STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NEW PERSPECTIVE - WEST FARGO	645 33RD AVENUE EAST WEST FARGO, ND 58078

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B 000	INITIAL COMMENTS For the unannounced complaint survey started on 10/07/25 and completed on 10/13/25, the sample included seven residents for complete review and six closed records for review. In addition, the sample included two supplemental residents to verify specific concerns during the survey. Tier II citations included B910, B920, B921, B922, B924, B950, B1220, B1240, B1320, B1410, B1510, B1540, B1700, B1800, B1820, B1830, B1910, B1920, B1930, B2000, B2302, B2305, B2404, B2405, and B2408.	B 000	See Attached.	
B 910	33-03-24.1-09,1 GOVERNING BODY 1. The governing body is legally responsible for the quality of resident services; for resident health, safety, and security; and to ensure the overall operation of the facility is in compliance with all applicable federal, state, and local laws. This State Licensing Rule is not met as evidenced by: Based on record review, review of a facility reported incident (FRI), and review of facility policy, the facility failed to ensure the safety and well-being for 1 of 2 closed records (Resident #13) reviewed for elopement. Failure to develop an effective behavior management plan and monitoring system for wandering/exit seeking residents does not allow the residents to maintain their highest level of functioning or support their overall quality of life, and resulted in a risk to Resident #13's safety due to continued exit-seeking and successful elopements from the	B 910		

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

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B 910	Continued From page 1	B 910		

secured memory care unit and the facility.

Findings include:

Review of a FRI, dated 10/28/24, identified Resident #13 eloped from the facility and later found by an employee at a local store located approximately three miles away.

Review of the facility policy titled "Assessment and Evaluations" occurred on 10/09/25. This policy, dated 12/04/24, stated, ". . . The Community will conduct assessments, observation, and reassessments . . . to determine individuals suitability for residence in the Community . . . in an effort to support their health, safety, and overall quality of life. . . ."

Review of the facility policy titled "Missing Residents and Elopement" occured on 10/09/25. This policy, dated 03/03/25, stated, ". . . Definitions. Elopement: When a secured dementia unit resident leaves the secured dementia unit, including any attached outdoor space, without . . . staff supervision . . . Wandering: Random or repetitive locomotion by a resident. This movement may be goal-directed such as the resident appears to be searching for something such as an exit . . . The Community will implement measures to reduce the risk of missing resident and resident elopement incidents . . ."

- Review of Resident #13's medical record occurred on 10/08/25 and identified diagnoses of dementia, Alzheimer's disease, aggression, agitation, and anxiety. An elopement assessment, dated 10/02/23, identified the resident intrusively wandered, exhibited exit seeking behaviors, and independent with ambulation without assistive

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B 910	Continued From page 2	B 910		

devices.

Review of Resident #13's progress notes from 01/01/24 through 01/28/25 identified the following:
* 03/04/24 at 11:19 a.m., "Writer showed up to work at 7:30am this morning and found resident wandering in AL main entrance attempting to get out sliding doors . . . but the doors were locked. Resident then tried to use the side door to go out main entrance but the door was too heavy for the resident to push. Writer unlocked side door . . . and entered . . . Resident was agitated and wandering all over near entrance of AL, resident then walked and went to doors near pool entrance. . . . the door was locked . . . able to redirect resident into memory care after multiple attempts . . ."
* 05/07/24 at 10:54 a.m., "Around 10:30 am resident walked out of main entrance door to BH into AL side . . . A family was moving into BH . . . resident saw door open, and decided to walk out behind the moving company. Writer then followed resident into AL and resident walked around through AL dining room . . . Resident walked back in BH with writer . . ."
* 10/28/24 at 8:40 p.m., "Triage note 19:15 [7:15 p.m.]: Team believes resident has eloped from community as resident cannot be found and a door was found unsecured. Team to do a room by room search in the community and begin searching the local area by car. . . ."
* 10/29/24 at 10:57 p.m., "On 10/28/24 at approximately 7:00 pm, staff were unable to locate Resident within the memory care neighborhood. Community immediately notified local law enforcement of the missing resident et conducted a search of the community outside of the memory care neighborhood et the community's premises outdoors. The resident's daughter, legal representative was updated et

