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
	8201	A. BUILDING: _____ B. WING _____	C 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WEST FARGO	645 33RD AVENUE EAST WEST FARGO, ND 58078

(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 licensure and complaint surveys, started on July 31, 2023 and completed on August 2, 2023, the sample included 8 residents for complete review and 1 closed record for review. During the complaint investigations the facility was found noncompliant with regulatory requirements. Tier II citations included B0910, B0927, B0950, B1230, B1320, B1410, B1450, B1520, B1540, B1700, B1800, B1820, B1830, B1930, B2000, and B2406.	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: 1. Based on information received from the complainant, observation, record review, review of facility policy, and resident, staff, and family interview, the facility failed to ensure the safety and well-being 1 of 1 sampled resident (Resident #1) with observed behaviors. Failure to develop an effective behavior management plan and monitoring system for Resident #1 does not allow the resident to maintain his highest level of functioning and resulted in a risk to Resident #1's safety due to continued exit-seeking and elopement. This failure also resulted in continued wandering, and verbally and physically	B 910	1. On 9/20/23 Care Conference was held with Resident #1's POA. Resident #1 POA responsible to provide 3rd party 1:1 supervision during overnight hours to support Resident #1 invasive nocturnal wandering. Resident #1 will be assisted with relocation services to another provider to support meeting Resident #1 behavioral needs. Resident #2 door lock replaced to auto lock upon exit. 2. Community reviewed resident records to determine residents that are invasive wanderers. 3. Community reviewed effectiveness of present interventions effectiveness for individuals found to be invasive wanderers. Community will review any reports of invasive wandering for adjustments to behavioral interventions and work with PCP & Legal Representative on additional supports for behavior management. Community team members to be educated on invasive vs. active wandering and available interventions to mitigate or avert the behavioral expression. 5. The Executive Director and Health & Wellness Director will review effectiveness of the corrective action weekly x 8 weeks and extend reviews as warranted.	4. Oct 30, 2023

Health Repsonse and Licensure

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jody Christrain, Executive Director — TITLE — (X6) DATE: 9/29/23

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B 910	Continued From page 1 aggressive behaviors which infringed upon the rights of other residents; caused anger, fear, and anxiety; and has the potential to negatively impact all residents residing in the facility. Findings include: Information received from the complainants identified concerns with wandering residents entering their family members' apartments, using their bathrooms, rummaging in their belongings, and causing anger/anxiety for their family members. Review of the facility policy titled "Admission and Denial of Admission of Residents" occurred on 08/02/23. This policy, dated 01/10/23, stated, ". . . The Community registered nurse determines whether the Community can accept a prospective resident based on the resident's needs, the team member levels in the Community, and team member qualifications and competencies. . . . According to applicable law and the Move-In Criteria Grid, the Community may admit and retain only an adult for whom the Community provides, directly or through contract, appropriate services within the Community to attain or maintain the individual at the individual's highest practicable level of functioning. . . . Procedure . . . 2. A nurse, in collaboration with the executive director, will also determine whether the Community has sufficient current resources within the Community's chosen scope of practice consistent with its licensure, such as team members sufficient in qualifications, competency, and numbers, to adequately provide the care and services agreed to in the service plan with the person. . . ." Review of the facility policy titled "Behavioral	B 910		

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B 910	Continued From page 2 Expression Management" occurred on 08/02/23. This policy, dated 07/11/23, stated, ". . . The nurse will assess residents for new or evidence of a decline in medical condition, cognitive decline, changes in functional mobility, changes in the resident's environment or social interactions, changes in emotion and psychological condition, changes in sleep pattern, insomnia, and sun downing, as warranted. . . . Interventions are designed to improve the ability for a resident to meet the goals associated with service plan objectives . . . In circumstances where the Community determines it is unable to manage a resident's behavioral expressions, the Community will collaborate with the resident, resident's legal representative, and/or the resident's physician to determine the appropriate steps in relocating the resident. . . ." - Review of Resident #1's medical record occurred on all days of survey. Current medications included: "Buspar . . . For: Anxiety . . . Aricept . . . For: Agitation . . . Neurontin . . . For: Agitation . . . Vistaril . . . For: Anxiety . . . Ativan . . . For: Anxiety . . . Melatonin . . . For: Insomnia . . . Zyprexa . . . For: Delirium, GAD [generalized anxiety disorder], Neurocognitive disorder . . . Effexor XR [extended release] . . . For: Anxiety/Depression . . . Remeron . . . For: Depression . . . Vistaril as needed [PRN] . . . Zyprexa PRN." Resident #1's "Comprehensive Assessment," dated 07/19/23, stated, ". . . Cognitive Pattern/Behavioral Expressions . . . Expressions: All behavioral expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan . . . Forgetful . . . Minor socially inappropriate behaviors . . . Uncooperative with Care . . .	B 910		

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B 910	Continued From page 3 Wanders . . . Refusals . . . Does not accept redirection . . . Verbally aggressive . . . Physically aggressive . . . Delusions . . . Anxious . . . Depressed/Withdrawn . . . Hoarding, Rummaging . . ." Resident #1's "Resident Service Agreement," dated 07/25/23, failed to identify behavioral expressions such as: socially inappropriate behaviors, uncooperative with care, refusals, verbal and physical aggression, and failed to develop/implement individualized interventions related to these behaviors. Resident #1's progress notes identified the following: *12/23/22 at 10:16 a.m.: ". . . Yesterday between 0400-0500 [4:00 a.m. - 5:00 a.m.] [Resident #1] was found attempting to exit [memory care] through the double doors, in the nude et [and] had called 911 because he believed the building was on fire. . . . [medical provider] updated et will be making changes to his meds [medications] today . . ." *01/12/23 at 9:06 p.m.: ". . . [Resident #1] found exit seeking on multiple occasions this afternoon with his coat et mittens on insisting he was going to [grocery store] to buy more chewing tobacco. At one point he pushed through the CG [caregiver] et left [memory care], the LEC [life enrichment coordinator] followed [Resident #1] into AL [assisted living], was able to convince him not to go outside without a ride et walked him back to [memory care] . . ." *01/23/23 at 10:36 p.m.: ". . . [Resident #1] wandered into another male resident's apartment in [memory care] et attempted to climb into his bed early this morning. When the other male resident began yelling at him both got into an altercation et [Resident #1] punched the other	B 910		

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B 910	Continued From page 4 resident in the face. . . ." *02/21/23 at 2:15 p.m.: ". . . [Resident #1] is exit seeking frequently throughout the day. When the team attempts to re-direct him he becomes very agitated et combative in an attempt to get the team to allow him to leave. Call placed to [medical provider] requesting something for increased anxiety et agitation, new order provided: 1.) Increase Buspar to 10 mg [milligrams] BID [twice a day] 2.) Lorazepam [Ativan] 0.5 mg po [by mouth] q [every] 12hr PRN . . ." *03/19/23 11:12 a.m.: ". . . Team reports resident continues to be agitated at times, frequently up through the NOC [night] et refuses redirection. He rummages through the refrigerators et takes other resident's items. When the team has informed him he's taking others belongings her [sic] states, 'I don't care, what are you going to do about it? I'm the authority around here.' . . ." *03/22/23 at 2:08 p.m.: ". . . Resident seen and evaluated per [medical provider]. New orders obtained . . . 1. Psychiatry consult r/t [related to] increased agitation . . . 3. Buspirone [Buspar] 10 mg TID [three times a day] 4. Lorazepam po 0.5 mg in the PM . . ." *03/28/23 at 3:30 a.m.: ". . . TRIAGE: Call from caregiver [name] who reports [name of monitoring system] alarm went off in room 11. When they went in they found [Resident #1] in the room trying on clothes and the resident that belongs in the room still in bed sleeping. No one on the floor. Writer called [staff member] who reviewed the video and reports [Resident #1] was crawling around on the floor, turning lights on and off and trying on her clothes, but did not fall. . . ." *03/28/23 at 7:13 a.m.: ". . . TRIAGE: Call from caregiver [name]. Found at 7am laying on resident floor in [another resident's room]. States he laid himself down on the floor then proceeded	B 910		

