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 _____	11/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard medicare/medicaid recertification survey started on November 15th and was concluded on the 18th, 2021.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585		12/23/21

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

Electronically Signed | 12/09/2021

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 _____	11/18/2021

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 585	Continued From page 1	F 585		

(meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions

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 _____	11/18/2021

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 585	Continued From page 2 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, resident and staff interviews, and review of the Resident Council minutes, the facility failed to ensure the prompt resolution of grievance from 6 of 6 confidential Residents (Residents A, B, C, D, E, F) attending the resident council interview, and one supplemental resident (Resident G) interview. Failure to address the Residents' concerns in a timely manner resulted in continued dissatisfaction regarding water passes and evening (HS) snacks. Findings include: Review of the facility policy titled "Meal Times	F 585	To ensure corrective action for Residents A,B,C,D,E,F,G and any other resident that may be affected by failure of resolution to a grievance: The facility will review its revised Grievance Policy at the Monthly All Staff Meeting on 12/13/21. All grievances received from any of the residents or the Resident Council will be written on the grievance form. The grievance form will then be reviewed by the Interdisciplinary Team. Upon receipt of the grievance,the resident or resident council member(s)filing the grievance will receive a written response from the Interdisciplinary Team within 7 days	

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 _____	11/18/2021

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 585	Continued From page 3 and Frequency" occurred on 11/18/21. This policy, dated 09/01/21, stated, ". . . HS snack: 7:30 pm or as resident desires . . . Adequacy of snack will be determined both by individuals in the group (resident council) and evaluating the overall nutritional status of those in the facility. . . ." Review of Resident Council meeting minutes from September 13, 2021 to November 8, 2021 showed two of three meetings included concerns related to the evening water and snack pass with issues unresolved. The meeting minutes identified residents voiced the following concerns: * September, ". . . the evening snack cart only goes around once every third night, and often there's no cold-water pass at night. Weekends are especially bad for this. . . ." * October, ". . . Water is not being passed at night, and PM snacks are also inconsistent. . . ." * November, the concerns were not addressed. During the Resident Council interview on 11/17/21 at 11:00 a.m. the resident's made the following statements regarding the evening water and snack pass: * Resident A, "I do not receive a snack or water every night." * Resident B, "We only get snacks a few times a week and I have to ask for them to fill my water." * Resident C, "This has been an issue since I got here and it still is, why can't they just fix it?" * Resident D, agreed with the statements from the other residents. * Resident E, "I agree with [Resident C], they just don't have the staff. They are busy getting everyone ready for bed."	F 585	regarding the corrective action the facility is taking. Follow-up and QA monitoring will be completed to ensure the resident or resident council are satisfied with the actions of the facility. Education regarding snacks and hydration policy will be completed during the all staff meeting on 12/13/21. Since Residents A,B,C,D,E,F,G are confidential, the Resident Council will receive a written/verbal response to address the grievance they filed regarding water passes and evening (HS) snacks during the next scheduled monthly Resident Council Meeting on 12/13/21. QA monitoring will be completed by the Activity Director/designee with any residents or resident council that choose to file a grievance to ensure proper corrective action is accomplished weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Activity Director/designee will report all findings to the QA Committee monthly. Any deficient practice will be immediately corrected and reported to the Administrator.	

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 _____	11/18/2021

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 585	Continued From page 4 * Resident F, "We don't get a snack often and I have to ask for water in the evening or I don't get it." During an interview on 11/16/21 at 11:16 a.m., Resident G stated, "The staffing is terrible, there is always someone quitting. They don't even ask us if we want a [evening] snack and if I don't ask them to fill my water, it doesn't happen until the morning." During an interview on 11/18/21 at 08:20 a.m., a nurse (#3) and a medication aide (#4) stated, "The evening water and snack pass is at 7:00 p.m., the CNAs [certified nurse aides] are supposed to fill every resident's water mug and offer them a snack." During an interview on 11/18/21 at 8:57 a.m., an administrative nurse (#5) confirmed staff are expected to pass ice waters in the morning, between 2:00-3:00 p.m., and after supper. During an interview on 11/18/21 at 10:07 a.m., a social services staff stated, "I bring concerns from the resident council meetings to the DON [director of nursing] and Administrator, and I notified both after the September and October meetings." During an interview on 11/18/21 at 2:10 p.m., an administrative nurse (#5) stated, "This has been an issue since May [2021] but I thought it had gotten better."	F 585		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing	F 640		12/23/21