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drove to the community to assist with the search. At approximately 7:50 pm, an employee of JC Penney notified the resident's legal representative that resident was at their store. Resident's daughter picked up resident et returned her to the Community. . . . Resident assessed, was found to be at baseline without injury or apparent distress et dressed appropriately for the weather. . . ."
* 11/11/24 at 11:24 p.m., "At 1258 [12:58 p.m.] the MP [medication passer] reports the resident had an unaccompanied exit from MC. The team responded to a MC egress door alarming et immediately completed a head count. . . . The resident quickly found on second floor . . ."
* 11/28/24 4:28 p.m., ". . . Med [medication] Passer called stating the resident continues to exit seeking [sic] . . . The resident set off the egress door alarms in attempts to go home et/or find her daughter . . ."
* 12/7/24 at 8:07 p.m., "Triage calls 14:27 [2:27 p.m.]: resident eloped from the neighborhood about 5 feet outside the door before team members caught her . . . 15:28 [3:28 p.m.]: Resident again eloped through the neighborhood door, but was caught and escorted back before she made it more than a couple steps out of the door. . . ."
* 01/05/25 at 1:37 p.m., "01/05/25, 1147 [11:47 a.m.] TRIAGE CALL: Med passer called to report that resident exited memory care unit door but did not exit door to outside. Resident was found in area between two sets of doors. . . ."
* 01/26/25 at 2:59 p.m., "01/26/25, 1146 [11:46 a.m.] TRIAGE CALL: Resident had a witnessed fall in community living room. . . . when med passer attempted to assist her she became upset and swung at caregiver, causing her to lose her balance and fall . . . Resident hit her head on end table . . . c/o [complaints of] right leg pain and is not able to move leg. . . . transported to [hospitals

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B 910	Continued From page 4 name] ER [emergency room] via ambulance. . . ." * 01/28 25 at 2:42 p.m., "Spoke with daughter at this time. Daughter states that resident will be going to a nursing home from the hospital. . . ." The facility failed to manage Resident #13's wandering/exit seeking behaviors and ensure the resident's right to live in a safe and secure environment. Refer to B920 and B1240	B 910		
B 920	33-03-24.1-09,2 GOVERNING BODY 2. The governing body is responsible for approval and implementation of effective resident care and administrative policies and procedures for the operation of the facility. These policies and procedures must be in writing, signed, dated, reviewed annually, and revised as necessary, and shall address: This State Licensing Rule is not met as evidenced by: Based on record review, review of a facility reported incident (FRI), and review of facility policy, the facility failed to implement effective care policies/interventions to promote health and safety for 1 of 2 closed records (Resident #13) who eloped from the facility. Failure to effectively manage wandering, exit seeking, and elopement behaviors resulted in Resident #13 eloping the memory care unit on 11 occasions and may have resulted in serious injury/harm. Findings include: Review of a FRI, dated 10/28/24, identified	B 920		

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B 920	Continued From page 5 Resident #13 eloped from the facility and later found by an employee at a local store located approximately three miles away. Review of the facility policy titled "Assessment and Evaluations" occurred on 10/09/25. This policy, dated 12/04/24, stated, ". . . The Community will conduct assessments, observation, and reassessments . . . to determine individuals suitability for residence in the Community . . . in an effort to support their health, safety, and overall quality of life. . . ." Review of the facility policy titled "Missing Residents and Elopement" occurred on 10/09/25. This policy, dated 03/03/25, stated, ". . . Definitions. Elopement: When a secured dementia unit resident leaves the secured dementia unit, including any attached outdoor space, without . . . staff supervision . . . Wandering: Random or repetitive locomotion by a resident. This movement may be goal-directed such as the resident appears to be searching for something such as an exit . . . The Community will implement measures to reduce the risk of missing resident and resident elopement incidents . . . Where possible, have the residents reside in an apartment . . . and away from exits . . . When appropriate, lead the transition of residents to a more secure environment . . . via external transfers from the Community to a skilled nursing facility . . . assess the resident for . . . at risk for wandering or elopement . . . If assessment indicated that the resident is incapable of taking appropriate action for self-preservation . . . or at risk for wandering or elopement, add interventions to the resident's care/service plan . . ." - Review of Resident #13's medical record	B 920		

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B 920	Continued From page 6	B 920		

occurred on 10/08/25 and identified diagnoses of dementia, Alzheimer's disease, aggression, agitation, and anxiety. The record identified the resident resided in a room near an exit door on Unit Four of the memory care unit.

An Elopement Risk Assessment, dated 10/02/23, identified the resident had a history of elopement, wandered intrusively, exit seeks, appears agitated, combative, and depressed, and ambulated without assistive devices. The assessment stated a score of ". . . 3 or more . . . indicates someone who may be at moderate to high risk for elopement. . . ." The resident scored a 10 on the elopement assessment.

Review of Resident #13's Service Agreement, dated 01/01/25, stated, ". . . 07/30/24 Service Type: Cues . . . Exit seeking: 1.) Watch for indicators of elopement potential (e.g., verbal indicators, loitering near exits, multiple layers of clothing, packing belongings, disorientation, separation anxiety, homesickness). 2.) Familiarize resident with environment and routine. 3.) Engage the resident in activities. 4.) Offer toileting. 5.) Offer snack. 6.) Offer therapeutic fib to re-direct away from exit door. 7.) Stay with the resident if unable to re-direct and notify management. . . ."

