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	8099	A. BUILDING: _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MANDAN, LLC	2801 39TH AVE SE MANDAN, ND 58554

(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) COMPLETE DATE
B 000	INITIAL COMMENTS For the unannounced onsite complaint survey on 04/01/25, the sample included three residents for review and one closed record. Tier II citations included B921, B928, B1220, B1240, B1320, and B1700.	B 000	See Attached	
B 921	33-03-24.1-09,1,a GOVERNING BODY a. All services provided by the facility to meet the needs of the residents, including admission, transfer, discharge, discharge planning, and referral services. This State Licensing Rule is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure referral services were implemented for 1 of 1 closed record resident (Resident #4). Failure to provide referral services as ordered does not ensure resident care needs are met. Findings include: Review of the facility policy titled "Outside Health Care Agency" occurred on 04/01/25. This policy, dated January 2025, stated, ". . . To meet residents needs, Clinical Services should coordinate with health care agencies outside the Community including those related to home health. . . . Obtain a written physician's order . . ." Review of Resident #4's medical record occurred on 04/01/25. A physician's order, dated 01/31/25,	B 921		

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B 921	Continued From page 1 stated, ". . . Open wound of toe . . . Patient is also on HH [Home Health] - nursing to reach out for possible addition of SN [skilled nursing]." The medical record lacked documentation the facility contacted HH for SN care. During an interview on the morning of 04/01/25, an administrative staff member (#1) confirmed the facility failed to contact the Home Health Agency for the addition of skilled nursing services.	B 921		
B 928	33-03-24.1-09,2,h GOVERNING BODY h. Resident rights which comply with North Dakota Century Code chapter 50-10.2. This State Licensing Rule is not met as evidenced by: Based on record review, review of Resident Rights Booklet, and staff interview, the facility failed to notify the legal representative of a change in condition for 1 of 1 closed record resident (Resident #4). Failure to notify Resident #4's legal representative limited the representative's ability to fully participate in the resident's care and treatment. Findings include: Review of "A Guide to Your Rights as a Resident of a Basic Care Facility In North Dakota"	B 928		

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B 928	Continued From page 2 occurred on 04/01/25. This booklet, dated March 2023, stated, "Involvement in Health Care . . . You should choose who you want involved in or notified about your care. . ." Review of Resident #4's medical record occurred on 04/01/25 and identified Resident #4 had a healthcare and financial power of attorney (POA). A physician's order, dated 01/31/25, stated, ". . . Open wound of toe . . . Left foot toe wound . . . Wound orders - cleanse toe wound daily with betadine [topical antiseptic used to disinfect and cleanse a wound] . . . Patient is also on HH [Home Health] - nursing to reach out for possible addition of SN [skilled nursing]. . . ." The medical record lacked evidence the facility notified the resident's representative of the toe wound. During an interview on 04/01/25 at 2:35 p.m., an administrative nurse (#2) stated she expected staff to notify the resident's family member (POA) of a toe wound and the new orders received.	B 928		
B1220	33-03-24.1-12,2 RESIDENT ASSESSMENTS/CARE PLANS 2. The assessment must be completed in writing by an appropriately licensed professional. The assessment must include: a. A review of health, psychosocial, functional, nutritional, and activity status. b. Personal care and other needs. c. Health needs. d. The capability of self-preservation.	B1220		

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B1220	Continued From page 3 e. Specific social and activity interests. This State Licensing Rule is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to initially assess and routinely assess the status of a wound for 1 of 1 closed record resident (Resident #4). Failure to assess a wound on an initial and ongoing basis contributed to a delay in treatment and deterioration of the wound. Findings include: Review of the facility policy titled "Assessments" occurred on 04/01/25. This policy, dated January 2025, stated, ". . . Significant change in condition: A Registered Nurse (or licensed practical nurse where applicable) is responsible for evaluating a significant change in resident condition. Significant change in condition is defined as - any deviation from the residents' typical clinical baseline . . . Complete a clinical update in electronic chart . . . Document actual clinical symptoms . . . Implement new orders . . . Initiate appropriate referrals . . . develop a revised plan of care . . ." Review of the facility policy titled "Protocol Skin" occurred on 04/01/25. This policy, dated January 2025, stated, "The skin protocol, along with the below interventions should be implemented at the order of the resident's provider or based on an assessment. Interventions - Apply treatment/medications as delegated - The following observations should be reported to a registered nurse . . . discoloration of skin,	B1220		

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B1220	Continued From page 4	B1220		

increased swelling, redness or irritation, . . . signs of infection . . . licensed nurse to evaluate resident status weekly . . . and document evaluation on Skin Condition Report or in Progress Notes."