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 _____	11/18/2021

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 640	Continued From page 5 requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an	F 640		

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 _____	11/18/2021

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 640	Continued From page 6 initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure timely electronic data submission of a required Minimum Data Set (MDS) assessment for 1 of 12 sampled residents (Resident #35). Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility (RAI) Manual revised October 2019, page 2-36 stated, ". . . The Entry tracking record . . . Must be completed within 7 days after the admission/reentry. Must be submitted no later than the 14th calendar day after the entry. . . ." Review of Resident #35's medical record occurred on all days of survey and identified the an admission date of 10/15/21. The facility failed to submit the Entry Tracking MDS until 11/04/21 (22 days). During an interview on 11/18/21 at 9:42 a.m., an administrative nurse (#1)confirmed the facility	F 640	To ensure the facility transmits Resident Assessments timely on Resident #35 and any other residents that may be affected by this practice: The MDS Coordinator, DON, and Business Office Manager will be trained on MDS submissions by 12/23/21. Training will include the required transmission dates for each MDS 3.0 Assessment using CMS's RAI Version 3.0 Manual. A MDS excel spreadsheet was developed to ensure that MDSs are submitted timely. The MDS Coordinator, DON, and Business Office Manager will meet at a minimum of two times per week to review and ensure the MDSs are transmitted timely. QA monitoring will be completed by the Business Office Manager/designee on resident #35 and 20% of the MDSs that are completed to ensure transmissions of scheduled MDS assessments are submitted in a timely manner weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year. The Business Office Manager/Designee will report findings during the monthly QA Committee meeting for review. Any issues identified will be reported to the Administrator 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 _____	11/18/2021

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 640	Continued From page 7 failed to complete timely submission.	F 640	corrected immediately.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and resident and staff interview, the facility failed to complete Minimum Data Sets (MDSs) that accurately reflected the residents' status for 4 of 12 sampled residents (Resident #5, #10, #28, and #33). Failure to accurately code the MDS may negatively affect the development of a comprehensive care plan and the care provided to the residents. Findings include: Section H: Bladder and Bowel The Long-Term Care Facility RAI Manual, revised October 2019, page H-8 - H-11, stated, ". . . H0300: Urinary Continence . . . Steps for Assessment . . . Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination. . . . Interview the resident . . . Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes. . . . H0400: Bowel Continence . . . Steps for Assessment . . . Review the medical record for bowel records and incontinence flow sheets, nursing assessments	F 641	To ensure the facility has accuracy of assessments for Resident #5,#10,#28,and #33 and any other resident that may be affected: The facility will re-educate their MDS Coordinator/Interdisciplinary Team on the importance of following the MDS requirements as identified in CMS's RAI 3.0 user manual for instruction of accurately completing the MDS on 12/14/21. The following MDS corrections were completed: Resident #5 Section K was updated with correct weight Resident #10 Section K significant weight loss was removed Resident #28 Section I wound infection was removed Resident #33 Section H changed to reflect continence of bowel and bladder These corrections were completed and transmitted to CMS/State agencies 12/09/21. MDSs on all residents will be reviewed by the DON/Administrative RN prior to submission to CMS/State agencies. To ensure correction is achieved and maintained with coding MDSs for Resident #5,#10,#28,and #33 and any other resident this may affect:	12/23/21