Review of Resident #13's progress notes from 01/01/24 through 01/28/25 identified the resident eloped the memory care unit and/or the facility on 11 occasions. Progress notes also showed the following:
* 11/03/24 at 9:22 p.m., ". . . Family requested care conference post resident elopement [on 10/28/24] to discuss safety interventions to mitigate risk of elopement. . . . Family requested a 'guarantee' the resident would not elope and

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B 920	Continued From page 7 requested resident be assigned the same caregivers daily. Writer explained staff structure by acuity and noted staff schedule not modified due to need to cover per community acuity. . . ." * 11/12/24 at 11:37 p.m., "[Provider's name] here to see resident . . . POA [Power of Attorney] here for visit . . . The PCP [primary care provider] discussed resident safety, need for higher level of care et geri psych [geriatric psychiatry - specializes in older adult mental health] stay. . . ." * 01/28 25 at 2:42 p.m., "Spoke with daughter at this time. Daughter states that resident will be going to a nursing home from the hospital [hospitalized due to a fall at the facility]. . . ." The facility failed to implement effective elopement policies and/or service agreement/plan interventions, move the resident to a room away from exit doors, and consider/pursue a higher level of care earlier which resulted in multiple elopements from the memory care unit and may have resulted in serious injury/harm to Resident #13. Refer to B910 and B1240	B 920		
B 921	33-03-24.1-09,1,a GOVERNING BODY a. All services provided by the facility to meet the needs of the residents, including admission, transfer, discharge, discharge planning, and referral services. This State Licensing Rule is not met as evidenced by:	B 921		

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B 921	Continued From page 8	B 921		

Based on observation, record review, policy review, and staff interview, the facility failed to refer and obtain services for 1 of 1 sampled resident (Resident #4) with an order for a daily wound dressing. Failure to provide referral services for treatment as ordered does not ensure resident care needs are met and resulted in a worsening condition of Resident 4's leg ulcer.

Findings include:

Review of the facility policy titled "Skin and Nail Management" occurred on 10/09/25. This policy, revised 05/01/25, stated, ". . .The nurse in charge is responsible for ensuring that appropriate interventions for wound management are documented in the resident's service plan and where applicable progress notes. Interventions will include an at least weekly wound evaluation and documentation by a licensed nurse until the wound is resolved. . . . The nurse will contact the resident's physician for treatment orders, an order for home healthcare wound consult, or an appointment for further evaluation."

Observation on 10/08/25 at 10:22 a.m. showed an unbandaged quarter-sized recessed wound on Resident #4's right lower leg. The dry dark red wound bed contained minimal moisture around the perimeter and reddened skin surrounding wound.

Review of Resident 4's medical record occurred on all days of survey. A progress note, dated 09/16/25 at 11:25 a.m., stated, ". . . late entry for 09/15/25 8:00 AM: CG [caregiver] noted change in wound. . . gotten worse. . . .Was noted it was scabbed over yesterday. Today . . . med [medication] passer noticed the [wound] is now a hole. RN [registered nurse] assessed . . . wound.

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. . notified [hospice agency] nurse so that assessment can be completed and orders given on dressing. . ."

A physician's order for Resident #4, dated 09/16/25, stated, "Wound to left [right] leg-apply saline wash to clean, then calcium alginate dressing, then cover with mepilex [type of foam dressing] and change daily. Update in 2 weeks."

Hospice visit reports for Resident #4 stated the following:
* 09/19/25 ". . . Wound supplies delivered to facility. . . . Nursing will continue to visit biweekly . . ."
* 10/07/25 ". . . was informed that they [basic care] wanted hospice to perform wound cares daily for patient as their med aide is not supposed to be doing this. Nursing team made aware and changes will be made to wound care order at next visit."

During an interview on 10/08/25 at 12:17 p.m., a staff manager (#1) stated, "Hospice was here on Monday or Tuesday [October 6 or 7, 2025] and tried to give me wound care supplies. I told them I thought hospice did the wound cares and did not take the supplies."

During an interview on 10/08/25 at 2:25 p.m., an administrative nurse (#16) stated, "We do not do wound care here. Either home health or hospice does. Wound treatments are not usually put on the MAR [medication administration record] or TAR [treatment administration record]. We don't do measurements or treatments. We will make a note on [wound] progress like if it's getting better or worse."

During an interview on 10/09/25 at 10:40 a.m., a

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B 921	Continued From page 10 regional administrator (#8) stated, "We do not have a wound care policy. We do not do wounds [wound care] here unless it's a simple bandage." She stated the nurse will get the wound order from the doctor, will ask the resident or family who they would like to do the wound cares and will arrange for an outside wound care agency. The medical record lacked documentation the facility implemented the physician's order from 09/16/25 for daily wound care or placed a referral to an outside agency to perform daily wound care until 10/07/25, 21 days later.	B 921		
B 922	33-03-24.1-09,2,b GOVERNING BODY b. Protocols developed by appropriately licensed professionals for use in the event of serious health threatening conditions, emergencies, or temporary illnesses. These protocols must include provisions for: (1) Designation of a licensed health care practitioner for each resident and arrangements to secure the services of another licensed health care practitioner if the resident's designated licensed health care practitioner is not available. (2) Notification of an appropriately licensed professional in the event of an illness or injury of a resident. This State Licensing Rule is not met as evidenced by: Based on record review, review of the facility	B 922		

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Medication Passer Guide, and staff interview, the facility failed to implement policies regarding notification of an appropriately licensed professional for 2 of 2 sampled residents (Resident #3 and #6) and one closed record (Resident #12) with health indicators outside set parameters. Failure to notify the nurse or health care provider of blood pressure and blood glucose results as ordered or according to facility policy may result in further health complications.