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B 910	Continued From page 5 to get up and walk back to his own apartment. . . ." *04/04/23 at 11:52 p.m.: ". . . [provider name] here to psych [psychiatric] rounds and to establish care with the resident. . . . Discussed [Resident #1] aggressive behavior, alcohol induced dementia, agitation and insomnia. . . . New orders provided: . . . 2.)Start Olanzapine [Zyprexa] 2.5 MG PO at HS and 2.5 MG PO BID PRN. . . ." *04/13/23 at 10:05 p.m.: ". . . After consulting with [psych provider] increased psych med. approved. New order per [medical provider]: 1.) Increase Buspar 20 mg TID (anxiety) 2.) Increase Tylenol 1000 mg po TID now . . ." *04/14/23 at 12:59 p.m.: ". . . This RN [registered nurse] to resident's room to prepare for transportation to the ER [emergency room] s/p [status post] fall. Upon entering the room [Resident #1] was standing with his head up against the wall leaning over at the waist. He was assisted to the chair and was very unsteady on his feet. Upon assessment he had a bleeding area to the bridge of his nose and above the left eyebrow. He complained of a headache and pain to his right ribcage and left hip. He could not verbalize what had led to his fall. . . ." Resident #1 returned from the hospital on 04/18/23. *04/19/23 at 7:47 p.m.: ". . . Triage nurse, RN receives call from med passer reporting resident walking around naked and screaming. Med passer requests to give PRN Vistaril 25 mg to help manage behavior . . ." *04/19/23 at 11:15 p.m.: ". . . Night shift med passer call reporting resident disrupting and disturbing other residents, going into other resident rooms, naked no longer wearing clothes. . . . Med passer reports this resident in another resident's apartment triggers her [monitoring system] alert with staff finding resident fast asleep	B 910		

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B 910	Continued From page 6 in bed and not up or on floor. . . . intruding resident [Resident #1] was on floor, got himself back up, did not hit his head or appeared injured. . . ." *04/20/23 at 3:21 a.m.: ". . . Triage nurse, RN receives call from caregiver reporting fall with bleeding wound to forehead. . . . Nurse instructs caregiver to call 911 for transport to ER for physician evaluation as directed by his PCP [primary care provider] when taking anticoagulant [blood thinner]. . . ." *04/20/23 at 9:58 a.m.: ". . . Multiple calls received from the team throughout the NOC regarding resident being aggressive, intrusively wandering into other apartments et even with a 1:1 most times the team was unable to re-direct him. The CTM [care team manager] reports this morning he was having the same behaviors yesterday afternoon. His intrusive wandering et aggression has caused other resident's [sic] to become fearful et put others safety at risk. . . . New order provided: 1.) Send resident for psych hold for agitation, aggression, combativeness et inability to re-direct. . . . He's currently at [hospital] d/t [due to] fall w/ [with] headstrike early this morning. . . ." *04/30/23 at 1:44 p.m.: ". . . Spoke with [psych provider] regarding resident's on-going behaviors, wandering nude, the need to lock all [memory care] doors to prevent him from intrusively wandering et becoming physically aggressive with residents/staff when attempting to re-direct rummaging et verbal aggression. Increased behaviors/aggression are typically seen starting in the late afternoon through out the night shift. . . . New order provided . . . 1.)Aricept 5 mg po q HS 2.) Gabapentin [neurontin] 100 mg Take 1 tablet po q evening at HS . . ." *05/30/23 at 10:50 p.m.: ". . . Triage: Received phone call from caregiver stating that [Resident	B 910		

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B 910	Continued From page 7 #1] is "out of control." He is fully naked, going into other resident's rooms, and is not redirectable. Writer can hear him yelling in the background. Caregiver states he is scaring other residents, especially certain females as he is going in their rooms naked and yelling. . . . Writer gives caregiver permission to call 911 regarding behaviors. . . ." *07/05/23 at 2:15 p.m.: ". . . Late Entry for 7/1/2023 1:20 AM: Memory Care staff received electronic notification of door alarm activation. Immediately responded to area. Unable to locate anyone who had activated the door as the exterior was dark and interior had nobody present in area. Caregivers initiated a head count of all residents. . . . One resident [Resident #1] was unaccounted for. Med passer notified [police department]. [Police department] returned resident shortly thereafter. . . ." *07/05/23 at 10:22 p.m.: ". . . The team reports continued exit seeking et agitation when the team attempts to re-direct him back into the MC [memory care], most recently as of early this morning. Medications to aid with sleeping work for approximately 2-3 hrs [hours], then resident is up the rest of the noc wandering, watching TV, or exit seeking. . . ." *07/06/23 at 11:44 p.m.: ". . . Call placed to psych provider requesting call back for med mgmt [management] regarding increased exit seeking, agitation et sleep. . . ." *07/07/23 at 12:49 p.m.: ". . . spoke with [power of attorney (POA)] regarding resident's exit seeking. Asked she seek a 1:1 provider through NOC shift for safety until behavioral expressions are better managed. . . ." *07/07/23 at 11:57 p.m.: ". . . [psych provider] returned this writer's call . . . New orders obtained: 1.) Increase Gabapentin to 200 mg po q evening et HS. 2.) Increase Aricept to 10 mg po q	B 910		

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B 910	Continued From page 8 HS . . ." *07/11/23 at 12:00 p.m.: ". . . Resident exited out of [memory care] this morning and was found by physical therapy at approximately 0756 [7:56 a.m.] and brought him back without difficulty back into the unit. . . ." Observation on 07/31/23 at 5:10 p.m. showed Resident #4 seated in a chair outside of her room. The resident was visibly upset and stated, "They locked me out again! I don't know why they do that." The surveyor found a staff member (#6) to unlock the resident's door. The staff member stated, "[Resident #1] goes in there and messes everything up." Observations on the morning of 08/01/23 showed Resident #1 wandered the hallways and either entered or attempted to enter various residents' rooms. Observation showed a staff person sitting in the TV area with other residents and made no attempt to redirect or provide interventions. The resident eventually asked the surveyor, "Is my room that way (pointing down the hall)?" During an interview on the morning of 08/01/23, Resident #4 pointed at Resident #1 and angrily stated, "He's always walking around here, going into places he shouldn't be." Failure to ensure the health, safety, and security of Resident #1 as evidenced by the staff's inability to meet his needs regarding his continuous and increasingly invasive, disruptive, and/or threatening behaviors, lack of 24 hour nursing care to monitor for side effects of increasing psychotropic medications possibly contributing to his falls, and lack of interventions for his behaviors increases the risk of injury to Resident #1 and does not allow him to reach his highest	B 910		

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B 910	Continued From page 9 physical, mental, or psychosocial well-being. This failure may also negatively impact the safety and security of all the residents in the facility. 2. Based on observation, record review, and family interview, the facility failed to ensure the safety and well-being of 1 of 1 sampled residents (Resident #2) care planned to have her apartment door locked. Failure to ensure Resident #2's door remained locked resulted in fear and anxiety due to an uninvited resident entering her room. -Review of Resident #2's medical record occurred on all days of survey. Resident #2's "Comprehensive Assessment," dated 07/06/23, stated, ". . . Resident resides in MC [memory care]. For resident's peace of mind, the POA has requested the door be locked at all times. . . ." Resident #2's "Resident Service Agreement," dated 07/08/23, stated, ". . . Lock apartment at all times per [POA]. Ask Med [medication] passer to lock the apartment. Team to unlock apartment as resident or family requests. . . ." During a family interview on 08/02/23 at 10:29 a.m., Resident #2's family member stated other residents enter Resident #2's room uninvited (specifically a male, Resident #12) and "she is scared." Observations on all days of survey showed Resident #2's apartment door remained unlocked. Review of Resident #2's electronic monitoring for the night of 07/29/23 showed a male resident (Resident #12) entered Resident #2's apartment at 12:20 a.m. Resident #2 confronted the intruding resident, gesturing her hands toward the door, and the other resident left her room without an altercation. Observations	B 910		