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 _____	11/18/2021

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 641	Continued From page 8 and progress notes, physician history and physical examination. . . . Interview the resident . . . Ask direct care staff who routinely work with the resident . . . " - Review of Resident #33's medical record occurred on all days of survey. A quarterly MDS, dated 10/13/21, identified the resident as occasionally incontinent of urine and frequently incontinent of bowel. A Bowel Assessment, dated 10/07/21, identified Resident #33 as continent of stool. The care plan identified Resident #33 continent of bowel and bladder. Review of the "Routine Toileting Schedule" documentation for October 7-13, 2021, showed the resident had no incontinent episodes of bowel or bladder. During an interview on 11/17/21 at 3:52 p.m., Resident #33 stated, "I don't have those problems yet. I wore a pull-up one time when I didn't have any underwear back from the laundry." During an interview on 11/17/21 at 4:08 p.m., a certified nursing assistant (CNA) (#9) stated Resident #33 has had no episodes of incontinence. During an interview on 11/18/21 at 9:30 a.m., an administrative nurse (#1) confirmed the staff inaccurately coded the MDS. Section I: Active Diagnosis The Long-Term Care Facility RAI Manual, revised October 2019, page I-8, stated, ". . . I: Active	F 641	The DON/Administrative RN will monitor completion and accuracy of MDSs weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. Any errors found will be corrected immediately and reported to the Administrator. Findings will be reported to the QA Committee monthly.	

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 _____	11/18/2021

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 641	Continued From page 9 Diagnoses in the last 7 days . . . Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period . . . " - Review of Resident #28's medical record occurred on all days of survey. A quarterly MDS, dated 09/29/21, identified an active diagnosis of wound infection (other than foot). A nurse progress note, dated 08/31/21, stated, ". . . skin intact, has 3 scabs from history of cellulitus [skin infection] to left leg below knee cap, scabs intact." A physician progress note, dated 09/29/21, stated, ". . . Exam . . . Left lower leg eschars [dead tissue], no redness, or warmth, left lower leg . . . Integumentary: negative for skin lesions or rashes . . . " During an interview on 11/17/21 at 3:30 p.m., an administrative nurse (#1) confirmed Resident #28's infection was not active and staff inaccurately coded the MDS. Section K: Nutrition - The Long-Term Care Facility RAI Manual, revised October 2019, page K-3, stated, "Steps for Assessment for K0200B, Weight . . . If the resident's weight was taken more than once during the preceding month, record the most recent weight. . . ."	F 641		

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 _____	11/18/2021

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 641	Continued From page 10 Review of Resident #5's medical record occurred on all days of survey. Review of weights identified the following: * 07/26/21 of 134 pounds * 08/02/21 of 133 pounds * 08/16/21 of 130 pounds Review of the quarterly MDS, dated 08/18/21, showed section K0200B weight as 136 pounds. The facility failed to use the most current on the quarterly MDS. - The Long-Term Care Facility RAI Manual revised October 2019, page K-5, stated, ". . . K0300: Weight Loss . . . From the medical record, compare the resident's weight in the current observation period to . . . weight in the observation period 30 days ago. . . . If the weight is less than the weight in the observation period . . . calculate the percentage of weight loss. . . . compare the resident's weight in the current observation period to . . . weight in the observation period 180 days ago. . . . If the current weight is less than the weight in the observation period . . . calculate the percentage of weight loss. . . . " Review of Resident #10's medical record occurred on all days of survey. Review of weights identified the following: * 02/22/21 87 pounds * 07/22/21 98 pounds * 08/23/21 94 pounds (a weight loss of 4% in 30 days or a weight gain of 8% in 180 days). A quarterly MDS dated 08/25/21 identified weight loss of greater than 5% in 30 days or 10% in 180 days.	F 641		

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 _____	11/18/2021

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 641	Continued From page 11 During an interview on 11/17/21 at 2:49 p.m., two dietary management staff (#7 and #8) verified facility staff incorrectly coded weight loss for Resident #10.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		12/23/21

