North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8049	A. BUILDING: _____ B. WING _____	C 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MINOT SENIOR LIVING, LLC	706 16TH AVE SE MINOT, ND 58701

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B 000	INITIAL COMMENTS An unannounced onsite complaint investigation occurred on April 30, 2026 and included two resident records for review. The facility was found out of compliance with the licensing requirements under our jurisdiction.	B 000		
B 910	33-03-24.1-09,1 GOVERNING BODY 1. The governing body is legally responsible for the quality of resident services; for resident health, safety, and security; and to ensure the overall operation of the facility is in compliance with all applicable federal, state, and local laws. This State Licensing Rule is not met as evidenced by: Based on record review, review of facility policy, review of general event reports, and staff interviews, the facility failed to ensure residents' health and safety for 1 of 1 cognitively impaired resident (Resident #1) who experienced nonconsensual sexual contact from another resident. Failure to ensure the health and safety of residents resulted in continued sexual abuse to Resident #1. Findings include: Review of the facility policy titled "Abuse Prevention, Intervention, Reporting and Investigation" occurred on 04/30/26. This policy, dated June 2025, stated, ". . . Residents are to be free from . . . sexual . . . abuse . . . exploitation . .	B 910		

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carma McLaughlin — TITLE: E.D. — (X6) DATE: 5-28-26

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B 910	Continued From page 1 . at all times. . . . The Community has developed a system for identifying, investigating, preventing, and reporting any incident, or suspected incident, of abuse . . . All reports of resident . . . sexual . . . abuse . . . exploitation . . . are promptly and thoroughly investigated by Community management. . . . Reporting: If such incidents occur . . . after normal working hours, the Executive Director (or designee) is called . . . The Executive director (or designee) notified the following of the suspected abuse incident: a. law enforcement officials, b. adult protective services. c. Resident's attending physician. d. State licensing/certification agency. e. Resident's legal representative on record. . . . g. Local ombudsman. . . . Investigation: The individual conducting the investigation, at a minimum: a Reviews the complete resident report. b. Reviews the resident's record to determine events leading up to the incident. c. interviews the persons reporting the incident. d. Interview any witnesses to the incident. e. interview the residents. f contacts the resident's attending physician and provides an update. g Interviews staff members who have had contact with the resident during a period of the alleged incident. h. Reviews all events leading up to the alleged incident. . . . Witness reports are documented in writing and are signed and dated . . . Report all instances of actual or suspected abuse . . . immediately . . . as soon as possible and not more than 24 hours from the time of the initial report. . . . Notify the family . . . as soon as possible. . . ." Review of Resident #1's medical record occurred on 04/30/236. Diagnoses included dementia and frontotemporal neurocognitive disorder (a progressive brain disorder). a cognitive exam, completed 01/05/26, identified dementia. The resident's care plan stated, ". . . Resident has	B 910		

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B 910	Continued From page 2	B 910		

dementia and may need time to understand and process . . . Staff will monitor the resident every 1 hour for any indicators of possible sexual abuse or exploitation. If staff observe resident having any sexual relations staff to ensure relations are consensual. Staff are to ask resident if he is consenting to sexual interactions. If resident responds no staff are to intervene immediately and ask other resident to leave. Do not leave residents alone. Staff are to contact the nurse or nurse on call immediately and contact the police. Staff to document and report to nurse or nurse on call immediately if any sexual interactions occur and report if resident was consenting of interactions. Visualize and ensure that resident is safe and all needs are being met. Documentation at end of shift verifies that safety checks were performed throughout the shift as directed by care plan. Staff are to document and report any concerns to the nurse or on call nurse immediately. . . ."

