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	8201	A. BUILDING: _____ B. WING _____	R-C 01/14/2026

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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{B 000}	INITIAL COMMENTS For the on-site revisit and complaint survey started on 01/12/26 and completed on 01/14/26, the sample included seven residents for complete review and three closed records for review. In addition, the sample included one supplemental resident to verify specific concerns during the survey. Tier II citations included B924, B1320, B1510, B1520, B1540, B1700, B1800, B2000, and B2302	{B 000}	See attached	
{B 924}	33-03-24.1-09,2,d GOVERNING BODY d. Infection control practices, including provision of a sanitary environment and an active program for the prevention, investigation, management, and control of infections and communicable diseases in residents and staff members. This State Licensing Rule is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to follow standards of infection control for 2 of 2 sampled residents (Resident #5 and #6) observed during blood glucose testing. Failure to follow infection control standards places residents, staff, and visitors at risk for transmission of infections within the facility. Findings include: Review of the Centers for Disease Control and Prevention (CDC) for injection safety at https://www.cdc.gov/injection-safety/hcp/infection-	{B 924}		

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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{B 924}	Continued From page 1 control/index.html, dated 08/07/24, titled "Considerations for Blood Glucose Monitoring and Insulin Administration, stated, ". . . Clean and disinfect blood glucose meters after every use . . ." - Observation on 01/12/26 at 4:52 p.m. showed a medication aide (MA) (#4) utilized a glucometer dedicated to Resident #5 to perform blood glucose testing. The MA failed to clean and disinfect the glucose meter prior to placing it into a labeled zippered black pouch in the medication cart. - Observation on 01/12/26 at 5:12 p.m. showed the MA (#4) used a glucometer dedicated to Resident #6 to perform blood glucose testing. The MA failed to clean and disinfect the glucose meter prior to placing it into an unlabeled zippered black pouch in the medication cart. During an interview on 01/12/26 at 5:30 p.m., the MA (#4) confirmed she failed to clean and disinfect Resident #5 and #6's glucose meters before placing them into the zippered pouches.	{B 924}		
{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.	{B1320}		

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{B1320}	Continued From page 2 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 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.	{B1320}		

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{B1320}	Continued From page 3 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, policy review, and staff interview, the facility failed to ensure a complete medical record for 1 of 3 closed records (Resident #10) reviewed for falls. Failure to include complete post fall observations and vital signs may affect care decisions and continuity of care. Findings include: Review of the facility policy titled "Fall Mitigation and Management" occurred on 01/14/26. This policy, dated 11/05/24, stated, ". . . Post-Fall. If a resident has fallen . . . Obtain vital signs and notify Community licensed nurse immediately. . . . If the Community licensed nurse is not immediately available, notify the nurse on call. . . . Post-Fall Vital Signs and Observations. 1. Following a resident fall, the Community licensed nurse will direct delegated team members to . . . Obtain post-fall vital signs and conduct observations . . . Document the fall and the frequency of vital signs and observations . . ." Review of Resident #10's record occurred on all days of survey and identified the following: * A fall on 09/07/25 with orders received from the	{B1320}		

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{B1320}	Continued From page 4 triage nurse to complete post-fall vital signs every 2 hours for 24 hours (a total of 12 times). Staff failed to obtain/document vital signs and observations on 8 of the 12 ordered times. * A fall on 10/21/25 with orders received from the triage nurse to complete post-fall vital signs once a shift for 24 hours. Staff failed to obtain vital signs and observations on one of the three shifts. During an interview on 01/14/26 at 9:41 a.m., an administrative staff member (#1) confirmed staff failed to complete Resident 10's post fall vitals as ordered by the triage nurse.	{B1320}		
{B1510}	33-03-24.1-15,1 PHARMACY/MED ADM SERVICES 1. The facility shall provide assistance to the resident in obtaining necessary medications and medical supplies. This State Licensing Rule is not met as evidenced by: Based on information received from the complainant, record review, and staff interview, the facility failed to transcribe the physician's orders and ensure the availability of medication for 1 of 7 sampled residents (Resident #2). Failure to transcribe the physician's orders and supply the medications as ordered has the potential to result in untreated symptoms. Findings include: The facility failed to provide a policy as requested. Information received from the complainant	{B1510}		

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{B1510}	Continued From page 5 identified a resident did not receive medication as ordered. Review of Resident #2's medical record occurred on all days of survey. A physician's order, dated 01/21/25, identified "Start Zyrtec [antihistamine] 10 mg [milligrams] PO [by mouth] daily x [times] 2 weeks. Dx [diagnosis]: Allergies. Update provider in 2 weeks." The resident's January and February 2025 medication administration records (MARs) identified Resident #2 did not receive Zyrtec for two weeks as ordered. The facility updated the provider 28 days later, and recieved a new order for Zyrtec on 02/18/25. During an interview on 01/13/26 at 1:01 p.m., an administrative nurse (#2) stated, "there was a failure in faxing the order [dated 01/21/25] to the pharmacy, therefore, the medication was not received." During an interview on 01/14/26 at 8:00 a.m., an administrative nurse (#1) confirmed she expected staff to implement medications as ordered.	{B1510}		
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	B1520		