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 _____	11/18/2021

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 656	Continued From page 12 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/21/19 Based on record review, review of facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 5 sampled residents (Resident #1) selected for unnecessary medication review. Failure to develop a care plan that includes the care and services staff provide to the resident may negatively impact the resident's quality of life. Findings include: Review of the facility policy titled "Care Planning" occurred on 11/17/21. This undated policy stated, ". . . must develop a comprehensive care plan . . . to meet a resident's medical, nursing, and mental and psychosocial needs . . ." Review of Resident #1's medical record occurred on all days of survey. The physician's orders, dated 06/15/21, stated, "XANAX [an anxiolytic] 0.5 MG [milligrams] TABLET - Administer one tablet by mouth daily at 1[1:00] pm. . . ." and "ELIQUIS [an anticoagulant] 2.5 MG Tablet -	F 656	To ensure the facility develops a comprehensive care plan for Resident #1 and any other resident that may be affected: The facility will re-educate licensed nurses and the Interdisciplinary Team during their meeting on 12/21/21. The care plan for Resident #1 was updated on 12/09/21 to reflect the goals and interventions related to antianxiety use and anticoagulant use. All other resident care plans will continue to be reviewed and updated upon admission, quarterly, annually, and with any significant change by the Interdisciplinary Team. The DON/designee will complete QA monitoring on Resident # 1 and a random sample of 20% of the residents to ensure that every resident has a comprehensive person-centered care plan. QA monitoring will occur weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The DON/Designee will report the results of the QA audit to the monthly QA Committee meeting for review. Any issues identified will be corrected immediately and reported to 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 _____	11/18/2021

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 656	Continued From page 13 Administer 1 tablet by mouth twice daily." The quarterly Minimum Data Set (MDS), dated 07/22/21, identified Resident #1 received antianxiety and anticoagulant medications on all seven days of the assessment period. Resident #1's care plan failed to address the resident's antianxiety and anticoagulant use and/or provide goals/interventions to manage the resident's anxiety and anticoagulant status. During an interview on 11/17/21 at 4:04 p.m., an administrative nurse (#1) agreed the resident's care plan failed to address the need for antianxiety and anticoagulant therapy.	F 656	Administrator.	
F 658 SS=D	Services Provided Meet Professional Standards 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 observation, review of professional reference, record review, and resident and staff interview the facility failed to ensure professional standards of practice were followed for 1 of 3 sampled residents (Resident #33) with physician's orders for tubigrips (tubular support bandages). Failure to follow physician's orders for application and accurately document the application of tubigrips may result in worsening edema and complications for the resident. Findings Include:	F 658	To ensure professional standards are followed for Resident#33 and any resident that may be affected the facility will re-educate their nurses and med techs during their scheduled nurses' meeting on 12/21/21. Resident #33 chose not to wear tubi-grips and this was order was discontinued by Resident #33's Primary Care Physician on 11/19/21. Resident #33's Treatment Record was updated on 11/19/21 to reflect this change. To ensure professional standards are followed with physician orders for	12/23/21

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 _____	11/18/2021

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 658	Continued From page 14 Kozier & Erb's "Fundamentals of Nursing, Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 64-65, state, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . . The client's medical chart is a legal document . . . Failure to properly document can constitute negligence . . . Insufficient or inaccurate assessments and documentation can hinder proper diagnosis and treatment and result in injury . . . " Review of Resident #33's medical record occurred all days of survey. Diagnoses included edema and venous insufficiency and intact cognition. A physician's order, dated 07/08/21, stated, "Tubigrips applied to bilateral legs. On with AM [morning] cares, off at HS [bedtime]." Observations showed the following: * 11/15/21 at 2:15 p.m., resident seated in recliner, edema to bilateral lower legs, no tubigrips on. * 11/16/21 at 9:26 a.m., resident seated in wheelchair in the hallway, edema to bilateral lower legs, no tubigrips on. * 11/17/21 at 9:50 a.m., resident seated in recliner, edema to bilateral legs, no tubigrips on. Review of Resident #33's treatment administration record (TAR) showed nurses initialed the TAR to indicate the tubigrips were applied/removed on 11/15/21, 11/16/21, and applied on 11/17/21. During an interview on 11/17/21 at 8:23 a.m., Resident #33 stated, "I've worn them [tubigrips] in	F 658	Resident #33 and any other resident that may be affected: QA monitoring will be completed by the QA Nurse/designee weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The QA Nurse/Designee will report the audit results to the QA Committee monthly. Any issues identified will be corrected immediately and reported to the Administrator.	