Review of Resident #4's medical record occurred on 04/01/25. Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (nerve disorder). A physician's order, dated 01/31/25, stated, ". . . Open wound of toe . . . Left foot toe wound . . . Patient has no sensation of her lower extremities . . . Wound orders - cleanse toe wound daily with betadine [topical antiseptic used to disinfect and cleanse a wound] . . . Patient is also on HH [Home Health] - nursing to reach out for possible addition of SN [skilled nursing]."

Resident #4's medical record lacked a nursing assessment, on-going assessments, documentation and evaluation of the toe wound.

A nursing progress note, dated 02/14/25 stated, "Resident had podiatry appointment today 2/14 for the sore on her toe. Before leaving for her appointment, nurse practitioner, [name], went to see resident. Resident's toe was swollen, was black in color, and her foot was red and swollen. Podiatry provider sent resident to the ER due to findings of a severe infection. Resident admitted at [hospital name] for the diabetic foot ulcer."

During an interview on the morning of 04/01/25, an administrative staff member (#1) confirmed nursing staff failed to assess, monitor, evaluate, and follow the facility skin policy for Resident #4's toe wound.

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B1240	Continued From page 5	B1240		
B1240	33-03-24.1-12,4 RESIDENT ASSESSMENTS/CARE PLANS 4. The care plan must be updated as needed, but no less than quarterly. This State Licensing Rule is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 1 of 1 closed record resident (Resident #4). Failure to revise the care plan limited staffs' ability to communicate care needs and ensure continuity of care for the resident. Findings include: Review of the facility policy titled "Assessments" occurred on 04/01/25. This policy, dated January 2025, stated, ". . . Significant change in condition: A Registered Nurse (or licensed practical nurse where applicable) is responsible for evaluating a significant change in resident condition. Significant change in condition is defined as - any deviation from the residents' typical clinical baseline . . . Complete a clinical update in electronic chart . . . Document actual clinical symptoms . . . Implement new orders . . . Initiate appropriate referrals . . . Develop a revised plan of care . . ." Review of Resident #4's medical record occurred on 04/01/25. Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (nerve disorder). A physician's order, dated 01/31/25, stated, ". . . Open wound of toe . . . Left foot toe wound . . . Patient has no sensation of her lower extremities . . . Wound orders - cleanse toe	B1240		

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B1240	Continued From page 6 wound daily with betadine [topical antiseptic used to disinfect and cleanse a wound] . . . Patient is also on HH [Home Health] - nursing to reach out for possible addition of SN [skilled nursing]." Resident #4's care plan lacked a diagnosis and interventions related to the resident's toe wound. During an interview on the morning of 04/01/25, an administrative staff member (#1) confirmed nursing staff failed to update Resident #14's care plan.	B1240		
B1320	33-03-24.1-13,2 RESIDENT RECORDS 2. Resident records must include: a. The resident's name, social security number, marital status, age, sex, previous address, religion, personal licensed health care practitioner, dentist, and designated representative or other responsible person. b. The licensed health care practitioner's orders and report of an examination of the resident's current health status. c. An admission note. d. A copy of an initial and current assessment and care plan. e. Documentation of resident observations by authorized staff. f. Documentation of death, including cause and disposition of the resident's personal effects, money, or valuables deposited with the facility.	B1320		