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B1520	Continued From page 6 own medication administration must be provided a secure storage place for their medications. This State Licensing Rule is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to assure safe and secure storage of medications for 1 of 4 medication carts (Unit 1). Failure to store all medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Medication Management/Medication Storage" occurred on 01/12/26. This policy, dated 06/28/24, stated, ". . . Medications will be centrally located stored in locked medication carts . . ." Observation on 01/12/26 at 1:31 p.m., showed an unlocked medication cart in Unit 1 with no nursing staff nearby. This medication cart remained unlocked until 1:51 p.m. when the surveyor notified an administrative staff member (#1) of the unlocked cart. This staff member (#1) confirmed she expected staff to lock the medication cart.	B1520		
{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	{B1540}		

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{B1540}	Continued From page 7 administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered. This State Licensing Rule is not met as evidenced by: Based on observation, record review, review of the facility Med (medication) Passer Guide, review of professional reference, and staff interview, the facility failed to follow provider orders, ensure residents eat in a timely manner after insulin administration, ensure open/expiration dates on insulin pens, ensure labels on insulin pens match the orders, document in resident record when medications administered, and administer medications as ordered for 2 of 7 sampled residents (Resident #5 and #6) and 1 closed record (Resident #10). These failures may result in significant medication errors and/or adverse health consequences for all residents who reside in the facility. Findings include: Review of the facility's Med Passers Guide occurred on all days of survey. This guide, dated 04/04/24, page 5, stated, ". . . For every administration of medication, med passers will follow the seven (7) rights . . . 1. Right Resident 2. Right medication 3. Right dose 4. Right route 5. Right time and day . . . 7. Right Documentation . . . Preparing for Medication Administration: 1. With the resident's electronic medication administration record (eMAR) open, compare the	{B1540}		

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{B1540}	Continued From page 8	{B1540}		

medication listed in the eMAR with the medication label to confirm rights 1-5 . . . 2. Check the expiration date on the medication label to verify the medication has not expired . . . 4. Repeat confirmation of right 3 ("right dose") by again comparing the dosage listed in the eMAR with the dosage on the label . . ." Page 6 stated, ". . . After Administration . . . 3. Document medication administration in resident's eMAR. . . ."

Review of the Insulin Aspart instructions for use at https://www.novo-pi.com/insulinaspart.pdf, revised February 2023, page 1, stated, ". . . Insulin Aspart is rapid acting human insulin . . . Inject subcutaneously [under the skin] within 5-10 minutes before a meal . . ." Page 9 stated, ". . . To avoid injecting air and to ensure proper dosing [priming the pen] . . . Turn the dose selector to select 2 units . . . Hold your Insulin Aspart FlexPen® with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge . . . Keep the needle pointing upwards, press the push-button all the way in . . . The dose selector returns to 0. . . ."

Review of the Admelog instructions for use at https://products.sanofi.us/admelog/admelog.pdf#page=11, revised May 2025, page 1, stated, ". . . ADMELOG is a rapid-acting human insulin . . . Administer ADMELOG by subcutaneous injection . . . within 15 minutes before a meal or immediately after a meal. . . ."

- Review of Resident #5's medical record occurred on all days of survey. A physician's order, dated 06/04/25, identified Admelog insulin 12 units three times daily five to ten minutes before meals.

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{B1540}	Continued From page 9 Observation on 01/12/26 at 4:47 p.m. showed a medication aide (MA) (#4) removed an Admelog insulin pen from the medication cart. The pen lacked an open and expiration date. The medication aide (#4) prepared the insulin pen for administration, primed the pen sideways, and administered the insulin to the resident. Staff failed to provide Resident #5 anything to drink or eat until 5:40 p.m. (approximately 40 minutes after insulin administration). - Review of Resident #6's medical record occurred on all days of survey. A physician's order, dated 12/18/25, identified Insulin Aspart 2 units before breakfast and 6 units before lunch and dinner. Observation on 01/12/26 at 5:12 p.m. showed the MA (#4) removed the insulin pen from the medication cart. The pen lacked an open and expiration date and the label stated "2 units before breakfast inject twice [surveyor unable to read remainder of the label]." The MA (#4) stated the label on the pen was the resident's "old order" and twice meant twice a day. At 5:17 p.m., the MA (#4) prepared the pen and administered the insulin to the resident. Staff failed to provide Resident #6 anything to drink or eat until 5:42 p.m. (approximately 20 minutes after insulin administration). - Review of Resident #10's medical record occurred on all days of survey. A hospice order, dated 12/18/25 at 10:00 a.m., stated, "4mg [milligrams] of hydromorphone [an opioid to treat moderate to severe pain] buccally [inside mouth near the cheek] one time now . . . may repeat in one hour if needed. . . ." A progress note, dated 12/18/25 at 12:19 p.m., stated, "RN [registered nurse] informed that resident was given 8MG of	{B1540}		