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 _____	11/18/2021

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 658	Continued From page 15 the past, but I haven't worn them here. My legs are more swollen than they were at home." During an interview on 11/17/21 at 9:40 a.m., an administrative nurse (#5) stated the certified nursing assistants(CNAs) apply/remove the tubigrips and the nurses should verify the tubigrips are on/off before documenting in the TAR. During an interview on 11/18/21 at 9:30 a.m., an administrative nurse (#1) agreed nursing staff failed to ensure Resident #33's tubigrips were on/off and inaccurately documented on the TAR.	F 658		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide care and services for the provision of hemodialysis consistent with professional standards of practice for 1 of 1 sampled resident (Resident #19) currently receiving dialysis. Failure to receive dialysis treatment communication, follow physicians' orders, and complete post-dialysis assessments may result in an unidentified change in the resident's condition. Findings include:	F 698	To ensure corrective action for Resident #19 and any other resident that may be affected by dialysis: A communication form to be used each dialysis visit was developed on 12/06/21 to improve communication between the Dialysis Unit and the Nursing Home Team. Nurses will be re-educated on completing the post-dialysis assessment and documentation of the assessment in the resident EMR at their nurse's meeting on 12/21/21. To ensure the dialysis requirement is met: QA monitoring will be	12/23/21

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 _____	11/18/2021

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 698	Continued From page 16 Review of the facility policy titled "Hemodialysis" occurred on 11/18/21. This policy, revised 08/02/21, stated, ". . . ongoing assessment of the resident's condition and monitoring . . . after dialysis treatments received . . . Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. . . . status of the resident's access site(s) upon return from the dialysis treatment . . ." Review of Resident #19's medical record occurred on all days of survey. The physician's order stated, "HEMODIALYSIS AT [name of facility] EVERY MON. WED. FRI." and "ASSESS BRUITS, CMS [circulation, motion, and sensation], DISTAL PULSE, S/S [signs and symptoms] OF INFECTION, VITALS SIGNS AND LUNG SOUNDS POST-DIALYSIS. . . ." Observation on 11/16/21 at 9:43 a.m. showed a dialysis fistula (dialysis access site) to Resident #19's right upper arm. The resident confirmed dialysis treatments three times a week. Review of the electronic treatment record and nurses' notes from 10/01/21 to 11/17/21 lacked documentation of communication/collaboration with the dialysis facility staff and lacked post-dialysis assessments on 37 of 37 occurrences reviewed. During an interview on 11/16/21 at 11:16 a.m., a nurse (#3) stated, "We chart that we completed the post-dialysis assessment on the TAR [treatment administration record] and put what our assessment was in the nurses notes and under the vital signs. We do not receive paperwork or hand off communication about the	F 698	completed by the QA Nurse/designee on Resident #19 weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year. The QA Nurse or designee will report findings to the QA Committee meeting monthly. Any deficient practice will be reported to the Administrator and immediately corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	11/18/2021