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B 910	Continued From page 10 during the survey showed this same resident (Resident #12) entering a resident's room (not his own), rummaging under the bed and on the bedside table, and also setting off the alarm on the secure doors which led to assisted living. Failure to lock Resident #2's door and manage Resident #12's wandering behaviors resulted in Resident #2 experiencing fear and may affect all residents' right to live in a safe and secure environment.	B 910		
B 927	33-03-24.1-09,2,g GOVERNING BODY g. 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 observation, review of the North Dakota Resident's Rights booklet, and staff interview, the facility failed to treat residents with respect and dignity for 1 of 1 sampled resident (Resident #6) who was denied access to her room. Failure to allow residents access to their rooms does maintain their dignity and violates their rights. Findings include: Review of the North Dakota Resident's Rights Handbook titled "A Guide to Your Rights as a Resident of a Nursing Facility in North Dakota,"	B 927	1. Resident #4's door will be unlocked during wake hours pursuant to Resident 4 legal representative's request. Staff will redirect wandering residents who attempt to enter the apartment of Residents whose door is unlocked. 2. All residents have potential to be affected by this practice. 3. All Resident apartment doors will remain unlocked during wake hours, unless requested by Resident/Legal Representative. To support the resident's right to privacy, staff will be educated to lock doors for residents during sleep hours and when requested. Resident care plans will be updated for times the door to their apartment is to be locked. 5. Executive Director and Care Team Manager will review effectiveness of corrective action weekly x 8 weeks and extend reviews weekly as warranted.	4. Oct, 30, 2023

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B 927	Continued From page 11 updated 03/21/23, page 16, stated, ". . . Personal and Privacy Rights . . . The facility staff must treat you courteously, fairly and with dignity. . . ." Observation on 07/31/23 at 12:40 p.m. showed Resident #4 seated in a chair outside of her room. The resident was visibly upset and stated, "I can't get in my room. It's locked. I don't want them to ever lock my door!" The surveyor found an unidentified staff member who unlocked the resident's door. Observation on 07/31/23 at 2:45 p.m. showed Resident #4 seated in a chair outside of her room. She stated her room was locked again, and she could not get in. The surveyor found a staff person (#6) to unlock the door and stated, "[Staff] have to keep [the doors] locked or other residents go through the rooms." Observation on 07/31/23 at 5:10 p.m. showed Resident #4 seated in a chair outside of her room. The resident was again visibly upset and stated, "They locked me out again! I don't know why they do that." The surveyor found a staff member (#6) to unlock the resident's door. The staff member stated, "[Resident #1] goes in there and messes everything up."	B 927		
B 950	33-03-24.1-09,5 GOVERNING BODY 5. The governing body shall ensure sufficient trained and competent staff are employed to meet the residents' needs. Staff must be in the facility, awake and prepared to assist residents twenty-four hours a day.	B 950		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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B 950	Continued From page 12 This state licensing rule is not met as evidenced by: Based on information received from the complainants and family interview, the facility failed to ensure sufficiently trained and competent staff to meet the needs of the residents on 3 of 3 days of survey (July 31-August 2, 2023). Failure to ensure the availability of competent and adequate staff resulted in unmet resident needs. Findings include: Information received from the complainants identified a lack of sufficient and available staff. One complainant identified a two hour time period where residents were alone on one wing of the unit with no staff present. Another complainant stated staff left the unit to go on a break together, leaving the unit without staff. A third complainant identified staff were often all together on one wing of the unit, leaving the other wing unattended. During a family interview on 08/02/23 at 10:29 a.m., the family member stated she brought her mother back to the facility at around 9:00 p.m. on 07/31/23, and there was no staff on her mother's side of the unit. She needed to find staff to unlock her mother's room door but could not find anyone. The family member stated all the staff were on the other wing, and the wing her mother resided on was without staff. Refer to B0910, B0927, B1410, B1450, B1540, B1700, B1800, B1830, B1930, and B2000.	B 950	1. Trained and competent staff in the facility are available to assist residents 24 hours a day. Staffing is scheduled in accordance to meet or exceed the E-score. 2. All residents have potential to be affected by this practice. 3. Staff breaks will be scheduled with coverage during breaks needed to support staffing within basic care 24/7. Community after-hours phone number will be prominently posted within Basic Care for families to contact staff should they need assistance with resident care. 5. Executive Director and Care Team Manager will review effectiveness of the corrective action weekly x 8 weeks and extend reviews weekly as warranted.	4. Oct 30, 2023
B1230	33-03-24.1-12,3 RESIDENT ASSESSMENTS/CARE PLANS	B1230		

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B1230	Continued From page 13 3. A care plan, based on the assessment and input from the resident or person with legal status to act on behalf of the resident, must be developed within twenty-one days of the admission date and consistently implemented in response to individual resident needs and strengths. This state licensing rule is not met as evidenced by: Based on observation, information received from the complainant, record review, and review of facility policy, the facility failed to develop a care plan based on the comprehensive assessment and/or consistently implement the residents' individualized plan of care for 5 of 8 sampled residents (Resident #1, #2, #4, #6, and #7). Failure to implement interventions may result in unmet care needs. Findings include: Information received from the complainant identified concerns with services not provided according to their service contracts (i.e., care plan). Review of the facility policy titled "Assessments and Evaluations" occurred on 08/02/23. This policy, dated 07/11/23, stated, ". . . The Community will conduct assessments, observation, and reassessments in accordance with state law to determine the level of assistance required by each resident in an effort to maximize their quality of life. Assessments should be thorough and timely to ensure that a resident's care needs are identified, and an individualized care plan is maintained. The assessment also serves to determine the prospective resident's suitability for placement in the Community. . . ."	B1230	1. The facility will develop a care plan based on comprehensive assessment and implement an individualized plan of care. 2. All residents have potential to be affected by this practice. 3. Updates have been made to the electronic health record to document incontinence care provided throughout the shift and is reflected on the resident individualized care plan. Education of staff regarding change in documentation of incontinence will be completed by 10/30/23. 5. Health and Wellness Director and Care Team Manager will review effectiveness of the corrective action weekly x 8 weeks and extend reviews weekly as warranted.	4. Oct. 30, 2023

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B1230	Continued From page 14 Review of the facility policy titled "Resident Service Plan" occurred on 08/02/23. This policy, dated 06/22/23, stated, ". . . A service plan addressing the individualized needs of the resident will be developed during the initial assessment and completed for each resident before nursing services are initiated . . . The nurse's initial assessment and any other Community evaluation conducted before nursing services are initiated and will be the basis for the resident's written service plan. . . . The service plan will: a. Identify the program services, frequency, and approaches the Community will provide under applicable law, to include personal care, supervision, activities, health monitoring, medication administration, behavior management, information and referral, and transportation . . . The service plan will serve as a basis for the service delivery contract between the Community and the resident. . . ." - Review of Resident #1's medical record occurred on all days of survey. Resident #1's "Resident Service Agreement," dated 07/25/23, stated, ". . . Bladder Cont [continence]: Asst [assist] 4-7x [times]/24 hr [hours] . . . Provide privacy while assisting resident with toileting needs and provide proper peri-care [perineal care]. . . ." Observation and record review identified staff failed to provide toileting services according to Resident #1's care plan. Refer to B1410. -Review of Resident #2's medical record occurred on all days of survey. Resident #2's "Comprehensive Assessment," dated 07/06/23, stated, ". . . Resident resides in MC [memory care]. For resident's peace of mind, the POA	B1230		