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{B1540}	Continued From page 10 Hydromorphone instead of the 4MG dose ordered [administered by a MA later identified as MA (#5)]. . . ." Resident #10's medical record also identified the following: * A provider order, dated 10/21/25, showed oxycodone 5 mg every four hours as needed for pain. A progress note, dated 10/22/25 at 10:38 a.m., stated, ". . . she complained of pain all over. RN [registered nurse] requested Med [medication] Passer to give PRN [as needed] Oxycodone [treats moderate to severe pain]. . . ." Review of the residents' October 2025 eMAR lacked documentation staff administered the oxycodone. * A hospice order, dated 12/18/25 at 10:00 a.m., showed administer 2mg of lorazepam (antianxiety medication) now and 4mg of hydromorphone (treats moderate to severe pain) now. Review of the residents' December 2025 eMAR lacked documentation staff administered the lorazepam and hydromorphone. During an interview on 01/14/26 at 11:00 a.m., an administrative nurse (#1) confirmed Resident #10 did receive the oxycodone on 10/21/25 and staff failed to document administration on the resident's eMAR.	{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}		

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{B1700}	Continued From page 11 This State Licensing Rule is not met as evidenced by: Based on record review the facility failed to provide nursing services to meet the medical and health needs for 1 of 7 sampled residents (Resident #7) and one closed record (Resident #10) reviewed. Failure to provide nursing services regarding notification of abnormal vital signs, rechecking blood sugars and transcribing/administering medications placed the residents at risk for complications, illness, and behaviors and may result in negative health outcomes for residents. Findings include: - Review of Resident #7's medical record occurred on all days of survey. The blood glucose levels from December 12 - 18, 2025 showed a glucose level of 58 on 12/15/25 at 7:24 a.m. A nursing progress note, dated 12/15/25 at 10:04 a.m., stated, "Med [medication] passer reached out to RN [Registered Nurse] this am [a.m.] that residents BS [blood sugar] 59. Instructed her to hold insulin and give juice. Resident to eat breakfast soon and Med Passer to recheck BS in 15 minutes." Resident #7's blood glucose level on 12/17/25 at 6:15 p.m. showed a glucose level of 477. A progress note dated 12/17/25 at 7:54 p.m., stated, "RN was notified that resident had fallen. . . . Also notified that residents BS was 477 and then with recheck 466. RN informed Med Passer that she needs to recheck blood sugar one time during night." The medical record lacked evidence facility staff rechecked Resident #7's blood sugar in 15 minutes on 12/15/25 and during the night of	{B1700}		

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{B1700}	Continued From page 12 12/18/25. Review of Resident #7's post fall vital sign record, dated 01/11/26, indicated to notify the nurse if blood pressure is greater than 170/90 or heart rate less than 60. The record showed a blood pressure of 187/61 and heart rate of 49 on 01/11/26 at 3:20 a.m. and a heart rate of 50 at 5:20 a.m. The medical record lacked evidence facility staff notified the nurse of the blood pressure and heart rate and received follow up instructions. During an interview on 01/13/26 at 4:23 p.m. and the morning of 01/14/26, an administrative nurse (#1) confirmed the medical record lacked evidence staff rechecked Resident #7' blood sugar level as instructed or notified the nurse of the elevated blood pressure and decreased heart rate. - Review of Resident #10's medical record occurred on all days of survey. Physician's orders for olanzapine (antipsychotic) showed the following: * 12/08/25 at 11:30 a.m., ". . . (update) take 5mg [milligrams] olanzapine by mouth at bedtime . . ." * 12/10/25 at 11:40 a.m., "(increase dose) take 7.5 mg of olanzapine by mouth at bedtime . . ." * 12/16/25 at 10:20 a.m., "Discontinue . . . olanzapine . . ." Review of the resident's December 2025 medication administration record (MAR) showed the following: * Staff administered olanzapine 5 mg at bedtime on 12/09/25 and 12/11/25. * Staff entered olanzapine 7.5 mg at bedtime on the MAR as an as needed order, not scheduled. Therefore, the resident received an incorrect	{B1700}		