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 698	Continued From page 17 [dialysis] run from the dialysis unit." During an interview on 11/17/21 at 4:04 p.m., an administrative nurse (#1) confirmed nursing staff do not receive hand off communication from the dialysis unit regarding the resident's condition during and after treatments. The administrative nurse confirmed the nursing staff failed to complete and document post-dialysis assessments as ordered by the physician.	F 698		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 6 sampled residents observed during medication administration (Resident #19 and #24). Two medication errors occurred during staff administration of 26 medications, resulting in a 7% error rate. Failure to properly prepare and administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of facility policy titled "Insulin Administration-Pen" occurred on 11/17/21. This policy, reviewed July 2020, stated, ". . . Turn dose selector to "2" units. Holding pen with the	F 759	To ensure that Resident #24 and any other resident that may be affected is free from medication error with insulin pens: Nurse #2 was immediately re-educated by an Administrative Nurse on how to properly prime and dial an insulin pen to the appropriate prescribed dosage. The facilities Consulting Pharmacist will re-educate nurses and medication aides during their monthly meeting on 12/21/21 on how to properly prime the insulin pen and dial the insulin pen to the prescribed dosage. To ensure proper priming and dosage of insulins pens is completed the QA Nurse/designee will monitor Residents #19 and #24 and any other resident that uses an insulin pen weekly x 1 month, monthly x 3 months, and	12/23/21

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 _____	11/18/2021

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 759	Continued From page 18 needle pointing up, tap the cartridge. Press the injection button all the way until the dose selector is back to "0". . . Select dose by turning the dose selector to the number of units to be administered. . . . Check the insulin label with the MAR again. . . ." - Observation of medication administration on 11/16/21 at 9:13 a.m. identified a Novolog insulin pen for Resident #24 dialed to 6 units. The nurse (#2) took the insulin pen to administer to the resident, questioned the insulin dosage, and returned to the medication cart to verify the dose with the Medication administration record (MAR). The nurse (#2) stated and the MAR showed an order for 20 units of Novolog insulin, dialed the insulin pen from 6 units to 22 units, and explained the 2 extra units were to prime the pen. Upon interview, the nurse verified the insulin dose for Resident #24 as 20 units, and stated she previously primed the pen. The nurse dialed the pen back to 20 units and administered the insulin. The nurse (#2) failed to confirm Novolog 6 units with the MAR prior to leaving the medication cart and approaching the resident for administrations; failed to dial the insulin pen to prescribed does of 20 units per Resident #24's MAR; and may have resulted in the resident receiving the incorrect dose of 22 units had the surveyor not intervened. - Observation of medication preparation on 11/16/21 at 11:16 a.m. for Resident #19, showed a nurse (#2) held the Novolog insulin pen horizontally, dialed the pen to 2 units, and primed the pen while horizontal.	F 759	quarterly thereafter x 1 year. Any issues identified will be immediately corrected and reported to the Administrator.	

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 _____	11/18/2021

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 759	Continued From page 19 During an interview on 11/18/21 at 08:20 a.m., a nurse (#3) and a medication aide (#4) stated, "You hold the insulin pen vertically with the needle pointing up and prime with 2 units."	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED 11/21/19 Based on observation, record review, review of	F 761	To ensure Resident #24 and any other residents' drugs and biologicals are labeled in accordance with currently acceptable professional principles and	12/23/21