Findings include:

Review of the facility's "Med [medication] Passers Guide" occurred on all days of survey. This document, dated 04/04/24, page 33, stated, ". . . Report vital signs outside normal range to the nurse unless the resident has a different, provider-established range in the electronic medication administration record (eMAR). . . . Notify the nurse if a resident is . . . indicated by blood glucose readings either outside the range provided in the resident's eMAR or, if a range is not provided, less than 70 or greater than 450. . . ."

- Review of Resident #3's medical record occurred on all days of survey. The service plan for the service "Monthly Vital Signs," dated 12/15/23, stated, ". . . notify nurse for Systolic Blood Pressure [first number of a blood pressure reading] lower than 100 . . . ."

The vital sign record, dated 10/01/25 at 9:27 a.m., showed a blood pressure reading of 90/51. The record lacked evidence staff notified the nurse of the low reading.

During an interview on 10/08/25 at 5:30 p.m., an administrative nurse (#16) stated "it looks like"

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B 922	Continued From page 12 the staff who checked Resident #3's blood pressure failed to notify the nurse and agreed they should have notified the nurse. - Review of Resident #6's medical record occurred on all days of survey. Review of the resident's blood glucose readings from 10/01/25 through 10/06/25 showed a documented glucose reading of 65 on 10/05/25 at 8:19 a.m. The record lacked evidence staff notified the nurse of the low reading. - Review of Resident #12's medical record occurred on October 8-9, 2025. Review of the May 2025 MAR identified a blood glucose reading of 58 on 05/07/25. The medical record lacked evidence staff notified the nurse of the low reading. During an interview on 10/08/25 at 4:52 p.m., an administrative staff nurse (#16) confirmed staff should follow facility policy for low blood glucose readings if there are no specific ordered parameters.	B 922		
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:	B 924		

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Based on observation, review of the facility Medication Passer Guide, and facility policy review, the facility failed to follow standards of infection control for 2 of 7 sampled residents (Resident #1 and #6) and one supplemental (Resident #14) observed during cares, blood glucose testing, and insulin pen preparation. 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 Medication Passer Guide, dated 04/04/24, page 19, stated, "Insulin Pen . . . sanitize rubber seal located at the top of the pen with an alcohol wipe . . . Remove safety pen needle from packaging and apply to the top of the pen . . ."

Review of the facility policy titled "Use of Gloves" occurred on 10/08/25. This policy, dated 10/14/24, stated, ". . . Team members will follow proper glove changing protocols to include: Changing gloves if a glove becomes . . . soiled when additional tasks must be performed for the resident; Performing hand hygiene between glove changes; and Never . . . reusing gloves after caring for a resident. . . ."

- Observation on 10/07/25 at 8:20 a.m. showed a medication passer (#6) performed hand hygiene, reached into her pocket for gloves, applied the gloves, and performed Resident #1's blood glucose check. The medication passer removed her gloves, performed hand hygiene, and without sanitizing the glucometer, placed the glucometer into an unlabeled zippered pouch, and placed the pouch into a medication cart drawer. When asked if the glucometer was a shared glucometer, the

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B 924	Continued From page 14	B 924		

medication passer stated, "No. This is his." When asked how she could ensure the glucometer is Resident #1's as neither the glucometer nor the pouch had resident identification, the passer stated, "I just know because it sits on top of his [Resident #1's] insulin pens [located inside an emesis basin inside the medication cart]. Observation also showed the medication passer (#6) failed to sanitize the rubber seal on Resident #1's insulin pen before applying the needle.

- Observation on 10/07/25 at 8:30 a.m. showed a medication passer (#6) performed hand hygiene, reached into her pocket for gloves, applied the gloves, and performed Resident #6's blood glucose check. The medication passer removed her gloves, performed hand hygiene, and without sanitizing the glucometer, placed the glucometer into a zippered pouch labeled with the resident's room number, and placed the pouch into a medication cart drawer. Observation also showed the medication passer (#6) failed to sanitize the rubber seal on Resident #6's insulin pen before applying the needle.

- Observation on 10/07/25 at 8:40 a.m. showed a certified nurse aide (CNA) (#2) removed gloves from her pocket, applied the gloves, and assisted Resident (#14) to the toilet to remove her incontinence brief and soiled pants. The CNA exited the bathroom to provide privacy, and without removing her gloves, the CNA made the resident's bed. The CNA removed the soiled gloves and placed them in her pants pocket. Without performing hand hygiene or applying gloves, the CNA (#2) assisted the resident in applying a clean brief and pants, tied the garbage bag containing the soiled brief, exited the resident's room, carried the garbage bag down the hallway, and placed the bag into a trash bin.