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{B1700}	Continued From page 13 dose on 12/11/25 and no doses between December 12-16 (4 days). Physician's orders for Resident #10's lorazepam (antianxiety) included the following: * 12/16/25 at 10:20 a.m., ". . . take 0.25mg lorazepam every 4 hours around the clock . . ." * 12/17/25 at 10:57 a.m., ". . . take 0.5mg of Lorazepam . . . every 4 hours around the clock . . ." Review of the resident's December 2025 MAR showed the following: * A one time order for Lorazepam 0.25 mg tablet on 12/17/25 (not around-the-clock as ordered). The MAR lacked documentation staff administered the lorazepam on 12/17/25. * Lorazepam 0.5 mg tablet three times daily versus every 4 hours as ordered, effective 12/16/25. The MAR showed staff administered the 0.5 mg three times a day on December 16-17. The transcription errors resulted in Resident #10 not receiving around-the-clock lorazepam for two days.	{B1700}		
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:	B1800		

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 _____	R-C 01/14/2026

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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B1800	Continued From page 14 Based on observation, review of facility policy, and staff interview, the facility failed to provide sanitary dietary services to meet residents' needs in 3 of 3 kitchenettes (Unit One, Unit Two/Three, and Unit Four). Failure to ensure the kitchenette food service areas, equipment, refrigerators, and floors are clean may result in unsanitary conditions and/or foodborne illness. Findings include: Review of the facility policy titled "Handwashing, Glove Usage, and Hair Restraints" occurred on 01/14/26. This policy, dated 11/06/25, stated, ". . . protocols to prevent cross-contamination, mitigate the spread of foodborne illnesses . . . When to wash hands . . . before starting work or handling food . . . before and after changing gloves . . . General . . . gloves do not replace hand washing- hands must be washed before putting on gloves and after removing them . . . when to change gloves . . . after touching any non-food surface (e.g. phone, register, equipment, trash, etc.) . . . when gloves are torn, dirty, or damaged. . . ." Review of the facility policy titled "Kitchen and Dining Room Cleaning and Sanitizing" occurred on 01/14/26. This policy, dated 11/06/25, stated, ". . . All kitchen . . . areas are cleaned and sanitized regularly throughout the day and at the end of each shift. . . . Surfaces, equipment, and food contact areas are free of food debris, grease, and residue . . . countertops, shelving . . . appliances and stainless-steel surfaces are kept clean and free of visible dirt . . . grease . . . Floors are thoroughly cleaned and mopped daily . . . Daily Cleaning Kitchen Tasks . . . Equipment . . . Wipe down and sanitize after use. Floors: Sweep and mop at the end of each shift . . .	B1800		

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B1800	Continued From page 15 Dishwashing station: clean and sanitize sinks . . . Ice machine: Clean per manufacturer guidelines . . . Countertops, shelving, dish areas, appliances, and stainless-steel surfaces: Clean and sanitize after each shift to prevent buildup . . ." Observations on 01/13/26 at 2:15 p.m. of the kitchenettes showed the following: * Unit One, Interior of fridge and freezer shelves and drawers contained food debris and dried liquid spillage, greasy residue on the microwave door and handle, interior of oven contained food debris and dried liquid spillage, the sink contained food debris, counter covered with food debris, toaster contained food debris and a dried substance on the exterior. * Unit Two/Three, Dried liquid spill on the floor, dried substance on the exterior of the coffee maker, juice, and ice machine, interior of freezer shelves and drawers contained food debris and dried liquid spillage, cabinet door was soiled with a dried substance, oven interior and exterior was soiled with food debris, exterior of the popcorn machine was soiled with a greasy residue. * Unit Four, the interior and exterior of the microwave was soiled with dried food splatter and greasy residue, range fan was soiled with debris, oven interior was soiled with food debris and dried liquid spillage, interior of fridge/freezer shelves and drawers were soiled with food debris and dried liquid spillage, toaster contained food debris and dried substance on the exterior. Observation on 01/12/26 at 11:50 a.m. showed certified nurse aide (CNA)(#3) picked up dirty silverware/plates and placed them on a cart with her gloved hands. Then, without performing hand hygiene and changing gloves, the CNA picked up a resident's meal plate and served the food to the resident.	B1800		

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B1800	Continued From page 16 During an interview on 01/14/26 at 8:00 a.m., an administrative staff (#1) confirmed that she would expect all staff to follow policy and procedures.	B1800		
{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, record review, and staff interview, the facility failed to provide and maintain a clean, orderly environment on 3 of 3 days of survey (January 12-14, 2026). Failure to maintain rooms in a clean and odor-free condition does not promote a homelike atmosphere. Findings include: Review of the facility document titled, "Rights of Health Care Facility" occurred on 01/14/26. This document, dated 12/01/25, stated, ". . . Personal and Privacy Rights . . . The Community will provide a safe, clean and comfortable environment . . ." Observations on all days of survey showed the following: *Room #9: Stained carpet inside and outside the room's main doorway and a strong urine smell throughout the room. *Unit 1 and Unit 2: A strong urine smell	{B2000}		