Review of Resident #1's progress notes identified the following:
* 04/07/26 at 10:06 p.m., ". . . resident was found performing a sexual act with another resident, documented."
*04/08/26 at 3:31p.m., "Staff completed incident report regarding resident performing sexual acts with a female resident. Staff member interviewed by writer. Staff member stated she went into resident's room around 9:00 PM on 04/07/26 to assist resident with completing HS [at bedtime] cares. Staff stated she observed resident laying on the bed with resident [resident initials] laying on resident with resident's penis in her mouth. Staff member stated she walked out of the room and shut the door. Staff member stated she asked another staff member to ask resident [resident initials] to leave resident's room. Staff

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B 910	Continued From page 3	B 910		

reported resident [resident initials] refused to leave room. . . . Resident [#1] was lying in bed and in agreement with assessment [Vital signs]. . . . Resident denied having a female friend or having sexual relations. Resident denied having sexual acts performed yesterday. Resident placed on 2 hour safety checks to monitor for signs of sexual abuse or exploitation. . . . Care plan updated."
*04/20/26 at 4:21 p.m., stated, ". . . there was a note from staff regarding an incident on 04/18/2026 at approximately 10:30 PM. . . . [Resident #1] was laying straight on his back, and [Resident #2] was lying next to him on her side with her top half over [Resident #1], making out with him. . . . Writer contacted staff member by phone for clarification. . . . Writer met with resident today in his room to discuss the reported incident. Writer asked resident whether he felt uncomfortable or was being forced to do anything he did not want to do. Resident stated "No." . . . Social worker to update resident's guardian. Resident to remain on 2 hour safety checks. . . ."
*04/24/26 at 12:16 p.m., stated, ". . . Care conference held. . . regarding recent sexual encounters with another resident. . . . Guardian [for Resident #1] stated she was not okay with the actions and wants them to stop. . . . Guardian stated she would want the police contacted only if resident was not agreeable to the situation. . . ."

Review of Resident #2's medical record occurred on 04/30/236. Diagnoses depression, . A cognitive exam, completed 07/25/25, identified dementia. The resident's care plan stated, ". . . has history of engaging in sexual interactions with a male resident. If staff observe resident having sexual relations staff to ensure relations are consensual. Staff are to ask resident if she is consenting to sexual interactions. If resident

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B 910	Continued From page 4	B 910		

responds no staff are to intervene immediately and police are to be contacted. Document and report any concerns to nurse immediately. . . ."

Review of Resident #2's progress notes identified the following:
*03/10/26 at 9:50 a.m., stated, ". . . Writer and [Resident#1's] guardian met with [Resident #2] per her request. . . . [Resident #2] has started to have a romantic relationship with the other resident who has frontal lobe dementia. The Residents guardian [Resident #1] is not comfortable with the relationship going beyond a friendship as he is not able to give consent or make decisions that could affect [Resident #2]. . . . Guardian stated she would like them to visit in public and only in their rooms if the doors are kept open. [Resident #2] expressed understanding . . . [Resident #2] agreed to visit [Resident #1] in public or keep door open while together. . . ."
*03/30/26 at 3:56 p.m., stated, ". . .Writer called [Resident #2's son] . . . Writer expressed concerns with a relationship she is having with another resident who has severe memory loss and can not provide consent. . . . [Son] will touch base with [Resident #2] . . ."
*04/07/26 at 10:10 p.m., stated, ". . . residents were found performing sexual acts together, when going to do his bedtime cares, female resident told staff to get out. . . ."
*04/20/26 at 5:03 p.m., stated, ". . . there was a note from staff regarding an incident on 04/18/2026 at approximately 10:30 PM. . . . [Resident #1] was laying straight on his back, and [Resident #2] was lying next to him on her side with her top half over [Resident #1], making out with him. . . .Writer visited with resident in her room regarding this incident. Resident denied being in resident's room with door closed on