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B 924	Continued From page 15 Without performing hand hygiene, the CNA then walked to the dining room, removed a new pair of gloves from her pocket, and began to clear tables.	B 924		
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. This State Licensing Rule is not met as evidenced by: Based on information received from the complainants, observation, review of the North Dakota Nurse Aide Registry (ND NAR), facility policy review, facility Team Member Handbook review, facility job description review, record review, and resident, family and staff interview, the facility failed to ensure competent staff were available and prepared to assist residents on 3 of 3 days of survey (October 7-9, 2025). Failure to ensure available competent prepared staff resulted in unmet resident needs. Findings include: Information received from the complainants identified a lack of available staff, staff sit around or walk away when asked questions, staff ignore visitors who wish to enter/exit the unit, visitors unable to find a caregiver anytime of the day, and	B 950		

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residents were not provided assistance with activities of daily living. One complainant stated caregivers leave the memory care unit or hide in different rooms within the unit leaving the residents unattended for long periods of time. Another complainant alleged unlicensed facility staff passed medications.

Review of the facility's caregiver job description, dated 05/16/23, stated, ". . . the caregiver role provides residents with timely and quality care services, to include, but not limited to assistance with activities of daily living . . . such as grooming, assistance with eating, and other care giving services to residents. . . . Champions the delivery of care to each resident assigned in accordance with each resident's daily assignment sheet and personalized service plan. . . ."

Review of pages 23 and 24 of the "Team Member Handbook," occurred on 10/08/25. This hanbook, dated December 2017. Page 23 stated, ". . . Keys, Telephones, and Portable Devices . . . Communication devices are to remain at the Community at all times and passed on to the oncoming shift. . . ." and page 24 stated, ". . . Care of Equipment. Team members are expected to demonstrate proper care when using the Company's property and equipment. . . ."

- During an interview on 10/07/24 at 9:02 a.m., a family member (A) stated, "There are times I cannot locate any staff."

- During an interview on 10/07/25 at 9:37 a.m., Resident (#2) pointed to a summoning device pull cord on her wall stating that she waits a while for staff when she pulls the cord.

- Observations during survey showed the

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B 950	Continued From page 17	B 950		

following:
* On all days of survey, the memory care unit staff congregated in the common areas of Units Two and Three for most of their day/evening shifts, leaving residents on Units One and Four unattended unless staff passed medications, attended to call lights, or provided routine care. After staff completed the tasks, they returned to the common area of Units Two and Three.
* On 10/08/25 at approximately 11:00 a.m., an unidentified resident wandered the halls in Unit Four. The resident tugged on all the locked medication cart drawers, and when not able to open the drawers, entered a nearby resident's room, stood inside the room for a while, turned around, exited the room, and walked down the hall towards Unit Two.
* On 10/08/25 at 5:00 p.m., Resident #2 verbalized she needed help while seated on the toilet. The surveyor activated the wall unit summoning device and waited approximately 10 minutes with the resident and no staff arrived. The surveyor exited the resident's room and approached a certified nurse aide (CNA) (#5) in the basic care Unit Two/Three kitchenette and asked if there were any active call lights. The CNA (#5) denied having a phone which would alert staff of active call lights. Three of five CNAs approached by the surveyor did not have a phone on them. The two CNAs who had phones on them were not aware the call lights were active until the surveyor questioned them. The two observed phones showed a banner on the screen indicating active call lights.
* On 10/08/25 at 6:15 p.m., a family member (A), visibly upset, walked arm-in-arm with an unidentified resident down the Unit One hall, and stated to the resident, "This is not your bathroom. Hope we can find someone [staff] today." There were no staff present in the hallways of Units One

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or Four. Upon the family members' return, the surveyor asked how frequently the resident enters the spouse's room, the family member, still visibly upset, stated, "all the time!"
* On 10/08/25 at 6:35 p.m., one caregiver and four residents sat in the Unit Two lounge area watching television. When asked where the other staff members were, the caregiver pointed to a caregiver exiting a resident's room and stated, "she must be done giving the resident a shower" and further stated two additional caregivers were in resident rooms giving showers.

During an interview on 10/08/25 at 5:32 p.m. an administrative staff member (#1) stated that unless staff members are training, they are required to carry phones, the phones audibly alarm and do not vibrate, and a banner will appear on the phone's home screen with the call light information. The staff member (#1) stated today's average call light response time was 16 minutes. The manager checked the staff phone sign out sheet and confirmed caregiver (#5) had not signed out a phone.

Review of an email from an administrative staff member (#7), received on 10/09/25 at 10:30 a.m., stated, "Notify is our call system- [phone alert] Does continue to ping until someone picks it up. It [phone alert] rings every 2 minutes - if it [call light] if not picked up after 30 minutes it rings our CTM [Caregiver Team Manager] after 60 minutes the ED [Executive Director]."