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{B2000}	Continued From page 17 throughout the hallway in shared resident space. During an interview on 01/13/26 at 8:35 a.m., an administrative staff member (#1) confirmed that room #9 had a strong odor of urine and expected staff to clean apartments daily.	{B2000}		
{B2302}	33-03-24.1-23,2 End-of-Life Services 2. A facility providing end-of-life care must employ or contract with a registered nurse to supervise resident care to meet the needs of the residents at all times, either directly or indirectly. The facility must employee a licensed nurse who is on the premises at least forty hours per week to identify and respond to the resident needs, care plan accordingly, provide oversight related to care, and review and document the resident's individual needs and care provided. This State Licensing Rule is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to provide timely oversight related to care for 1 closed record resident (Resident #10) receiving end-of-life services. Failure to provide nursing oversight related to new provider orders resulted in the unavailability of medication which may have resulted in the resident's increased behaviors. Findings include: Review of the facility policy titled "Medication Management: Orders, Refills, and Delivery" occurred on 01/14/26. This policy, dated 11/11/24, stated, ". . . New or changes in medication and	{B2302}		

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{B2302}	Continued From page 18 treatment orders will be implemented with the next cycle fill unless related to an acute change in resident condition or otherwise indicated on the order. . . ." Review of Resident #10's medical record occurred on all days of survey. Physician's orders included the following: * 12/05/25 at 3:20 p.m., "Admit to [hospice facility name] . . . lorazepam 0.25mg [milligrams] every 4 hours PRN [as needed] call to initiate . . ." * 12/08/25 at 11:30 a.m., ". . . Initiate PRN lorazepam (0.25mg every 4 hours as needed . . .) . . ." A progress note, dated 12/12/25 at 11:39 a.m., stated, "This nurse was informed by staff of resident's increased behaviors . . . [Hospice nurse name] contacted and informed. Per [hospice nurse], she will reach out to their pharmacy again to make sure they send the PRN lorazepam . . . over to NPSL [New Perspective Senior Living] ASAP [as soon as possible] as this is something that has not been received since resident was admitted back to NPSL. . . . resident is currently refusing all cares by staff after multiple attempts. . . ." During an interview on 01/14/26 at 11:20 a.m., an administrative staff member (#1) stated the lorazepam was delivered to the facility on 12/12/25 at 1:00 p.m. The facility nurse failed to ensure the availability of the PRN lorazepam which resulted in staff's inability to administer the as needed lorazepam for 3.5 days and may have contributed to Resident #10's increased behaviors.	{B2302}		

Tag: B 924

Regulation: 33-03-24.1-09(2)(d) – Governing Body – Infection Control Practices

The issue was addressed immediately after detection. On January 12th, 2026, the medication aide who failed to clean and disinfect glucometers for Residents #5 and #6 was removed from medication pass and received re-education on CDC standards for blood glucose monitoring and infection control, including the need to clean and disinfect meters after each use before storage. Residents #5 and #6 were checked for signs of infection, with no adverse effects found. All glucometers were promptly cleaned and disinfected across the facility, and proper

storage procedures were reinforced. A comprehensive audit of all staff performing blood glucose tests showed no other equipment disinfection failures. As a comprehensive corrective measure, all licensed nurses and medication aides re-educated on infection control for blood glucose monitoring, following CDC guidelines. The infection control audit tool was updated to include direct observation of glucometer cleaning and storage, and competency validation for blood glucose testing was completed for all relevant staff.

To support continued compliance, the Director of Nursing or designee will conduct weekly direct observation audits of blood glucose testing, including cleaning and disinfection procedures, for four consecutive weeks. Following this period, monthly audits will be conducted for three months. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement process to confirm sustained compliance with infection control standards. Any identified deviations will result in immediate retraining and corrective action as appropriate. The Director of Nursing is responsible for oversight and monitoring of this corrective action plan.

The deficiency was corrected on January 21, 2026.

Tag: B1320

Regulation: 33-03-24.1-13(2) – Resident Records

A full review of Resident #10's medical record confirmed there were no adverse outcomes from incomplete post-fall vital sign documentation, and no injuries or hospitalizations resulted. The record was examined with the Director of Nursing and licensed staff to emphasize that post-fall vital signs and observations must be completed and documented per triage nurse or healthcare practitioner orders and facility policies. Staff responsible for incomplete documentation received counseling and re-education on following physician and triage nurse orders, documentation standards, and maintaining complete medical records to support clinical decisions and care continuity. To ensure no other residents were affected by similar omissions, a retrospective audit of all falls in the past 90 days was conducted to verify proper post-fall monitoring and recording. System-wide corrective measures included re-educating all licensed nurses and medication aides on the facility's "Fall Mitigation and Management" policy, reinforcing that all post-fall monitoring ordered must be documented as required, and adding a standardized post-fall documentation checklist within the electronic health record to ensure prompt completion of monitoring intervals.

