: * Resident A stated he/she waits to go to the dining area, hoping to get his/her tray sooner, but the wait time is approximately twenty to thirty minutes. * Resident F stated the wait time for staff to serve meals is half an hour or more and occurs daily. * Resident I stated the wait time for staff to serve meals is about thirty minutes or longer. * Resident J stated it does not matter what time he/she arrives to the dining room, there is approximately a thirty to forty minute wait for staff to serve his/her meal.	F 565	process to improve delivery time with implementation of a new menu system on 10/31/2018. The new menu system consists of one main entree and an always available menu. This new menu streamlines the delivery time because it has eliminated the process of taking meal orders which was very time consuming. The new menu system still allows residents the ability of meal choice options. During a Resident Council Committee Meeting held on 11/01/18 discussion was held regarding the serving process and rotation of tables to ensure residents at each table were served together and in a timely manner. Meal times were reviewed at resident council meetings. The Resident Council Committee voted in favor of these changes on 11/01/18 and it was also reviewed and approved at the monthly Resident Council Meeting on 11/12/18. Certified Dietary Manager (CDM) or designee to monitor meal delivery times in the dining room and trays delivered to resident rooms. Social Service Designee (SSD) or designee will complete QA to ensure that all grievances presented by residents, resident groups/family or family group are addressed, resolved, and do not reoccur. To ensure solutions are sustained, QA monitoring will occur weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. Results of QA audit will be reported to monthly QA committee for review. Any issues identified will be reported to the	

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F 565	Continued From page 6 Dining observations showed the following: * 10/15/18 at 4:50 p.m., Resident #37 sat at a table with two other residents, who had begun eating their food. Staff served Resident #37 sixteen minutes later. * 10/16/18 at 11:47 a.m., Resident #19 sat at a table with four other residents, when staff served her. Staff served the last resident at her table at 12:12 p.m., twenty-five minutes later. * 10/17/18 at 11:48 a.m., Resident #5 sat at a table with two other residents, when staff served him. Staff served the last resident at his table at 12:13 p.m., twenty minutes later. During an interview on 10/18/18 at 11:28 a.m., an administrative staff (#1) stated she understands residents wait a long time in the dining room for staff to serve the noon/evening meals and reported the facility is working on a solution to help the situation.	F 565	Administrator and will be immediately corrected.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and	F 644		11/22/18

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F 644	Continued From page 7 all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Pre-admission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 2 of 4 sampled residents (Resident #2 and #12) with a new diagnosis of mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with the residents' needs. Findings include: The North Dakota PASARR Provider manual states, ". . . change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC] was not identified at the Level I screen process, and that condition later emerged or was discovered . . ." - Review of Resident #2's medical record	F 644	F-644 Coordination of PASARR and Assessments: To Ensure appropriate PASARR screenings for residents #2, and #12 any other residents in the facility are correct. SSD will review all resident charts including Resident #2 and #12 to ensure necessary PASRR screenings are in place. SS Designee or assigned Designee will complete necessary QA monitoring. QA monitoring will occur weekly x1 month, monthly x 3 months, and quarterly thereafter x 1 year on any new admissions or any residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for level 11 resident review upon a significant change in status assessment. Results of QA audit will be reported to monthly QA Committee meeting for review. Any issues will be reported to the Administrator and immediately corrected.	

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F 644	Continued From page 8 occurred on all days of survey. The initial PASARR screening, dated 10/06/14, stated, ". . . has no diagnosis of major mental illness . . . no signs and symptoms related to a major mental illness . . ." The current care plan stated, ". . . Start date 03/26/18 . . . having a diagnosis of unspecified psychosis, major depressive order, dementia with behavioral disturbance . . ." The record lacked evidence of an updated Level I screening/change in status assessment. During an interview on 10/18/18 at 11:24 a.m., an administrative nurse (#1) confirmed the facility failed to update the Level I screening change in status assessment. - Review of Resident #12's medical record occurred on all days of survey. The initial PASARR screening, dated 01/08/18, identified Resident #12 did not have a major mental illness/disorder. A "Psychiatric Care Evaluation," dated 05/22/18, identified Resident #12's as newly diagnosed with psychosis and major depressive disorder. The record showed facility staff failed to complete a Level I screening/change in status assessment at that time. During an interview on 10/18/18 at 11:42 a.m., a social services staff member (#2) confirmed facility staff failed to complete a Level I screening/change in status assessment for Resident #12 following his visit with the geriatric psychiatrist.	F 644		
F 658	Services Provided Meet Professional Standards	F 658		11/22/18

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F 658 SS=D	Continued From page 9 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a current physician's order for 1 of 4 sampled residents (Resident #35) receiving dialysis. Failure to obtain a current order may result in the resident receiving unauthorized dialysis treatment. Findings include: Review of Resident #35 medical record occurred on all days of survey. An outpatient progress note, dated 10/09/18, identified Resident #35 receives dialysis three days per week. During an interview on 10/15/18 at 2:40 p.m., an unidentified staff member reported, "[Resident #35] is at dialysis right now." Facility staff failed to obtain a physician's current order for Resident #35's ongoing dialysis treatments.	F 658	F-658 Services Provided Meet Professional Standards: To ensure the facility provides appropriate/current physician order for Resident #35 and any other resident that may be affected, current physician order was obtained for Resident #35 on Dialysis and any other residents in facility receiving dialysis physician order for current dialysis was obtained by their PCP. Nurses were educated on 10/30/2018 during their nurse's meeting that ongoing current physician orders for dialysis are needed. Any nurse nurse not at the meeting will be reeducated by 11/22/2018. DON/Designee will complete QA monitoring that physician orders are obtained/maintained for Resident #35 and any other residents that may be affected will occur weekly x 1 month, monthly x 3 months, quarterly thereafter x 1 year. Results of QA audit will be reported to monthly QA Committee meeting for review. Any issues identified will be reported to the Administrator and will be	