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B1230	Continued From page 15 [power of attorney] has requested the door be locked at all times. . . ." Resident #2's "Resident Service Agreement," dated 07/08/23, stated, ". . . Lock apartment at all times per [POA]. Ask Med [medication] passer to lock the apartment. Team to unlock apartment as resident or family requests. . . . Bladder Cont: Asst 1-3x/24 hr . . . Please encourage resident to get up and toilet between 1-2 AM. . . ." Observations on all days of survey showed Resident #2's apartment door remained unlocked. Review of Resident #2's electronic monitoring for the evening/night of July 31-August 1, 2023 showed staff failed to offer Resident #2 toileting between 1:00 a.m. and 2:00 a.m. - Review of Resident #4's medical record occurred on all days of survey. Resident #4's "Resident Service Agreement," dated 08/02/23, stated, ". . . Bladder Cont: Asst 4-7x/24 hr . . . Assist of one with four wheeled walker. Provide privacy while assisting resident with toileting needs and provide proper peri-care . . ." Observation and record review identified staff failed to provide toileting services according to Resident #4's care plan. Refer to B1410. - Review of Resident #6's medical record occurred on all days of survey. The "Resident Service Agreement" dated 08/02/23, stated, ". . . Bladder Cont: Asst 4-7x/24 hr . . . I need assistance finding the bathroom to develop my routine . . ." Observation and record review identified staff failed to provide toileting services according to Resident #6's care plan. Refer to B1410.	B1230		

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B1230	Continued From page 16 - Review of Resident #7's medical record occurred on all days of survey. The "Resident Service Agreement" dated 08/02/23, stated, ". . . Bladder Cont: : 2 Asst. 8 + x/24 hr . . ." Observation and record review identified staff failed to provide toileting services according to Resident #7's care plan. Refer to B1410.	B1230		
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. g. A quarterly progress note documenting the resident's current health condition, level of functioning, activity involvement, nutritional	B1320	1. Staff will be re-educated to complete Emergency Transfer form for resident transfers to the ER. Emergency Transfer Forms will be signed and sent with Residents when transferring to the emergency room, with a copy retained by Community. 2. Any resident that is transferred to the emergency room has the potential to be affected by this practice. 3. Staff have been trained on how to complete the Emergency Transfer form and retain a copy for Community's records. Upon notice of an emergency room transfer, Nursing will conduct a check to verify Emergency Room transfer form was completed in accordance with regulation and a copy was retained. 5. Health and Wellness Director is responsible to verify the effectiveness of the corrective action and revise to support compliance as warranted.	4. Oct 30, 2023

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B1320	Continued From page 17 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, review of facility policy, and staff interview, the facility failed to ensure complete medical records, including evidence of transfer forms for 3 of 8 sampled residents (Resident #1, #4, and #8) transferred to the	B1320		

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B1320	Continued From page 18 emergency room (ER). Failure to provide residents and families/guardians with a notice of transfer/discharge does not ensure the safe and orderly transfer/discharge from the facility. Findings include: The facility policy titled "Health Record Standards" occurred on 08/02/23. This policy, dated 07/11/23, stated, ". . . The resident health record will be initiated at the time of move in and will contain at least the following information, per applicable law: . . . Transfer forms completed by, or received at, the Community . . ." Review of Resident #1's medical record identified a transfer to the ER and subsequent admission to the hospital on 04/14/23 and 04/20/23. Resident #1's medical record lacked evidence of transfer forms completed by the facility. Review of Resident #4's medical record identified a transfer to the ER and subsequent admission to the hospital on 04/16/23. Resident #1's medical record lacked evidence of a transfer form completed by the facility. - Review of Resident #8's medical record identified a transfer to the ER and subsequent admission to the hospital on 07/22/23. Resident #8's medical record lacked evidence of transfer forms completed by the facility. During an interview on on 08/02/23 at 10:10 a.m., an administrative staff member (#10) confirmed the staff failed to complete a hospital transfer form.	B1320		

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B1410	Continued From page 19	B1410	1. Trained and competent staff in the facility are available to assist residents 24 hours a day. Updates have been made to the electronic health record to document peri care provided in accordance with resident individualized care plans. 2. All residents who receive toileting assistance have potential to be affected by this practice. 3. Updates have been made to the electronic health record to document peri care provided in accordance with resident individualized care plan. Education of staff on documentation of peri care will be completed by 10/30/23. PRN staff will be trained prior to working their next scheduled shift, if after 10/30/23. 5. Care Team Manager is responsible to verify the effectiveness of the corrective action and revise to support compliance as warranted.	4. Oct 30, 2023
B1410	33-03-24.1-14,1 PERSONAL CARE SERVICES 1. Activities of daily living and instrumental activities of daily living and observation and documentation of changes in physical, mental, and emotional functioning, as needed. This state licensing rule is not met as evidenced by: Based on observation, information received from the complainants, review of facility policy, record review, and staff and family interview, the facility failed to provide assistance with activities of daily living (ADL) for 5 of 8 sampled residents (Resident #1, #2, #4, #6 and #7). Failure to provided toileting assistance may result in unnecessary incontinence, odors, skin breakdown, and urinary tract infections. Findings include: Information received from the complainants identified concerns with a lack of toileting. One complainant stated residents often smell of urine and have wet clothes. Another complainant stated residents went into rooms that were not theirs to use the bathroom with no assistance/intervention from staff present. - Review of Resident #1's medical record occurred on all days of survey. Resident #1's "Resident Service Agreement" stated, ". . . Bladder Cont [Continence]: Asst [assist] 4-7x [times]/24 hr [hours]. . . Provide privacy while assisting resident with toileting needs and provide proper peri-care. . . ." Resident #1's "Service Delivery Record" for the months of May-July 2023 identified staff failed to toilet Resident #1 4-7 times in 24 hours on 30 of 31 days in May, 30 of 30 days in June, and 30 of 31 days in July.	B1410		

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B1410	Continued From page 20 Observation on 08/01/23 at approximately 9:00 a.m. showed Resident #1 attempted to enter his room, but the door was locked. The resident yelled down the hallway, "I need to go to the bathroom," however, no staff responded to his request. The surveyor found a staff member to unlock the door, and Resident #1 again stated he needed to use the bathroom as he entered his room. The staff member returned to the dining room without offering assistance to the resident. - Review of Resident #4's medical record occurred on all days of survey. Resident #4's "Service Checkoff List" stated, ". . . Bladder Cont: Asst 4-7x/24 hr . . . Assist of one with four wheeled walker. Provide privacy while assisting resident with toileting needs and provide proper peri-care [perineal care]. . . ." Resident #4's "Service Delivery Record" for the months of May-July 2023 identified staff failed to toilet Resident #4 4-7 times in 24 hours on 30 of 31 days in May, 29 of 30 days in June, and 31 of 31 days in July. Observation on 07/31/23 identified Resident #4 seated in a chair outside her room. She stated her door was locked, and she needed to use the bathroom. The surveyor found a staff member to unlock the door; however, the staff member failed to offer toileting assistance to Resident #4. During an interview on 08/01/23 at 2:50 p.m., a staff member (#4) stated Resident #4 takes herself to the bathroom, but they (the staff) also help her at times. - Review of Resident #6's medical record occurred on all days of survey. The "Service Checkoff List" stated, ". . . Bladder Cont: Asst	B1410		