To support ongoing compliance, the Director of Nursing or designee will perform a comprehensive audit of all post-fall records for 30 days. This will verify that vital signs and observations are taken and recorded as required. After this initial period, monthly audits will continue for three months. The results will be reviewed through the facility's Quality Assurance and Performance Improvement process to confirm continued compliance with documentation standards. Any omissions identified will lead to immediate retraining and appropriate corrective actions. The Director of Nursing is responsible for overseeing and monitoring this correction plan.

The deficiency was corrected on January 21st, 2026.

Tag: B1510

Regulation: 33-03-24.1-15(1) – Pharmacy / Medication Administration Services

Resident #2's medical record was reviewed in full to assess for any adverse outcomes related to the failure to transcribe the physician's order and obtain Zyrtec as prescribed on 01/21/25. The provider was contacted, and the current medication order was verified. No adverse outcome was identified related to the missed medication. The process breakdown related to failure to fax the order to the pharmacy was reviewed with the licensed nurse and medication management staff. Staff involved were counseled and re-educated regarding the requirement to promptly transcribe physician orders, ensure orders are communicated to the pharmacy, verify receipt of medications, and follow up to confirm medication availability and administration as ordered. To determine if other residents had the potential to be affected by similar transcription or pharmacy communication failures, a retrospective audit of all physician orders from the previous 60 days was completed to verify timely transcription, pharmacy notification, and medication availability. No additional discrepancies were identified. System-wide corrective action included re-education of all licensed nurses and medication aides on physician order transcription procedures, implementation of a standardized order verification checklist to confirm orders are faxed or electronically transmitted to the pharmacy, and establishment of a secondary verification process requiring the licensed nurse to confirm medication receipt within 24 hours of a new order.

To support continued compliance, the Director of Nursing or designee will conduct weekly audits of new physician orders for four consecutive weeks to confirm timely transcription, pharmacy notification, and medication availability. Following the initial four-week period, monthly audits will be conducted for three months. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement process to evaluate sustained compliance with medication management requirements. Any identified discrepancies will result in immediate retraining and corrective action as appropriate. The Director of Nursing is responsible for oversight and monitoring of this corrective action plan.

The deficiency was corrected on January 28th, 2026.

Tag: B1520

Regulation: 33-03-24.1-15(2) – Pharmacy / Medication Administration Services

On January 12, 2026, when the unlocked medication cart in Unit 1 was identified, the cart was secured immediately. The licensed nurse and medication aides assigned to Unit 1 were re-educated the same day regarding the requirement that medication carts remain locked at all times when not under the direct supervision of authorized staff. A full review of all medication carts in the facility was completed to confirm they were functioning properly and capable of

being locked securely. A 100% audit of all medication carts was conducted to determine if other carts were left unsecured, and no additional unsecured carts were identified. The medication storage policy was reviewed with all licensed nurses and medication aides to reinforce expectations for secure storage, key accountability, and continuous supervision of medication carts during medication administration. System-wide corrective action included immediate re-education on medication cart security requirements, reinforcement of the expectation that carts must be locked when unattended even briefly, and implementation of shift-based medication cart security checks.

To support continued compliance, the Director of Nursing or designee will conduct daily random medication cart security checks for two weeks to confirm carts are locked when not directly attended. Following this period, weekly random audits will be conducted for three months. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement process to monitor sustained compliance with secure medication storage requirements. Any identified noncompliance will result in immediate retraining and corrective action as appropriate. The Director of Nursing is responsible for oversight and monitoring of this corrective action plan.

The deficiency was corrected on January 27th, 2026.

Tag: B1540

Regulation: 33-03-24.1-15(4) – Pharmacy / Medication Administration Services

The medication aide involved in the observations for Residents #5 and #6 and the medication administration error involving Resident #10 was removed from medication pass duties pending retraining and competency validation. Residents #5 and #6 were assessed for adverse effects related to insulin timing, labeling concerns, and administration technique, and no adverse outcomes were identified. Resident #10's record was reviewed to evaluate for adverse effects related to the incorrect hydromorphone dose and undocumented medication administrations; hospice and the attending provider were notified at the time of occurrence, and no additional adverse outcomes were identified. All insulin pens within the facility were immediately reviewed to verify appropriate labeling, open dates, expiration dates, and consistency with current physician orders. Any insulin pens lacking required labeling were properly labeled or replaced. A 100% audit of all medication carts and resident eMARs was conducted to verify compliance with proper documentation, medication labeling, expiration dating, and adherence to provider orders.

System-wide corrective actions included mandatory re-education for all licensed nurses and medication aides on the seven rights of medication administration, insulin administration standards, manufacturer guidelines for priming and timing of rapid-acting insulin, documentation requirements in the eMAR, and verification that medication labels match current provider orders. Competency validation for insulin administration and high-risk medication administration was completed for all staff authorized to administer medications. The facility reinforced the requirement that residents receiving rapid-acting

insulin must have a meal available within the manufacturer-recommended timeframe. A secondary nurse verification process was implemented for hospice STAT and high-alert medication orders to reduce risk of dosing errors. Additionally, a medication documentation audit process was implemented to verify that all administered medications are recorded in the eMAR at the time of administration.