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F 658	Continued From page 10	F 658	immediately corrected,	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide consistent transfer methods to prevent accidents for 1 of 9 sampled residents (Resident #7) who required staff assistance with transfers. Failure to ensure staff transfer residents in a consistent manner may result in falls and/or injuries. Findings include: Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia and a history of seizure activity. The resident's current care plan identified assist of one staff for transfers. Observation on 10/16/18 at 10:57 a.m. showed two certified nursing assistants (CNAs) (#4 and #6) transferred Resident #7 on and off the toilet using a sit-to-stand mechanical lift. Observation on 10/17/18 at 11:01 a.m. showed two CNAs (#3 and #5) transferred Resident #7 on and off the toilet using a gait belt, walker, and	F 689	F-689 Free of Accident Hazards/Supervision/Devices: To ensure that Resident #7 and any other resident in the facility remains as free of accident hazards as is possible and each resident received adequate supervision and assistance devices to prevent accidents. Resident #7 had PT review and her care plan was updated on 10/22/2018 to use stand lift/2 assist at all times to maintain safety and appropriate device used. All other residents are reviewed upon admission, quarterly, annually, and with any significant change MDS to ensure resident receives the adequate supervision and assistance devices to prevent accidents. QA Nurse/Designee will complete QA monitoring on Resident #7 and random sample of at least 5 other residents to	11/22/18

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F 689	Continued From page 11 two staff assist. During an interview on 10/17/18 at 11:11 a.m., a CNA (#3) identified the CNAs have care cards which show how to care for the residents. The CNA showed the care card to the surveyor and identified Resident #7 needs assistance of two staff members for transfers, and no mechanical lift. Failure to ensure staff transfer residents in a consistent manner and ensure care plans and care cards contain the same information may result in incorrect transfers, falls, and/or injuries.	F 689	ensure that residents are transferred in the safest manner possible. To ensure solutions are sustained,QA monitoring will occur weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year. Results of QA audit will be reported to monthly QA Committee meeting for review. Any issues identified will be reported to Administrator and will be immediately corrected.	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident interview, the facility failed to ensure 2 of 12 sampled residents (Resident #5 and #31) received the adaptive eating equipment/utensils necessary to maintain safe oral intake. Failure to ensure Resident #5 and #31 received adaptive eating equipment/utensils prior to being offered food and/or hot liquids placed them at a higher risk of spillage with/without injury, aspiration, and weight loss. Findings include:	F 810	F-810 Assistive Devices - Eating Equipment/Utensils: To ensure Resident #5 and #31 and any other resident in the facility receives the appropriate adaptive/eating equipment/utensils necessary to maintain safe oral intake is met. On 11/07/2018 OT completed a Dining Room Assessment/review on Resident #5, #31, and all other residents to ensure appropriate adaptive eating equipment/utensils are in place. The	11/22/18

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 _____	10/18/2018

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 810	Continued From page 12 Review of the facility policy titled, "Adaptive Eating Devices," occurred on 10/18/18. This undated policy stated, ". . . Physician order is obtained for adaptive devices. . . . The food service department is responsible for ensuring that each individual receives the appropriate feeding devices for each meal. . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included impaired vision/blindness. The current care plan identified, ". . . Colored plate. Colored cups at meals. Liquid set-up and verbalizing placement. . . . Built-up Silverware. . . ." Observations showed the following: * 10/16/18 at 11:49 a.m., Staff served Resident #5's noon meal on a red plate on a red tray, with regular silverware. * 10/16/18 at 5:10 p.m. and 10/17/18 at 8:25 a.m., Staff served Resident #5's liquids in clear glasses. * 10/17/18 at 11:48 a.m., Staff served Resident #5's noon meal with regular silverware. Resident #5 did cough during the meal. When asked questions about the tray set-up, Resident #5 stated, "I can't see anything." * 10/17/18 at 12:00 p.m., Staff served Resident #5's noon meal on a red plate on a red tray. * 10/18/18 at 8:00 a.m., Staff served Resident #5's noon meal on a red plate on a pink tray, with liquids in red glasses and with regular silverware. - Review of Resident #31's medical record occurred on all days of survey. Diagnoses included impaired/blurry vision. The current physician's orders identified, ". . . Keep red tray	F 810	importance of ensuring residents receive the appropriate adaptive/eating equipment/utensils was reviewed at All Staff meeting on 10/30/2018. Any staff member not at All Staff meeting will be educated by 11/22/2018. QA monitoring will occur weekly x 1 month, monthly x 3 months, quarterly x 1 year thereafter by CDM or designee to ensure resident #5, #31 and other residents utilizing adaptive equipment have their appropriate adaptive eating equipment/utensils to meet their individualized needs as identified in their care plan. Results of the QA audit will be reported to monthly QA Committee meeting for review. Any issues identified will be reported to Administrator and will be immediately corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	10/18/2018

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F 810	Continued From page 13 under plate on table for meals - Vision. Divided plate, leave tray under plate on table. . . . Large 8 oz [ounce] glasses for all liquids. . . ." The current care plan also identified, ". . . Use straws. . . ." Observations showed the following: * 10/16/18 at 12:31 p.m. and 5:10 p.m., Staff served Resident #31's liquids in 4 ounce clear glasses. * 10/17/18 at 8:25 a.m. and 12:00 p.m., Staff served Resident #31's liquids in 4 ounce clear glasses and failed to provide straws for each glass.	F 810		