During an interview on 10/09/25 at 10:49 a.m., a regional administrator (#8) stated, "The call system beeps initially and every two minutes until answered. It [the call system] will notify the manager after 30 minutes if the call is not answered. However, staff can shut off the ringer

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B 950	Continued From page 19 on the phone." -Review of the facility policy titled "Medication Assistant I (MAI) Training Program" occurred on 10/09/25. This policy, dated 12/05/22, stated, ". . . The community HWD [health and wellness director] or licensed nurse designee will submit to the North Dakota Department of Health a list of team members who are eligible to be registered as MAI med [medication] passers within two (2) weeks after completing the training and competency evaluation . . ." Review of staffing schedules from September 15-October 9, 2025 showed the following: *Employee #4 scheduled as a medication passer on 09/30, 10/02, 10/05, and 10/09. *Employee #13 scheduled as a medication passer on 10/03, 10/06, and 10/09. Review of the October 2025 medication administration records (MARs) identified Employee #4 and #13 passed medications on 10/05/25 and 10/06/25. Review of the ND NAR on 10/09/25 showed these four employees did not have active status as medication assistants (MAs). Refer to B1540	B 950		
B1220	33-03-24.1-12,2 RESIDENT ASSESSMENTS/CARE PLANS 2. The assessment must be completed in writing by an appropriately licensed professional. The assessment must include: a. A review of health, psychosocial,	B1220		

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B1220	Continued From page 20 functional, nutritional, and activity status. b. Personal care and other needs. c. Health needs. d. The capability of self-preservation. e. Specific social and activity interests. This State Licensing Rule is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to conduct an assessment for 1 of 2 sampled residents (Resident #3) following a fracture. Failure to assess a resident's health status on an ongoing basis following a fracture may contribute to a deterioration of the resident's functional status, unnecessary pain, and a delay in treatment. Findings include: Review of the facility policy titled "Assessments and Evaluations" occurred on 10/09/25. This policy, dated 12/04/24, stated, ". . . Assessments will be thorough and timely to support the identification of resident care needs and the maintenance of an individualized service plan. . . . Additional assessments, reassessments, and evaluations will be: 1. Conducted by a licensed nurse . . . After changes in condition of a resident, including a fall . . . 2. Documented in the resident health record . . . 3. Accompanied by progress notes. . . ." Review of Resident #3's medical record occurred	B1220		

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B1220	Continued From page 21 on all days of survey. The resident's current care plan for pain control, dated 04/27/25, stated, "Leave brace to right hand in place except when performing cares. Resident has a right wrist fracture. . . ." A nurse's note, dated 04/30/2025 at 12:57 a.m., stated, "4/27/25 At approx. [approximately] 1230 [12:30 p.m.] Resident was seen at the [clinic name] et [and] it was confirmed resident has a displaced wrist fx [fracture]. . . . Resident was sent back in a brace velcro et will f/u [follow-up] with Ortho [orthopedic physician] for surgical consult. New orders provided for ice packs, scheduled Tylenol and as needed Tylenol." Observation throughout the survey showed Resident #3 without a brace on her right wrist. During an interview on 10/08/25 at 5:30 p.m., an administrative nurse (#16) agreed Resident #3's record lacked a reassessment of the resident's right wrist. The facility nurse failed to complete a reassessment and evaluation of Resident #3's right wrist function, adjustment to and use of the brace, skin condition, effectiveness of treatments, or pain level in the days after the fracture. The nurse failed to confer with the health care practitioner or assess the resident's wrist prior to discontinuing the use of the wrist brace.	B1220		
B1240	33-03-24.1-12,4 RESIDENT ASSESSMENTS/CARE PLANS 4. The care plan must be updated as needed, but no less than quarterly.	B1240		

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B1240	Continued From page 22	B1240		

This State Licensing Rule is not met as evidenced by:
Based on record review, facility policy review, and staff interview, the facility failed to ensure the care plan (service plan) reflected each resident's current status for 7 of 7 sampled residents (Resident #1, #2, #3, #4, #5, #6, and #7) and 4 of 6 closed records (#9, #11, #12, and #13) reviewed. Failure to review and revise the care plan limited staff's ability to meet the residents' current care needs.

Findings include:

Review of the facility policy titled "Resident Service Plan" occurred on 10/09/25. This policy, dated 12/30/24, stated, "A service plan addressing the individualized needs of the resident will be developed during the initial assessment . . . 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; . . . c. Identify the activities and social connections the resident will be assisted in maintaining. 5. . . . It will be updated to reflect changes to the services provided to the resident due to change in the resident's condition, after receipt of new or revised orders . . ."