To support continued compliance, the Director of Nursing or designee will conduct weekly medication pass observation audits for four consecutive weeks, focusing specifically on insulin administration timing, priming technique, labeling accuracy, expiration dating, and real-time eMAR documentation. In addition, weekly audits of high-alert medications and hospice STAT orders will be conducted for four weeks. Following this period, monthly audits will continue for three months. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement process to evaluate sustained compliance with medication administration requirements. Any identified deviations will result in immediate retraining and corrective action as appropriate. The Director of Nursing is responsible for oversight and monitoring of this corrective action plan.

The deficiency was corrected on January 28th 2026.

Tag: B1700

Regulation: 33-03-24.1-17 – Nursing Services

Resident #7's medical record was reviewed to evaluate for adverse outcomes related to failure to recheck blood sugars as instructed and failure to notify nursing staff of abnormal vital signs. No adverse hospitalization or additional complications were identified. Licensed nursing staff were re-educated on the requirement to follow through on delegated instructions, including timely rechecks of blood glucose levels, documentation of results, and notification of abnormal findings consistent with facility parameters. Reinforcement was provided regarding escalation and documentation requirements when abnormal vital signs meet established notification thresholds.

Resident #10's medical record was reviewed to evaluate for adverse outcomes related to medication transcription errors and failure to implement provider orders as written. Hospice and the attending provider were previously notified at the time of the occurrences. A full review of current medication orders and MAR entries was completed to verify accuracy of transcription, scheduling, and dosing. Staff responsible for transcription and medication administration were counseled and re-educated regarding the requirement that nursing services include accurate transcription of provider orders, timely implementation of medication changes, and verification that MAR entries reflect scheduled versus PRN status as ordered.

To determine whether other residents had the potential to be affected by similar issues, a retrospective audit of all active residents' medication orders and MARs for the previous 60 days was conducted to verify accurate transcription and implementation of provider orders. In

addition, a 30-day review of blood glucose monitoring records and abnormal vital sign documentation was completed to confirm timely rechecks and nurse notification consistent with policy. No additional systemic trends were identified. System-wide corrective action included mandatory re-education of all licensed nurses and medication aides on provider order transcription, high-risk medication changes, abnormal vital sign notification parameters, and required documentation in the medical record. A standardized provider order verification checklist was implemented requiring nurse review of all new and modified orders within 24 hours. The facility also implemented a structured abnormal vital audit tool to document nurse notification, instructions received, and follow-up actions taken.

To support continued compliance, the Director of Nursing or designee will conduct weekly audits for four consecutive weeks of new provider orders to verify accurate transcription and implementation. Weekly audits of abnormal blood glucose readings and vital sign documentation will also be conducted for four weeks to confirm timely rechecks and nurse notification. Following the initial monitoring period, monthly audits will continue for three months. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement process to evaluate sustained compliance with nursing service requirements. Any identified deviations will result in immediate retraining and corrective action as appropriate. The Director of Nursing is responsible for oversight and monitoring of this corrective action plan.

The deficiency was corrected on January 28th, 2026.

Tag: B1800

Regulation: 33-03-24.1-18 – Dietary Services

January 13, 2026, all three kitchenette areas (Unit One, Unit Two/Three, and Unit Four) were thoroughly cleaned and sanitized, including refrigerators, freezers, ovens, microwaves, sinks, countertops, shelving, appliances, ice machines, floors, and all food contact surfaces. Food debris, dried liquid spillage, and grease residue were removed, and sanitation procedures were completed in accordance with facility policy and North Dakota sanitary requirements for food establishments. The certified nurse aide observed failing to perform proper hand hygiene and glove changes during meal service was immediately re-educated on handwashing and glove usage requirements, including the requirement to wash hands before and after glove use and to change gloves after contact with non-food surfaces or soiled items. All dietary and caregiving staff were re-educated on the facility's "Handwashing, Glove Usage, and Hair Restraints" policy and "Kitchen and Dining Room Cleaning and Sanitizing" policy. To determine whether additional residents had the potential to be affected by unsanitary conditions, all kitchenette and food service areas were inspected, and no further deficiencies were identified following corrective cleaning and sanitation.

System-wide corrective action included reinforcement of daily and end-of-shift cleaning task accountability for each kitchenette, implementation of a documented kitchenette cleaning checklist requiring staff initials upon completion, and retraining of all dietary and caregiving staff on infection prevention practices related to food handling, glove usage, and cross-

contamination prevention. Supervisory staff were instructed to complete routine environmental rounds of kitchenette areas to verify compliance with sanitation standards. Hand hygiene and glove use expectations during meal service were reinforced during shift meetings and incorporated into ongoing staff competency review.