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B1320	Continued From page 7 g. A quarterly progress note documenting the resident's current health condition, level of functioning, activity involvement, nutritional status, psychosocial interactions, and needs. h. Documentation of review of prescribed diets. i. Transfer forms that are completed, signed, and sent with the resident when transferred to another facility. j. A medication administration record documenting medication administration consistent with applicable state laws, rules, and practice acts. k. Documentation of an annual medication regimen review. l. A written report of any funds kept at a resident's request. Such record shall show deposits to and withdrawals from the fund. m. Documentation of a fire drill walk-through within five days of admission. n. All agreements or contracts entered into between the facility and the resident or legal representative. o. A discharge note. This State Licensing Rule is not met as evidenced by: Based on record review and staff interview, the	B1320		

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B1320	Continued From page 8 facility failed to maintain a complete medical record for 1 of 1 closed record resident (Resident #4). Failure to maintain a completed medical record limited staffs' ability to communicate care needs and ensure continuity of care for the resident. Findings include: Review of Resident #4's medical record occurred on 04/01/25. Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (nerve disorder). A physician's order, dated 01/31/25, stated, ". . . Open wound of toe . . . Left foot toe wound . . . Patient has no sensation of her lower extremities . . . Wound orders - cleanse toe wound daily with betadine [topical antiseptic used to disinfect and cleanse a wound] . . . Patient is also on HH [Home Health] - nursing to reach out for possible addition of SN [skilled nursing]." Resident #4's medical record failed to include a copy of the current assessment, care plan, and documentation of resident observations related to the toe wound. During an interview on the morning of 04/01/25, an administrative staff member (#1) confirmed nursing staff failed to assess, care plan, and document Resident #4's toe wound.	B1320		
B1700	33-03-24.1-17 NURSING SERVICES 33-03-24.1-17. Nursing services. Nursing services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate individual or agency providing nursing services.	B1700		

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B1700	Continued From page 9 This State Licensing Rule is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide nursing services to meet the individual medical and health needs for 1 of 1 closed record resident (Resident #4). Failure to provide nursing services in accordance with acceptable professional standards placed Resident #4 at risk for complications and illness. Findings include: Review of the facility policy titled "Medication Administration" occurred on 04/01/25. This policy, dated January 2025, stated, ". . . In states where Medication Aids administer medications, the standard of practice for medication administration or provision will be established by state or Community standardized medication administration training. . . . A Registered Nurse will determine competency of staff authorized to administer medications where applicable. N. Staff who are authorized to administer medications, will report to a licensed nurse where applicable. . . ." Review of Resident #4's medical record occurred on 04/01/25. Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (nerve disorder). A physician's order, dated 01/31/25, stated, ". . . Open wound of toe . . . Left foot toe wound . . . Patient has no sensation of her lower extremities . . . Wound orders - cleanse toe wound daily with betadine [topical antiseptic used to disinfect and cleanse a wound] . . ." A nursing progress note, dated 02/14/25, stated,	B1700		

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B1700	Continued From page 10 "Resident had podiatry appointment today 2/14 for the sore on her toe. Before leaving for her appointment, nurse practitioner, [name], went to see resident. Resident's toe was swollen, was black in color, and her foot was red and swollen. Podiatry provider sent resident to the ER due to findings of a severe infection. Resident admitted at [hospital name] for the diabetic foot ulcer." Review of Resident #4's medication administration record showed from February 7th - 14th, 2025, five different medication assistants (MAs) signed off the use of a betadine swabstick and cleansing of the left toe. During an interview on 04/01/25 at 2:35 p.m., an administrative nurse (#2) stated she expected the nurse receiving the above orders would train/educate the MAs on use of a betadine swab to the toe and MA needed to report any signs of infection to the nurse. The nurse (#2) verified the MAs files failed to contain this education. The nurse (#2) also verified the physician wrote the above orders on 01/31/25, the facility received the orders via fax on 02/05/25, and implemented the orders on 02/07/25. The facility failed to educate the MAs on the use of a betadine swab to Resident #4's toe wound and the MAs failed to report any signs of infection to the nurse. Refer to B0921, B0928, B1220, B1240, and B1320.	B1700		

North Dakota Health and Human Services
Health Response & Licensure
1720 Burlington Dr, Suite A
Bismarck, ND 58504-7736

Kelly Beechie, Manager
Health Facilities Unit

Please see below for the Plan of Correction for Edgewood Mandan regarding the April 1, 2025, survey.