- Review of Resident #1, #2, #3, #4, #5, #6, #7, #9, #11, #12, and #13's medical records occurred on all days of survey. Resident #6's care plan failed to include an activity section. Resident #1, #2, #3, #4, #5, #7, #9, #11, #12, and #13's care plans related to activities identified the following: "Resident will be invited, encouraged, and assisted as needed to participate in activities that

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B1240	Continued From page 23 enrich their lives or are of interest." The activity care plans lacked the residents' individualized interventions specific to these residents' interests identified through the comprehensive assessment. - Review of Resident #3's medical record occurred on all days of survey. The resident's current care plan for pain control, dated 04/27/25, stated, "Leave brace to right hand in place except when performing cares. Resident has a right wrist fracture. . . ." Observations throughout the survey showed Resident #3 without a brace on her right wrist. During an interview on 10/08/25 at 5:30 p.m., an administrative nurse (#16) stated the nurse should have removed the brace from Resident #3's care plan. - Review of Resident #7's medical record occurred on October 8-9, 2025. The resident's current care plan for falls management, dated 07/01/25, stated, ". . . [Resident #7] is at risk for falls due to impaired cognition. . . . uses a 2WW [two-wheel walker] for ambulation . . ." Observation throughout the survey showed Resident #7 ambulated with a 4-wheel walker with a seat and padded back. Staff often reminded the resident to use the walker as she walked away from it. The facility failed to update Resident #7's care plan related to the 4-wheel walker. - Review of Resident #5's medical record occurred on all days of survey. The resident's	B1240		

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B1240	Continued From page 24 current service identified the following: * "Effective 05/14/24 Dining: Risk for choking . . . Notes: 3/7/25 . . . thin liquids. . . 09/29/25 . . . Thickened liquids." * "Assist to and from activities, meals, apartment and away from exit doors." * "Assist of 1 [one staff] Use a transfer belt when assisting resident to transfer." *"Black hand brace to be on at all times . . . left wrist. . . Assist resident with DME [durable medical equipment] . . ." Observation on all days of survey showed Resident #5 not wearing a black hand brace on left wrist and walked independently throughout the basic care facility. During an interview on 10/09/25 at 11:15 a.m., a certified nurse aide (CNA) (#6) stated, "He [Resident #5] doesn't need transfer or walking assistance. He pretty much does things himself. We [CNAs] can do standby assist if needed." The service plan lacked an update to current mobility and transfer assistance needs, and DME status. The information related to the diet on the service plan was not transferred to the Face Sheet when the order changed.	B1240		
B1320	33-03-24.1-13,2 RESIDENT RECORDS 2. Resident records must include: a. The resident's name, social security number, marital status, age, sex, previous address, religion, personal licensed health care practitioner, dentist, and designated representative or other responsible person.	B1320		

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B1320	Continued From page 25 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 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.	B1320		

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B1320	Continued From page 26 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 information from a complainant, record review, policy review, and staff interview, the facility failed to ensure a complete medical record for 3 of 7 sampled residents (Resident #1, #3, and #7) and 3 of 6 closed resident records (Resident #9, #10, and #12). Failure to include changes in orders, advance directives/code status forms, changes in a resident's condition including observations and vital signs, transfer forms, and a discharge note may affect care decisions and continuity of care. Findings include: Review of the facility policy titled "Health Record Standards" occurred on 10/09/25. This policy, dated 05/09/24, stated, "Policy: The Community [Basic Care Memory Care Unit] will maintain a resident health record that reflects the accurate and progressive condition of the resident, including care provided, interventions, and outcomes . . . Procedure: Contents: The resident health record . . . will include the following . . . 2. Face sheet to include: . . . g. Code Status . . . 9.	B1320		

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B1320	Continued From page 27 Progress Notes . . . f. All health record entries will: i. Be entered timely, objective in nature, include facts, direct observations and observations reported by the resident, legal representative, or others. . . . g. A nursing progress note, or nurse assessment will be included . . . ii. Any change of condition, including illness, injury, . . . requirement for activities of daily living (ADL) assistance, changes in medication or other physician orders, etc.; iii. Ongoing follow-up to any of the above conditions . . ." Review of the facility policy titled "Advanced Directives" occurred on 10/09/25. This policy, dated 03/23/25, stated, "The community will comply with . . . each resident's wishes regarding end-of-life decisions. . . . If the resident or resident's legal representative changes the resident's code status, they will notify the Community. . . . If the resident or their legal representative reports that the resident has an executed advance directive, the Community will 1. Request copies of the advance directives and any DNR [do not resuscitate] orders; and 2. Store copies of . . . DNR orders in the resident health record . . ." Review of the facility policy titled "Fall Mitigation and Management" occurred on 10/09/25. This policy, dated 11/05/24, stated, ". . . Post-Fall. If a resident has fallen . . . Obtain vital signs and notify Community licenses nurse immediately. . . . If the Community licensed nurse is not immediately available, notify the nurse on call [identified as Triage call in the resident's medical record]. . . . the nurse will instruct the team member . . ." The facility assessment titled "Post-Fall Vital	B1320		

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Signs and Observations (Head Impact)" stated, ". . . Vital signs and observations are to occur at the time of fall. If the resident does not have a fever, the nurse will direct team members to obtain vital signs and observations, with the exception of temperature, every two (2) hours thereafter - totaling 12 times - in an effort to identify increased intracranial pressure or other signs of internal head injury. . . ."