To support continued compliance, the Executive Director or designee will conduct daily kitchenette sanitation checks for two weeks to verify that cleaning and sanitizing tasks are completed and documented. Following this period, weekly sanitation audits will be conducted for three months. In addition, random meal service observations will be conducted weekly for four weeks to verify proper hand hygiene and glove use. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement process to monitor sustained compliance with dietary and sanitation requirements. Any identified deviations will result in immediate retraining and corrective action as appropriate. The Executive Director is responsible for oversight and monitoring of this corrective action plan.

The deficiency was corrected on January 27th, 2026.

Tag: B2000

Regulation: 33-03-24.1-20 – Housekeeping and Laundry Services

On January 13, 2026, Room #9 was thoroughly cleaned, including deep cleaning of carpeted areas inside and outside the doorway to remove staining and odor. Odor-neutralizing treatment was applied, and housekeeping staff verified that the room was free of detectable urine odor. Hallways in Unit 1 and Unit 2 were cleaned, and floors were treated to address odor concerns in shared resident spaces. The housekeeping supervisor reviewed the cleaning schedule and confirmed daily cleaning expectations with housekeeping staff. Staff were re-educated on the requirement to maintain resident rooms and common areas in a clean, sanitary, and odor-free condition consistent with facility policy and resident rights to a safe and comfortable environment. To determine whether other residents had the potential to be affected by similar environmental concerns, a full facility environmental round was conducted, and no additional rooms or common areas were identified with strong odor or unaddressed sanitation concerns.

System-wide corrective action included reinforcement of daily housekeeping assignment sheets for resident rooms and common areas, implementation of a documented daily odor and cleanliness check by housekeeping staff, and supervisory environmental rounds to verify compliance. Housekeeping staff were re-educated on identifying and promptly reporting odor concerns related to incontinence, spills, or carpet staining so that timely intervention can occur. The facility also implemented a weekly environmental services checklist requiring verification that hallways and shared resident spaces remain clean and free of persistent odors.

To support continued compliance, the Executive Director or designee will conduct environmental rounds three times per week for four weeks to verify that resident rooms and common areas are clean, orderly, and odor-free. Following this period, weekly environmental rounds will be conducted for three months. Findings will be reviewed through

the facility's Quality Assurance and Performance Improvement process to monitor sustained compliance with housekeeping and laundry service requirements. Any identified deficiencies will result in immediate corrective cleaning and staff retraining as appropriate. The Executive Director is responsible for oversight and monitoring of this corrective action plan.

The deficiency was corrected on January 28th, 2026.

Tag: B2302

Regulation: 33-03-24.1-23(2) – End-of-Life Services

Resident #10's medical record was reviewed in full to evaluate the timeline of hospice admission orders, PRN lorazepam orders, and medication delivery. Hospice and the attending provider had been notified at the time of the resident's increased behaviors. The facility reviewed the communication process between hospice, pharmacy, and nursing staff to identify the breakdown that resulted in the unavailability of PRN lorazepam for 3.5 days. Licensed nursing staff were re-educated regarding their responsibility to provide oversight of new and changed provider orders for residents receiving end-of-life services, including verification of medication delivery and availability when orders are initiated outside of routine cycle fills. The Director of Nursing completed a review of all residents currently receiving hospice or end-of-life services to verify that all active medication orders were accurately transcribed, available in the facility, and implemented as written.
No additional discrepancies were identified.

System-wide corrective action included reinforcement of the facility's process for implementing new and changed provider orders related to hospice and acute changes in condition. The Community's Med Cart Audit Tool was re-implemented requiring licensed nurse confirmation of pharmacy transmission, confirmation of delivery, and documentation of medication availability in the resident record. Nursing staff were re-educated on the requirement that end-of-life residents must have timely nursing oversight to identify and respond to changing needs, coordinate with hospice providers, and verify implementation of new medication orders. The facility clarified expectations that orders related to hospice admission, symptom management, or behavioral escalation are not to be delayed to routine cycle fill processes when immediate implementation is indicated.

To support continued compliance, the Director of Nursing or designee will conduct weekly audits for four consecutive weeks of all new and changed medication orders for residents receiving end-of-life or hospice services to verify timely transcription, pharmacy communication, and medication availability. Following the initial four-week period, monthly audits will continue for three months. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement process to monitor sustained compliance with nursing oversight requirements for end-of-life care. Any identified discrepancies will result in immediate retraining and corrective action as appropriate. The Director of Nursing is responsible for oversight and monitoring of this corrective action plan.

The deficiency was corrected on January 27th, 2026.

ALLI PADELFORD, RN, SR. DIRECTOR, REGULATORY COMPLIANCE & INFORMATICS
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