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B1410	Continued From page 21 4-7x/24 hr . . . I need assistance finding the bathroom to develop my routine . . ." Resident #6's "Service Delivery Record" for the months of May-July 2023 identified staff failed to toilet Resident #6 4-7 times in 24 hours on 31 of 31 days in May, 29 of 30 days in June, and 31 of 31 days in July. - Review of Resident #7's medical record occurred on all days of survey. The "Service Checkoff List" stated, ". . . Bladder Cont: : 2 Asst. 8 + x/24 hr [2 assist 8 plus times in 24 hours]. . .provide privacy while assisting . . ." Resident #7's "Service Delivery Record" for the months of May 10th -July 2023 identified staff failed to toilet Resident #7 8 + times in 24 hours on 22 of 22 days in May, 30 of 30 days in June, and 31 of 31 days in July.	B1410	1. Identified needed repairs have been completed. 2. Environmental Services Director will identify needed repairs and respond timely to resident repair requests. Community staff educated on process to report needed repairs timely.	
B1450	33-03-24.1-14,5 PERSONAL CARE SERVICES 5. Clothing and other personal effects as well as maintenance of personal living quarters. This state licensing rule is not met as evidenced by: Based on observation and information received from the complainant, the facility failed to provide maintenance of personal living quarters on 3 of 3 days of survey (July 31-August 2, 2023). Failure to provide maintenance services does not promote a homelike atmosphere and may result in falls/accidents. Findings include: Information received from the complainant identified concerns with a loose toilet seat and carpeting that was loose and pulling away from	B1450	3. Scuffed walls have been cleaned or painted before 8/30/23; the loose toilet seat was repaired on 7/31/23; the loose carpet was repaired on 7/31/23. Community staff will be educated on process to report needed repairs timely. Environmental Services Director will verify timely completion of repair tickets at least once monthly. 4. Training will be completed by all team members by 10/30/23. PRN staff will be trained prior to working their next scheduled shift, if after 10/30/23. 5. Executive Director and Environmental Services Director are responsible to verify effectiveness of corrective action.	4. Oct 30, 2023

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B1450	Continued From page 22 the floor (i.e., accident/fall hazards). The complainant stated her family member had fallen due to the loose carpet. The family member identified she informed facility staff, but the problems remained. Observations during the survey showed the following: *Room 7: Scuffed walls *Room 14: Scuffed walls and chipped paint *Rooms 16: A loose toilet seat which moved easily from side to side *Room 17: Scuffed walls *Room 22: Scuffed walls and chipped paint *Room 23: Loose carpet pulling away from the floor at the doorway to the bathroom, a loose toilet seat which moved easily from side to side	B1450	Work orders for needed repairs will be obtained by 10/15/23, with anticipated repairs made by 10/30/23. Safety Audit Tool Education will be completed by all team members by 10/30/23, with PRN staff will be trained prior to working their next scheduled shift, if after 10/30/23. Environmental Services Director is responsible to monitor corrective action.	
B1520	33-03-24.1-15,2 PHARMACY/MED ADM SERVICES 2. The facility shall provide a secure area for medication storage consistent with chapter 61-03-02. a. A specific system must be identified for the accountability of keys issued for locked drug storage areas. b. Residents who are responsible for their own medication administration must be provided a secure storage place for their medications. This state licensing rule is not met as evidenced by:	B1520	1. MA #6 trained in real-time on the requirement to have the medication cart locked at all times when not in use. Medication carts will be locked when not in use to ensure medication remain secure. 2. All residents have the potential to be affected by this practice. 3. Verbal coaching with MA #6 on the importance of locking the medication cart when not in use was completed on 7/31/23. Education provided to all med passers on the importance of locking the medication cart when not in use will be completed by 10/30/23. PRN staff will be trained prior to working their next scheduled shift, if after 10/30/23.	

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B1520	Continued From page 23 Based on observation and review of professional reference, the facility failed to assure safe and secure storage of medications for 1 of 3 medication carts. Failure to store all medications securely may result in unauthorized access to medications. Findings include: Cozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 840, stated, ". . . Lock the medication cart before entering the client's room . . . This is a safety measure because carts are not to be left open when unattended. . . ." Observation 07/31/23 at 5:00 p.m. showed a medication aide (MA) (#6) preparing residents medications in the hallway. The MA (#6) left the keys in the unlocked and unattended medication cart and entered the dining room to administer the medications.	B1520	Verbal coaching with MA #6 on the on the requirement to lock the medication cart when use completed on 7/31/23. Education provided to all med passers on the on the requirement to lock the medication cart when use completed will be done by 10/30/23. PRN staff will be trained prior to working their next scheduled shift, if after 10/30/23. 5. Health & Wellness Director is responsible to verify the effectiveness of the corrective action.	4. Oct 30, 2023
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered.	B1540	1. All medication administered will be the correct medication at the correct time and route following proper manufacturer's guidelines. MA #6 received verbal coaching on the requirement to follow the seven rights of medication administration on 7/31/23. 2. All residents receiving medication management have the potential to be affected by this practice.	

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	8201	A. BUILDING: _____ B. WING _____	C 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WEST FARGO	645 33RD AVENUE EAST WEST FARGO, ND 58078

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B1540	Continued From page 24 This state licensing rule is not met as evidenced by: Based on observation, information received from the complainant, record review, review of facility policy, review of manufacturer's guidelines, and staff interview, the facility failed to ensure proper administration of medications for 2 of 3 supplemental residents (Resident #10 and #11) observed during medication administration. Failure to administer the correct medication, at the correct time, to properly administer an inhaler following physician's orders and properly administer, label, prime, cleanse, and date an insulin pen may result in adverse consequences for the residents. Findings include: Information submitted by the complainant identified concerns with medication errors. INHALED/ORAL MEDICATIONS Review of the facility policy titled "Medication Administration - Inhaled Medications" occurred on 08/02/23. This policy, dated 07/07/23, stated, ". . . The med [medication] passer . . . Compares the medication orders on the eMAR [electronical medication administration record] and label on medication container per the seven (7) rights . . . Asks the resident to place their mouth around the opening of the inhaler . . . Gives the resident a glass of water to rinse their mouth and throat of the medication to prevent burning and irritation. . . ." Review of Resident #10 medical record occurred on 07/31/23. Physician's orders dated 07/12/23 stated, Advair discus inhale one puff orally 2	B1540	3. Re-education on the requirement to follow the seven rights of medication administration was completed on 7/31/23. 5. Health & Wellness Director and Care Team Manager are responsible to verify effectiveness of corrective action.	4. Aug 2, 2023

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B1540	Continued From page 25 times a day - rinse mouth after use. Protonix 40 milligrams (mg) by mouth 2 times a day with meals. - Observation of medication administration for Resident #10 occurred on 07/31/23 at 5:00 p.m. with a medication aide (MA) (#6). The MA administered Resident's #10 Protonix (stomach medication) during the supper meal. The MA (#6) obtained an unlabeled albuterol inhaler from the medication cart. When asked how the MA (#6) knew it was Resident #10's inhaler the MA stated, "it's in his slot." The MA (#6) prepared to administer the albuterol inhaler when stopped by the surveyor. The surveyor asked the MA to verify the medication with eMAR. The MA (#6) stated, "It's albuterol [a bronchodilator]" as he pointed to the Advair (a steroid-bronchodilator combination) order. The MA (#6) called an administrative nurse (#9) to the unit. The nurse stated, "this [albuterol inhaler] is discontinued, give this one [Advair inhaler]". The MA (#6) prepared the Advair inhaler and handed it to Resident #10. The MA (#6) failed to ask the resident to place mouth around the opening of the inhaler and the resident took a puff from the side of the inhaler. After the Resident #10 correctly inhaled the medication the MA (#6) failed to offer the resident water to rinse his mouth. INSULIN INJECTION Review of the facility policy titled "Medication Administration - Insulin Injection" occurred on 08/02/23. This policy, dated 02/21/23, stated, ". . . med passer . . . Removes cap and cleanses the rubber area on the tip of the pen with an alcohol wipe . . . Primes the needle of the insulin pen to the two (2) units mark to ensure the accurate dose of insulin is administered . . . Press the	B1540		

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B1540	Continued From page 26 plunger with their thumb using a slow and steady push until all of the insulin is injected, holding the insulin pen needle in place for approximately ten (10) seconds . . ." Review of manufacturers guideline's for "Novolog Insulin" occurred on 08/02/23. This guideline stated, ". . . Penfill cartridge you are using should be thrown away after 28 days, even if it still has insulin left in it . . ." - Review of Resident #11's medical record occurred on 08/01/23. A Physician's order stated, Novolog Flex Pen - "INJECT THREE TIMES DAILY WITH MEALS: 12 UNITS SUBCUTANEOUSLY (BEYOND USE 28 DAYS) . . ." Observation of insulin administration for Resident #11 occurred on 08/01/23 at 11:31 a.m. with a MA (#8). The insulin pen label failed to identify the units of insulin to administer and had a written open date of 07/21/23 and discard date of 08/21/23 (31 days). The MA (#7) failed to cleanse the rubber area with alcohol, prime the insulin pen, and failed to hold the insulin pen in the resident's skin for 10 seconds.	B1540		
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	1. Community nurses re-educated on the requirement to provide nursing services to meet the needs of the residents. 2. All residents have potential to be affected by this practice.	