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 _____	11/18/2021

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 761	Continued From page 20 facility policy, review of professional literature, and staff interview, the facility failed to correctly label, store, and discard medications/biological's in 2 of 2 medication carts. Failure to correctly label medication, properly store/secure medication, and date insulin pens when opened increases the risk of residents receiving outdated medications with reduced efficacy, inaccurate dose of medications, and may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Insulin Administration -Pen" occurred on 11/17/21. This policy, revised January 2020, stated, ". . . If a new pen is obtained from the refrigerator . . . document the "date open" on the pen body. If it is an in-use pen (stored at room temperature), check the "date open" to assure that the medication is not expired or in use past the Manufacturer's guidelines. . . ." The manufacturer's instructions for the Novolog pen found at https://www.mynovoinsulin.com/insulin-products/fiasp/how-to-take-fiasp/taking-fiasp.html, stated ". . . in use (opened) at room temperature up to to 86 degrees F (Fahrenheit) for use up to 28 days. . . ." Review of the facility policy titled "Medication Labels" occurred on 11/17/21. This policy, revised January 2020, stated, ". . . Each prescription medication label includes . . . specific directions for use . . . If the physician's directions for use change or the label is inaccurate, the nurse may place a "direction change-refer to	F 761	include all appropriate accessory and cautionary instructions and the expiration date when applicable. The Nurses and Med Techs will be educated during their 12/21/21 meeting: * that all medications must be labeled appropriately with the date open marked and expiration dates clearly labeled and legible. * that medications need to stay locked in the medication cart until the time of administration by the nurse/med tech. * anytime the nurse or Med Tech leaves the medication cart unattended, it needs to be locked. QA will be completed by the QA Nurse/Designee to ensure proper labeling, storage of drugs, and biologicals are done weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. Any issues identified will be corrected immediately and reported to the Administrator.	

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 _____	11/18/2021

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 761	Continued From page 21	F 761		

chart" label on the container indicating there is a change in direction for use. . . ."

- Observation on 11/16/21 at 8:34 a.m. Resident #24's Novolog insulin pen on top of the medication cart C in the hall. The insulin pen contained a needle and the pen dial showed six units. The staff nurse (#2) walked away from the cart and left the insulin pen unattended.

On 11/16/21 at 9:08 a.m., an administrative nurse (#1) observed the insulin pen on top of the medication cart and confirmed the insulin pen should be locked in the cart until ready for administration.

- Observation of medication administration on 11/16/21 at 9:13 a.m. showed Resident #24's Novolog pen without an open date. The directions on the label identified one unit of insulin in the AM. The resident's medication administration record (MAR) stated to administer 20 units in the AM. The facility failed to place a new label with the current physician order for dosage and failed to identify an open date.

- Observation on 11/17/21 from 2:45 p.m. to 2:55 p.m. showed the medication cart AB unlocked and unattended for 10 minutes.

- Observation of the medication cart AB on 11/17/21 at 3:00 p.m. showed an opened Lantus (insulin) pen in the top drawer with an unreadable open date.

During an interview on 11/17/21 at 3:00 p.m., an administrative nurse (#5) confirmed the insulin pen "date opened" was unreadable, 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 _____	11/18/2021

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 761	Continued From page 22 expected the medication cart AB to be locked when unattended.	F 761		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.	F 838		12/23/21

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 _____	11/18/2021

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 838	Continued From page 23 §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to conduct a facility-wide assessment to include all the required components. The facility failed to evaluate the resident population and identify the resources needed to competently provide care and services to residents during both day-to-day operations and emergencies. This failure has the potential to affect all residents currently residing in the facility. Findings include:	F 838	To ensure compliance with the facility assessment which may affect all residents: The facility will revise its current facility assessment by 12/23/21 to include all of the required components necessary to identify resources needed to competently provide care and services to residents during day to day operations and emergencies in the following areas: *Emergency staffing; *Health Information Technology	

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 _____	11/18/2021

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 838	Continued From page 24 Review of the Facility Assessment occurred on 11/17/21. The facility assessment lacked the following: * Emergency staffing * Health information technology resources used * Evaluation of the facility's ability to maintain continuity of operation and ability to secure required supplies and resources during an emergency or natural disaster * How the facility determines the acuity of the resident population and staff needed for the different acuity levels.	F 838	Resources used; *Evaluation of the ability to maintain continuity of the operation and the ability to secure the required supplies and resources during an emergency or natural disaster; *How the facility determines the acuity of the resident population and staffing levels needed for the different acuity levels. QA monitoring/review of the facility assessment will be completed by the QAPI Team to ensure the facility assessment meets the outlined requirements weekly x 1 month, monthly x 3 months,and quarterly thereafter x 1 year. Any issues identified will be immediately corrected and reported to the Administrator.	