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B 910	Continued From page 5 04/18/26. . . . Resident denied anyone making her comfortable [sic] or forcing her to do anything against her will. . . . Writer and ? resident about male guardian's only wanting resident's to have a friendship and not romantic relationship. Resident stated, "I know and we are only having a friendship." Resident to remain on 1 hour safety checks. . . . Social worker to update son." *04/21/26 at 1:24 p.m., stated, ". . . Writer visited with [Resident #2] today about her relationship with [Resident #1]. Writer asked if she ever felt like she was doing things for [Resident #1] against his will or that made her [sic] uncomfortable. [Resident #2] stated "no, not at all." Writer discussed that [Resident #1's] guardian still wants them to have just a non-sexual relationship and remain friends. [Resident #2] stated she understood. . . ." *04/22/26 at 2:30 p.m., stated, ". . . Writer called [son] . . . [Son] is aware of the continued relationship [Resident #2] is having as he stopped by on Saturday the 11th and writer talked to him in detail about the previous issues. . . ." *04/28/26 at 04:56 p.m., stated, ". . . Care conference was held . . . Writer stated due to the male resident's mental status he is not capable of consenting, therefore we have had a conversation with the male resident's guardian who would like their relationship to remain friends. . . ." Review of the general events reports identified the following: *04/25/26, ". . . Event 04/25/26 . . . [Resident #1] door was wide open as staff went to check on him as directed in his care plan. Another resident had her mouth on [Resident #1's] genitalia. Staff asked other resident to leave the room. *04/29/26, ". . . Event 04/28/26 . . . [female resident] was on her knees in front of the other	B 910		

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B 910	Continued From page 6 resident [Resident #1] and her head in the other resident's lap. The other resident had his pants unzipped and his penis out. . . ." During an interview on afternoon 04/30/26, an administrative staff member (#1) confirmed the sexual contact that occurred on 04/07/26 was reported to the state licensing/certification agency and the incidents on 04/18/26, 04/25/26, and 04/28/26 were not reported. The facility was found out of compliance with regulations as follows: *The facility failed to report all the sexual abuse allegations for 04/07/26, 04/18/26, 04/25/26, and 04/28/26 as soon as possible and not more than 24 hours from the time of the initial report to the state licensing/certification agency, guardian, provider, and ombudsman. *The facility failed to provide the survey team with a complete investigation, resident comprehensive assessments, cognitive assessments, and follow-up documentation for all the sexual occurrences that happened on 04/07/26, 04/18/26, 04/25/26, and 04/28/26. *The facility failed to follow the "Abuse Prevention, Intervention, Reporting, and Investigation" facility policy in place.	B 910		
B 925	33-03-24.1-09,2,e GOVERNING BODY e. Prohibition of resident abuse, neglect, and misappropriation of resident property, including investigation, reporting, and follow-up action.	B 925	The plan of correct for these survey findings begins on the next page.	

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B 925	Continued From page 7 This State Licensing Rule is not met as evidenced by: Based on record review, review of facility policy, review of the general event reports, and staff interview, the facility failed to implement their policy and procedure related to abuse for 1 of 1 cognitively impaired resident (Resident #1) who experienced nonconsensual sexual abuse. Failure to investigate, report incidents of sexual abuse to the state licensing/certification agency, and implement appropriate and immediate actions resulted continued sexual abuse to Resident #1. Findings include: Review of the facility policy titled "Abuse Prevention, Intervention, Reporting and Investigation" occurred on 04/30/26. This policy, dated June 2025, stated, ". . . Residents are to be free from . . . sexual . . . abuse . . . exploitation . . . at all times. . . . The Community has developed a system for identifying, investigating, preventing, and reporting any incident, or suspected incident, of abuse . . . All reports of resident . . . sexual . . . abuse . . . exploitation . . . are promptly and thoroughly investigated by Community management. . . . Intervention: Upon reports of . . . sexual abuse . . . appropriate personnel, is immediately notified to arrange for examination of the resident. . . . sexual abuse can mean . . . physical contact without penetration . . . Reporting: If such incidents occur . . . after normal working hours, the Executive Director (or designee) is called . . . The Executive director (or designee) notified the following of the suspected abuse incident: a. law enforcement officials, b. adult protective services. c. Resident's attending physician. d. State licensing/certification agency. e. Resident's legal representative on record. . . .	B 925	#1 Policy Review The policy titled, Abuse Prevention, Intervention, Reporting, and Investigation, was reviewed and no changes were necessary. #2 Root Cause Analysis A Root Cause Analysis was conducted to identify opportunities for improvement and prevention of subsequent events of this nature. #3 Staff Education In response to the survey findings, the following actions were taken: Education Plan of Correction for Staff: A course covering Abuse Recognition and Prevention was assigned to all staff with a due date of June 5, 2026. The Plan of Correction is Continued on the next Page.	5/27/26 5/20/26 6/5/26