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B1700	Continued From page 27 This state licensing rule is not met as evidenced by: Based on observation, information received from the complainants, review of facility policy, and family and staff interviews, the facility failed to provide nursing services to meet the needs of the residents for 5 of 8 sampled residents (#1, #2, #6, #7, and #8). Failure to notify resident's legal representatives after a fall and emergency room (ER) transfer, provide adequate monitoring after a fall, assess a side rail for safety, and report/monitor bruises may result in negative health outcomes for residents. Findings include: FALLS MONITORING Review of the facility policy titled "Falls Management" occurred on 08/02/23. This policy, dated 05/22/23, stated, ". . . Fall-related forms will be available for use to document findings post a resident fall. . . . The team member follow-up documentation will include: . . . (3) Post-Fall Vital Signs and Observations . . . If a resident has fallen, the following steps should be taken: . . . i. A nurse will notify the primary care provider (PCP) and legal representative. . . . If a resident experiences a fall resulting in serious injury requiring emergency room evaluation and/or treatment or hospital admission, the nurse will: a. Notify the resident's PCP and legal representative; . . ." - Review of Resident #1's medical record occurred on all days of survey. The progress notes identified the following: *01/19/23 at 4:41 p.m.: ". . . Received fall report from caregiver today that client had a witness fall early. Client has a 1 inch abrasion to his right side	B1700	3. Weekday clinical meetings will identify follow-up nursing services necessary to meet the needs of the residents, review of occurrences managed by after-hours nursing, residents with change in condition, any unusual occurrences to verify notifications to PCP & legal representatives. 5. Health & Wellness Director is responsible to verify effectiveness of corrective action and revise as warranted.	4. Oct 30, 2023

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B1700	Continued From page 28 of forehead. Area red, no bleeding. . . ." *04/13/23 at 7:59 a.m.: ". . . Triage call 02:42 [2:42 a.m.]: Resident tripped on a chair and fell, getting himself up and then notifying the team. . . . Team to monitor vital signs every 2 hours x 12 for surveillance . . ." *04/14/23 at 12:19 a.m.: ". . . Triage nurse, RN receives call from med [medication] passer reporting unwitnessed fall without apparent bodily injury and with minor bleeding cut/abrasion to R [right] forehead area. . . . Post fall protocol to include basic first aid to head wound with q2H [every 2 hours] x 24H [24 hours] vitals and observations . . ." Resident #1's medical record lacked evidence of post fall vital signs/monitoring after the above falls. During a family interview on 08/02/23 at 10:29 a.m., a family member (B) stated facility staff failed to notify her of Resident #2's fall and subsequent ER transfer on 05/18/23. The family member further stated staff did not check on Resident #2 during the night of 07/31/23 (after experiencing a fall earlier that evening). - Review of Resident #2's medical record occurred on all days of survey. Progress notes identified the following: *05/17/23 at 11:01 p.m.: ". . . Resident was found sitting on the floor at the foot of her bed. Resident with rug burn on her left knee and a bruise/bump at the side of her left eye. Team believes she was ambulating from her chair to her bed when she fell forward to her knees, hitting her head on either her bed or her chair . . . Vitl [sic] signs every 2 hours x 24 for surveillance. PCP notified via fax. Community to make other notifications . . ."	B1700		

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B1700	Continued From page 29 *05/18/23 at 3:28 p.m.: ". . . Care team manager calls to report pain and increased swelling of eye at 10:30 a.m. Advised to send to ED [emergency department] to have eye examined for possible injury. . . ." Resident #2's medical record lacked evidence of family notification or every 2 hour vitals signs/monitoring after the fall on 05/17/23. Observation on 07/31/23 at 4:27 p.m. showed Resident #2 attempted to stand from the dining room table. The resident fell and yelled out for help. Staff members (#6 and #7) entered the dining room, provided first aid, and called for the nurse. Resident #2's medical record identified, ". . . 07/31/23 11:50 PM . . . Resident had a witnessed fall within the DR [dining room] at approx. [approximately] 1625 [4:25 p.m.]. . . . The team was instructed to obtain VS [vital signs] q2h X 24 hrs et [and] notify the nurse with change of condition. . . ." Resident #2's medical record lacked evidence staff monitored her vital signs every 2 hours. Review of electronic monitoring in Resident #2's room confirmed no staff entered her room from 9:09 p.m. on 07/31/23 until 6:01 a.m. on 08/01/23. - Review of Resident #6 medical record occurred on all days of survey. Progress notes identified the following: *10/22/22 at 3:53 p.m. ". . . Resident had an unwitnessed fall in community common area . . . Resident noted to have a bruise to eye as well as appears to have bit inside of her lip. . . ." *10/22/22 at 8:50 p.m. ". . . Caregivers updated on resident returning . . . will continue VS every 2 hours for 24 hours . . . "	B1700		

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B1700	Continued From page 30 Resident #6's medical record lacked evidence staff monitored her vital signs every 2 hours. - Review of Resident #8's medical record occurred on all days of survey. Progress notes identified the following: * 06/18/23 at 4:26 p.m. ". . . call from staff to report unwitnessed fall for resident. . . . VS to be completed every 2 hours x 24 hours . . ." Resident #8's medical record lacked evidence staff monitored her vital signs every 2 hours. SIDE RAIL ASSESSMENT - Observation during all days of survey showed Resident #7's bed with a one half side rail on the right side of the bed. The Comprehensive Assessment dated 05/12/23 failed to identify Resident #7 with a side rail on her bed. During an interview on the afternoon of 08/02/23 an administrative staff member (#10) stated administrative staff did not know Resident #7 had a side rail therefore staff did not complete a side rail assessment. MONITORING BRUISES Observation during all days of survey showed Resident #7 with numerous bruises to both arms. The medical record failed to identify Resident #7's bruises. During an interview on 08/02/23 at 11:30 a.m., an administrative nurse (#9) stated she expected staff to complete a change alert form when a resident had bruises and staff failed to complete this form for Resident #7's bruises.	B1700		

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B1800	33-03-24.1-18 DIETARY SERVICES 33-03-24.1-18. Dietary services. The facility must meet the dietary needs of the residents and provide dietary services in conformance with the North Dakota sanitary requirements for food establishments. Dietary services must include: This state licensing rule is not met as evidenced by: Based on observation, information received from the complainant, review of professional reference, review of facility policy, and staff interview, the facility failed to provide dietary services to meet residents' needs and in conformance with the North Dakota sanitary requirements for food establishments in 2 of 2 dining rooms. Failure to wear hair restraints, ensure cold storage of 41 degrees Fahrenheit (F) or lower, discard potentially hazardous food by its best by date, label food items with an opened date, ensure proper hand hygiene, and cover foods to prevent contamination may result in unsanitary conditions and/or foodborne illness. Findings include: Information received from the complainants identified concerns with staff bringing food to the unit which was often uncovered and food/drink items not available at meals. The 2022 FDA Food Code, Chapter 2-21 and 2-22, stated, ". . . 2-402 Hair Restraints . . . FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their	B1800	1. Food service will conform with the North Dakota requirements for food establishments. Team members will wear hair restraints when in food service areas; properly store perishable food; discard potentially hazardous food by the best by date; perform hand hygiene per ServSafe standards; and cover food to prevent contamination. 2. All residents have the potential to be affected by this practice. 3. Basic Care staff will be in-serviced and culinary staff re-educated on the requirement to wear hair restraints when in food service areas; properly store perishable food; discard potentially hazardous food by the best by date; performing hand hygiene per ServSafe standards; and covering food to prevent contamination. 5. Care Team Manager and Culinary Services Director are responsible to verify effectiveness of corrective action.	4. Oct 30, 2023