Plan of Correction (PoC)
June 27, 2025-update

B921

1. The resident was seen by Podiatry on February 14, 2025, for treatment. Podiatry then sent the resident to the ER for further evaluation and medical treatment. The resident was admitted to the hospital for care that could not be provided in our community.

2. All existing residents will have their care plans, medical records, incident reports, and physician orders reviewed to identify any patterns or potential concerns.

3. All orders for third party services such as home health, physical therapy, occupational therapy, etc. will be reviewed immediately upon receipt from the provider with the order being added to the resident's chart. Confirmation of the third party being contacted will be retained in the nurse's notes.

4. Licensed nurses completed training on May 12, 2025, regarding referrals for third party services to ensure the referrals are complete and documented to ensure resident care needs are met.

5. Compliance date is May 12, 2025.

6. The clinical services director and the executive director will monitor this on a bi-weekly basis for three months, then monthly for three months and quarterly for three months.

B928

1. The resident was seen by podiatry on February 14, 2025, for treatment. Podiatry then sent the resident to the ER for further evaluation and medical treatment. The resident was admitted to the hospital for care that could not be provided in our community.

2. All existing residents will have their care plans, medical records, incident reports, and physician orders reviewed to identify patterns and potential concerns of notification to the POA.

3. Documentation of all notifications to resident legal representatives regarding the resident’s care and treatment will be retained in the nurses' notes.

4. Licensed nurses received education on proper notification of resident’s POA's on May 12, 2025.

5. Compliance date is May 12, 2025.

6. The clinical services director and the executive director will monitor this on a bi-weekly basis for three months, then monthly for three months and quarterly for three months.

B1220

1. The resident’s wound was not initially assessed, nor was the status of the wound routinely assessed.

2. Ensure all significant changes in conditions are evaluated and documented, including clinical symptoms, new physician orders, referrals, and updated care plans.

3. All orders for third party services such as home health, physical therapy, occupational therapy, etc. will be reviewed immediately upon receipt from the provider with the order being added to the resident’s chart. Confirmation of the third party being contacted will be retained in the nurse's notes.

4. All orders received from a provider will be reviewed by two licensed nurses to ensure all parts of the order are addressed and implemented. This will help to ensure residents are not at risk for complications and illness.

5. All resident care plans will be reviewed for protocols that require weekly evaluation by a licensed nurse to ensure all assessments, on-going assessments, documentation, and evaluation are completed.

6. Clinical Services staff members will have an additional training session to cover medication orders and observations to be aware of and reported to a licensed nurse regarding skin care.

6.a. Staff will need to observe and report any changes of discoloration of skin, complaints of pain, increased swelling, redness or irritation, signs of skin breakdown (increased redness, open areas), complaints of numbness or tingling, signs of infection (warm to the touch, redness, swelling, increased drainage, foul orders), if dressing is no longer intact and/or saturated with drainage, and changes in vital signs. The training for medication aids will include specifics on applications and administration of medications, ointments, creams, etc.

7. Compliance date is May 19, 2025.

8. The clinical services director and the executive director will monitor this on a bi-weekly basis for three months, then monthly for three months and quarterly for three months.

B1240

1. The resident's care plan was not reviewed and revised to reflect the resident's current care needs.

2. Ensure all significant changes in conditions are evaluated and documented including clinical symptoms, diagnosis, interventions, new physician orders, referrals, and updated care plans.

3. All orders for third party services such as home health, physical therapy, occupational therapy, etc. will be reviewed immediately upon receipt from the provider with the order being added to the resident's chart. Confirmation of the third party being contacted will be retained in the nurse's notes.

4. All orders received from a provider will be reviewed by two licensed nurses to ensure all parts of the order are addressed and implemented. This will help to ensure residents are not at risk for complications and illness.

5. All resident care plans will be reviewed for protocols that require weekly evaluation by a licensed nurse to ensure all assessments, on-going assessments, documentation, and evaluation are completed.