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B 925	Continued From page 8 g. Local ombudsman. . . . Investigation: The individual conducting the investigation, at a minimum: a Reviews the complete resident report. b. Reviews the resident's record to determine events leading up to the incident. c. interviews the persons reporting the incident. d. Interview any witnesses to the incident. e. interview the residents. f contacts the resident's attending physician and provides an update. g Interviews staff members who have had contact with the resident during a period of the alleged incident. h. Reviews all events leading up to the alleged incident. . . . Witness reports are documented in writing and are signed and dated . . . Report all instances of actual or suspected abuse . . . immediately . . . as soon as possible and not more than 24 hours from the time of the initial report. . . ." Findings include: Review of Resident #1's medical record occurred on 04/30/236. Diagnoses included dementia and frontotemporal neurocognitive disorder (a progressive brain disorder). A cognitive exam, completed 01/05/26, identified dementia. Review of the general event reports showed Resident #1 was subjected to sexual abuse by another resident on four occasions (04/07/26, 04/18/26, 04/25/26, and 04/28/26) . During an interview on afternoon 04/30/26, an administrative staff member (#1) confirmed the sexual contact that occurred on 04/07/26 was reported to state licensing/certification agency and not the incidents that occurred on 04/18/26, 04/25/26, and 04/28/26. The facility was found noncompliant with state	B 925	In addition to the course assigned through the learning management system, all current staff members were re-educated on the organization's Abuse Prevention and Reporting Policy, and on the definition of a vulnerable adult. Education included: •Definition and types of abuse, neglect, and exploitation •Definition of vulnerable adult •Recognition of signs and symptoms of abuse •Mandatory reporting requirements •Timelines for reporting •Staff responsibilities to ensure patient safety Staff received additional education that in the event of an incident, they are to take immediate steps to ensure resident safety, including: •Removing the resident from potential harm •Ensuring appropriate supervision •Initiating internal reporting processes •Cooperating fully with investigations Staff were also instructed that any suspicion of abuse must be reported immediately to the Executive Director in accordance with state and federal regulations; and that failure to report may result in disciplinary action, up to and including termination. Plan of Correction is Continued on the Next Page	6/5/26

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B 925	Continued From page 9 regulations as follows: *On 3/10/26 the facility became aware that Resident #1's guardian was not comfortable with the relationship going beyond a friendship as Resident #1 is not able to give consent or make decisions that could affect him. The facility allowed sexual abuse to continue. *The facility failed to report all the sexual abuse allegations that occurred on 04/07/26, 04/18/26, 04/25/26, and 04/28/26 as soon as possible and not more than 24 hours from the time of the initial report to the state licensing/certification agency, guardian, provider, and ombudsman. *The facility failed to provide the survey team with completed investigations, resident comprehensive assessments, cognitive assessments, and follow-up documentation for all the sexual occurrences. *The facility failed to follow the "Abuse Prevention, Intervention, Reporting, and Investigation" facility policy in place. Refer to B910	B 925	#4 Staff Attestation and Acknowledgement of Understanding of Education Received and reviewed during all staff meeting Responsibility to Resident. Following completion of training, all staff were required to sign a written attestation confirming: •They received and understood the abuse policy •They understood their obligation to immediately notify the Executive Director (or designee) if abuse is suspected •They acknowledge their responsibility to take immediate action to ensure the patient is safe and protected from harm This attestation is placed in each Employee's HR File. #5 Ongoing Monitoring and Follow up To ensure ongoing compliance and identification of opportunities for improvement, the Executive Director (or designee) will: •Maintain records of completed training and signed attestations •Conduct 10 random audits in 3 months of staff knowledge and incident reporting practices (audit tool created) •Review all reported incidents to ensure compliance with policy and timeliness of investigation and follow-up in accordance with policy and state regulation. Review and audits will occur on an ongoing basis. Incident reports will be evaluated regarding type, timely submission, and to determine whether there is a need to have a more formal investigation. If any investigation is initiated, it will be reviewed to ensure timely completion, adherence to organizational policy, and appropriate communication with regulatory agencies if necessary.	6/18/26 Begins on 5/27/26 and will be ongoing