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B1800	Continued From page 32 hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. . . ." Chapter 3-10 and 3-11, stated, ". . . 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: . . . storing the food in packages, covered containers, or wrappings . . ." The National Restaurant Association's "Serv Safe Manager," 7th edition, 2017, page 5.11 stated, ". . . Ready-to-eat TCS [time/temperature controlled for safety] food can be stored for only seven days if it is held at 41 [degrees Fahrenheit] or lower. The count begins on the day that the food was prepared or a commercial container was opened. . . ." Review of the facility policy titled "Flow of Food/Safe Food Temperatures occurred on 08/02/23. This policy, dated 12/06/22, stated, ". . . Storage temperatures keep pathogens in check, so store cold TCS foods at an internal temperature of 41°F or lower . . ." Observation on 07/31/23 at 11:10 a.m. showed uncovered pans of cake on the counter in each of the two dining rooms. The cake pans remained uncovered until staff began serving lunch at approximately 11:50 a.m. Observation in the dining room during the noon meal on 07/31/23 showed multiple residents without coffee. One resident stated to the surveyor, "She [her tablemate] didn't get any water or coffee or nothing." Another resident stated, "I didn't get a dessert. I didn't get my coffee either." When asked, a staff member stated, "We ran out of coffee." She then stated,	B1800		

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B1800	Continued From page 33 "I'll send my coworker to go get some," but made no attempt to do so for several minutes. When the other staff member eventually returned with a carafe, one of the residents stated, "I don't want coffee now. I'm done eating." Observation on 07/31/23 at 4:20 p.m. showed two staff members (#1 and #7) dished up food items and served dinner trays to residents without hair restraints in place. At 4:35 p.m., a staff member (#7), while wearing gloves, assisted a resident to put his shoes back on. Without performing hand hygiene, the staff member changed her gloves and resumed passing dinner trays/assisting with meal set up. Observation on 08/01/23 at 11:11 a.m. showed uncovered pans of cake on the counter in each of the two dining rooms. The cake pans remained uncovered until staff began serving lunch at approximately 11:35 a.m. A staff member (#2) dished up food items and served lunch trays to residents without a hair restraint in place. Observation on 08/01/23 at 5:15 p.m. in one of the dining room's fridges showed an open gallon of milk with a best by date of 07/23/23, open bottles of a protein drink and Ensure without an opened date, and two open pudding cups without an opened date. Although a thermometer was present in the fridge; staff failed to record fridge temperatures. Observation in the other dining room showed a fridge which contained an open gallon of milk with a best by date of 07/30/23 and a container of sour cream with a best by date of 06/15/23. The fridge lacked a thermometer or evidence of temperature monitoring by staff. During an interview on 08/02/23, a staff member (#3) stated the staff in the unit do not monitor	B1800		

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B1800	Continued From page 34 fridge temperatures or their contents.	B1800		
B1820	33-03-24.1-18,2 DIETARY SERVICES 2. No more than a fourteen-hour span between an evening meal and breakfast. This state licensing rule is not met as evidenced by: Based on observation, information received from the complainants, family interview, and staff interview, the facility failed to ensure no more than a 14 hour span between meals on 3 of 3 days of survey (July 31-August 2, 2023). Failure to provide evening snacks may result in unresolved hunger and weight loss. Findings include: Information received from the complainants identified concerns with a lack of snacks and residents stating they are hungry. Observation on 07/31/23 at 4:40 p.m. identified Resident #1 eating dinner in the dining room. The resident asked the surveyor, "Are they having dessert? A sandwich and coleslaw doesn't cut it." Observation on 08/01/23 at 8:30 a.m. showed this resident eating breakfast in the dining room (nearly 16 hours after eating dinner). During a family interview on 08/02/23 at 10:29 a.m., a family member (B) identified Resident #1 wandering around the unit on the evening of 07/31/23. "He was hungry and looking for food." During an interview on 08/01/23 at 5:06 p.m., a	B1820	1. Meals and/or substantial snacks are provided with no longer than 14 hour span between the evening meal and breakfast meal. 2. All residents have potential to be affected by this practice. 3. Basic Care and culinary staff will be educated on preparing and offering a scheduled substantial snack to Basic Care residents during the evening hours. 5. Care Team Manager and Culinary Services Director are responsible to verify effectiveness of corrective action.	4. Oct 30, 2023

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B1820	Continued From page 35 staff member (#4) stated they do not pass out evening snacks.	B1820		
B1830	33-03-24.1-18,3 DIETARY SERVICES 3. Snacks between meals and in the evening. These snacks must be listed on the daily menu. Vending machines may not be the only source of snacks. This state licensing rule is not met as evidenced by: Based on observation, information received from the complainants, and staff interview, the facility failed to provide snacks between meals and in the evenings and list these snacks on the daily menu on 2 of 3 days of survey (July 31-August 1, 2023). Failure to provide regular snacks may result in unresolved hunger and weight loss. Findings include: Information received from the complainants identified concerns with a lack of snacks and residents complaining of hunger. Observations on 07/31/23 and 08/01/23 identified staff failed to provide a snack between breakfast and lunch. Staff also failed to post daily menus and list snacks on the menus. During an interview on the evening of 08/01/23, a staff member (#4) stated they do not pass out evening snacks.	B1830	1. Snacks are provided between meals and in the evening. 2. All residents have potential to be affected by this practice. 3. Basic Care and culinary staff will be educated on preparing and offering a scheduled snack to Basic Care residents between meals and during the evening hours. Snack offerings will be listed on the daily menu. 5. Care Team Manager and Culinary Services Director are responsible to verify effectiveness of corrective action.	4. Oct 30,2023
B1930	33-03-24.1-19,3 ACTIVITY SERVICES 3. Activities must be available and provided	B1930		

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	8201	A. BUILDING: _____ B. WING _____	C 08/02/2023

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B1930	Continued From page 36 to meet the needs of all residents during the day, in the evening, and on the weekend. This state licensing rule is not met as evidenced by: Based on observation, information received from the complainants, review of facility policy, and staff interview, the facility failed to provide activities to meet the needs of 1 of 8 sampled resident (Resident #6). Failure to provide activities may result in decreased quality of life for residents. Findings include: Information received from the complainants' identified concerns with a lack of activities. Review of the facility policy titled "Activity Calendars" occurred on 08/02/23. This policy, dated 03/21/23, stated, ". . . The Community will offer dynamic and enriching activity programming that meet the needs of the whole person . . ." Resident #6 Resident Service Agreement/Care Plan stated, "I need encouragement/assistance to and from activities of choice. Resident will be invited, encouraged, and assisted as needed to participate in activities that enrich their lives or are of interest." Observation showed the following: 07/31/23 - Resident #6 sitting at the dining room table from 12:30 p.m. until approximately 3:00 p.m. when staff assisted her to the TV area. The resident did not participate in any afternoon activity. 08/01/23 - Resident #6 sitting at the breakfast	B1930	1. Resident #6 will be invited, encouraged, and assisted to participate in activities. If Resident #6 demonstrates resistance to joining activities community will notify Legal Representative and request assistance to have resident participate in activities. 2. All residents have the potential to be affected by this practice. 3. Basic Care and life engagement team members will be educated on how to approach and engage residents in activities. If a resident consistently refuses to join or behavioral expressions are triggered with inviting/encouraging team, staff will be trained to notify nursing. Nursing will notify legal representative to collaborate on options for approach. 5. Life Engagement Director and Care Team Manager are responsible to verify effectiveness of corrective action.	4. Oct 30, 2023