6. All residents will be reviewed including falls, injuries, and medication errors. Care plans will be reviewed and updated accordingly.

7. All changes in activities of daily living and any injuries that require provider intervention will be reviewed. Care plans will be reviewed and updated accordingly.

8. Licensed nurses completed training regarding referrals for third party services are complete and documented to ensure resident care needs are met. Training in reviewing and updating resident care plans that require weekly evaluations, on-going assessments, documentation, and evaluations was also completed.

9. Compliance date is May 12, 2025.

10. The clinical services director and the executive director will monitor this on a bi-weekly basis for three months, then monthly for three months and quarterly for three months.

B1320

1. The resident's medical record failed to include a copy of the current assessment, care plan, and documentation of resident observations related to the toe wound.

2. Ensure all significant changes in conditions are evaluated and documented including clinical symptoms, diagnosis, interventions, new physician orders, referrals, and updated care plans.

3. All orders for third party services such as home health, physical therapy, occupational therapy, etc. will be reviewed immediately upon receipt from the provider with the order being added to the resident's chart. Confirmation of the third party being contacted will be retained in the nurse's notes.

4. All orders received from a provider will be reviewed by two licensed nurses to ensure all parts of the order are addressed and implemented. This will help to ensure residents are not at risk for complications and illness.

5. All resident care plans will be reviewed for protocols that require weekly evaluation by a licensed nurse to ensure all assessments, on-going assessments, documentation, and evaluation are completed.

6. All residents will be reviewed including falls, injuries, and medication errors. Care plans will be reviewed and updated accordingly.

7. All changes in activities of daily living and any injuries that require provider intervention will be reviewed. Care plans will be reviewed and updated accordingly.

8. Licensed nurses completed training regarding referrals for third party services are complete and documented to ensure resident care needs are met. Training in reviewing and updating resident care plans that require weekly evaluations, on-going assessments, documentation, and evaluations was also completed.

8. Compliance date is May 12, 2025.

9. The clinical services director and the executive director will monitor this on a bi-weekly basis for three months, then monthly for three months and quarterly for three months.

B1700

1. Staff authorized to administer medications will report to a licensed nurse, where applicable. Staff failed to report changes in the sore on the resident's toe and/or use the proper medication, betadine swab, to cleanse the toe.

2. Licensed nurses will educate the staff authorized to administer medication in the proper way to use any medication, cream, ointment, etc. to ensure staff are competent to complete this task.

3. Licensed nurses will educate the staff to report any signs of infection to the nurse.

4. Ensure all significant changes in conditions are evaluated and documented including clinical symptoms, diagnosis, interventions, new physician orders, referrals, and updated care plans.

5. All orders for third party services such as home health, physical therapy, occupational therapy, etc. will be reviewed immediately upon receipt from the provider with the order being added to the resident's chart. Confirmation of the third party being contacted will be retained in the nurse's notes.

6. All orders received from a provider will be reviewed by two licensed nurses to ensure all parts of the order are addressed and implemented. This will help to ensure residents are not at risk for complications and illness.

7. All resident care plans will be reviewed for protocols that require weekly evaluation by a licensed nurse to ensure all assessments, on-going assessments, documentation, and evaluation are completed.

8. All resident incidents will be reviewed, including falls, injuries, and medication errors. Care plans will be reviewed and updated accordingly to ensure residents are not placed at risk for compilations and/or illness.

9. All changes in activities of daily living and any injuries that require provider intervention will be reviewed. Care plans will be reviewed and updated accordingly.

10. Licensed nurses completed training regarding referrals for third party services are complete and documented to ensure resident care needs are met. Training in reviewing and updating resident care plans that require weekly evaluations, on-going assessments, documentation, and evaluations was completed.

11. Medication administration training was completed to enforce current policies and procedures regarding the use of any medication, cream, ointment, etc. Staff was educated that they should not handle any medication, cream, ointment, etc. if they do not have a clear understanding of how to use the item and need to seek a licensed nurse for assistance.

11. Compliance date is May 19, 2025.

12. The clinical services director and the executive director will monitor this on a bi-weekly basis for three months, then monthly for three months and quarterly for three months.