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B1930	Continued From page 37 table from 9:00 a.m. until lunch time (11:30 a.m.). The resident did not participate in any morning activity. During an interview on 07/31/23 at 2:47 p.m., an activities staff member (#1) stated she is the only activities staff person right now. The staff member stated she tries to do an activity on each side of the unit in the morning and afternoon.	B1930		
B2000	33-03-24.1-20 HOUSEKEEPING/LAUNDRY SERVICES 33-03-24.1-20. Housekeeping and laundry services. The facility shall maintain the interior and exterior of the facility in a safe, clean, and orderly manner and provide sanitary laundry services, including personal laundry services, for residents. This state licensing rule is not met as evidenced by: Based on observation and information received from the complainants, the facility failed to provide housekeeping services to maintain a clean and orderly environment on 3 of 3 days of survey (July 31-August 2, 2023). Failure to ensure clean rooms free of odors does not promote a homelike atmosphere. Findings include: Information received from a complainant identified concerns with dirty resident bathrooms and carpets. One of the complainants stated her family member's room had not been vacuumed for almost three weeks (observed via electronic monitoring) and the bathroom smelled of urine. A third complainant voiced concerns regarding dirty	B2000	1. Identified cleaning tasks have been completed. 2. All residents have the potential to be affected by this practice. 3. Designated leadership will conduct daily checks of common areas and resident apartments for needed cleaning. Staff will be re-educated on cleaning protocols and requirement to maintain a clean and orderly environment and report if unable to remedy for any reason. Nursing will identify residents with inappropriate elimination for follow up with PCP and legal representative on options to mitigate or avert inappropriate urination. Cleaning and carpet shampooing was completed by 9.20.23. Resident #1 discharging by October 30, 2023. 5. Executive Director and Environmental Services Director are responsible to verify effectiveness of corrective action.	4. Oct 30, 2023

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B2000	Continued From page 38 bathrooms and overall cleanliness. Observations during the survey showed the following: *Room 7: Stained and dirty carpet, a toilet soiled with bowel movement, and a dirty bathroom floor *Room 10: A strong urine smell throughout the room *Room 11: Stained and dirty carpet and a sticky bathroom floor which smelled of urine *Room 13: Stained and dirty carpet and a toilet soiled with bowel movement *Room 14: Dirty carpet and sticky bathroom floor which smelled of urine *Room 19: Stained grout in the bathroom and a urine smell	B2000		
B2406	33-03-24.1-24,6 Optional Alzheimer's, Demential, Special Mem The person-centered care plans must be reviewed quarterly and anytime there is a change in need by the resident based on the assessment, and modified as needed. 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 develop an Alzheimer's/Dementia behavioral care plan based on the comprehensive assessment for 4 of 8 sampled residents (Resident #1, #4, #6, and #8) residing in the memory care unit. Failure to implement interventions may result in increased behaviors and unmet care needs. Findings include:	B2406	1. The facility will review person centered care/service plan quarterly and with a change of need. 2. All residents have the potential to be affected by this practice. 3. Interventions to mitigate and/or avert residents' behavioral expressions will be identified with the completion of a comprehensive assessments and documented in the resident care plan. 5. Health and Wellness Director is responsible to verify effectiveness of corrective action.	4. Oct 30, 2023

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B2406	Continued From page 39 Review of the facility policy titled "Assessments and Evaluations" occurred on 08/02/23. This policy, dated 07/11/23, stated, ". . . The Community will conduct assessments, observation, and reassessments in accordance with state law to determine the level of assistance required by each resident in an effort to maximize their quality of life. Assessments should be thorough and timely to ensure that a resident's care needs are identified, and an individualized care plan is maintained. The assessment also serves to determine the prospective resident's suitability for placement in the Community. . . ." Review of the facility policy titled "Resident Service Plan" occurred on 08/02/23. This policy, dated 06/22/23, stated, ". . . A service plan addressing the individualized needs of the resident will be developed during the initial assessment and completed for each resident before nursing services are initiated . . . The nurse ' s initial assessment and any other Community evaluation conducted before nursing services are initiated and will be the basis for the resident's written service plan. . . . The service plan will: a. Identify the program services, frequency, and approaches the Community will provide under applicable law, to include personal care, supervision, activities, health monitoring, medication administration, behavior management, information and referral, and transportation . . . The service plan will serve as a basis for the service delivery contract between the Community and the resident. . . ." - Review of Resident #1's medical record occurred on all days of survey. Resident #1's "Comprehensive Assessment," dated 07/19/23, stated, ". . . Cognitive Pattern/Behavioral Expressions . . . Expressions: All behavioral	B2406		

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B2406	Continued From page 40 expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan . . . Forgetful . . . Minor socially inappropriate behaviors . . . Uncooperative with Care . . . Wanders . . . Refusals . . . Does not accept redirection . . . Verbally aggressive . . . Physically aggressive . . . Delusions . . . Anxious . . . Depressed/Withdrawn . . . Hoarding, Rummaging . . ." Resident #1's "Resident Service Agreement," dated 07/25/23, failed to identify behavioral expressions such as: socially inappropriate behaviors, uncooperative with care, refusals, verbal and physical aggression, and also failed to implement individualized interventions related to these behaviors. - Review of Resident #4's medical record occurred on all days of survey. Resident #4's "Comprehensive Assessment," dated 05/16/23, stated, ". . . Cognitive Pattern/Behavioral Expressions . . . Expressions: All behavioral expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan . . . Forgetful . . . Minor socially inappropriate behaviors . . . Uncooperative with Care . . . Wanders . . . Refusals . . . Does not accept redirection . . . Anxious . . . Hoarding, Rummaging . . ." Resident #4's "Resident Service Agreement," dated 08/02/23, failed to identify behavioral expressions such as: socially inappropriate behaviors, uncooperative with care, wandering, refusals, hoarding, and rummaging and also failed to implement individualized interventions related to these behaviors. - Review of Resident #6's medical record	B2406		

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B2406	Continued From page 41 occurred on all days of survey. Resident #6's "Comprehensive Assessment," dated 07/25/23, stated, ". . . Cognitive Pattern/Behavioral Expressions . . . Expressions: All behavioral expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan . . . Forgetful . . . Uncooperative with Care . . . Wanders . . . Walks extensively, Pacing . . . Refusals . . . Physically aggressive . . . Hoarding, Rummaging . . ." Resident #6's "Resident Service Agreement," dated 08/02/23, failed to identify behavioral expressions such as: forgetful, uncooperative with care, wandering, walks extensively, pacing, refusals, physical aggression, hoarding, rummaging and also failed to implement individualized interventions related to these behaviors. - Review of Resident #8's medical record occurred on all days of survey. The progress notes stated: * 06/02/23 at 12:53 a.m. "[Resident name] is being very aggressive since yesterday. Writer can hear her yelling in the background. She is banging on doors, going from room to room, cursing and fighting. She won't change her clothes, she is knocking things off the wall . . ." * 06/08/23 at 10:13 p.m. Call received from [staff name] stating the resident is very agitated, aggressive, tearing items off the wall et [sic] yelling out. . . ." * 07/05/23 at 9:15 p.m. "[Name of nurse practitioner] . . . here to see resident . . . Provided update regarding behavioral expressions: spitting on staff, breaking items, pulling pictures of walls, agitated/paranoid . . ." Review of Resident #8's "Comprehensive	B2406		

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B2406	Continued From page 42 Assessment" dated 05/31/23 and "Resident Service Agreement" dated 08/02/23 failed to identify behavioral issues and interventions for the behaviors. During an interview on 08/02/23 at 10:10 a.m., an administrative staff member (#10) confirmed staff failed to document Resident #8's "outburst" on the resident service agreement/care plan.	B2406		