Review of the facility policy titled "Transfer and Termination" occurred on 10/09/25. This policy, dated 12/17/24, stated, ". . . Documentation: The Health and Wellness director (HWD) or licensed nurse designee will: 1. Prepare a discharge summary in the resident electronic health record (EHR) for residents who move out of the Community or pass away, which will include the process and related timeframe for removal of any personal property belonging to the resident . . ."

- Review of Resident #1's medical record occurred on all days of survey. A code status form, signed and dated 06/27/24, identified the resident a full code status (initiate cardiopulmonary resuscitation (CPR). A new code status form, signed and dated 07/18/25, indicated DNR. The resident's face sheet, service plan, medication administration record (MAR), and the spine on the paper chart all showed a full code.

Resident #1's record identified a history of falls. Progress notes showed the following:
* 07/30/25 at 10:11 p.m., "07/30/25, 1732 [5:31 p.m.] TRIAGE CALL: Resident had a fall witnessed by SafelyYou [a visual electronic fall monitoring system] in his room. . . . Caregivers were instructed to . . . continue VS [vital signs] every 2 hours for 24 hours and notify nursing with any changes or concerns. . . ."

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* 07/30/25 at 10:12 p.m., "07/30/25, 2042 [8:42 p.m.] TRIAGE CALL :Resident had a second fall witnessed by SafelyYou in his room. . . . Caregivers were instructed to . . . continue VS [vital signs] every 2 hours for 24 hours and notify nursing with any changes or concerns. . . ."
* 08/22/25 at 7:31 a.m., "TRIAGE NOTE 0635 [6:35 a.m.] Safely you reviewed. Resident was ambulating toward the bathroom and fell backwards. . . . Instructed staff to do VS Q [every] 2 hours for 24 hours. . . ."

Resident #1's medical record lacked evidence staff obtained vital signs every two hours after falls as instructed by the triage nurse and the facility staff failed to update the resident's code status to a DNR.

During an interview on 10/09/25 at 12:11 p.m., an administrative nurse (#17) confirmed staff failed to change Resident #1's code status to a DNR and staff failed to follow nursing instructions for every two hour vitals resident's falls.

- Review of Resident #3's medical record occurred on all days of survey. A nurse's note, dated 04/30/2025 at 12:57 a.m., stated, "4/27/25 At approx. [approximately] 1230 [12:30 p.m.] Resident was seen at the [clinic name] et [and] it was confirmed resident has a displaced wrist fx [fracture]. . . . Resident was sent back in a brace velcro et will f/u [follow-up] with Ortho [orthopedic physician] for surgical consult. New orders provided for ice packs, scheduled Tylenol and as needed Tylenol."

The medical record lacked evidence the facility nurse completed and documented observation or reassessment of Resident #3's wrist after the fracture, and the declination of the orthopedic

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consultation.

During an interview on 10/08/25 at 5:30 p.m., an administrative nurse (#16) stated Resident #3's family declined the follow-up appointment with the orthopedic surgeon and agreed the Basic Care staff should have documented the declination and follow-up assessment in the resident's record.

- Review of Resident #7's medical record occurred on October 8-9, 2025. The record identified a transfer to the emergency room (ER) on 10/03/25. The record lacked evidence facility staff completed a transfer form (hand-off information) for the emergency room staff.

- Review of Resident #10's medical record occurred on 10/09/25. A complainant requested the staff obtain a signed copy of the resident's "DNR" papers during an emergency response and resuscitation event on 08/23/25, and the facility was unable to provide the "DNR." A progress note, dated 08/23/25 at 4:45 p.m., stated, ". . . Team reported to HWD [Health and Wellness Director] [nurse] that resident had expired. . . ." Staff's inability to locate the resident's code status form stating his wishes resulted in unwarranted resuscitation efforts.

Resident #10's record contained a discharge summary, dated 08/26/25, with the reason for discharge "Expired," Service End Date of "8/26/2025 [even though death occurred 08/23/25]." The record failed to include disposition of the resident's personal effects, money, or valuables deposited with the facility.

- Review of Resident #9's medical record occurred on October 8-9, 2025. The record identified a transfer to the emergency room (ER)

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on 06/29/25. The record lacked evidence facility staff completed a transfer form. Resident #9 expired on 09/21/25. The record lacked documentation of death which included disposition of the resident's personal effects, money, or valuables deposited with the facility.

During an interview on the morning of 10/09/25, an administrative staff member (#8) confirmed staff failed to complete a transfer form for Resident #9's transfer to the ER.

- Review of Resident #12's medical record occurred on October 8-9, 2025. The record identified the following:
*02/08/25 7:01 a.m.: ". . . Resident had an unwitnessed fall in his apartment. . . . Resident was found lying on his left side in front of his closet with door open. Instructed staff to assist resident off floor per care plan and take VS [vital signs] q2hrs [every 2 hours] x 24 hours. . . ."
*03/04/25 10:26 a.m.: ". . . Resident had reported fall on 3/3/25. He stated he was going through the clothes in his closet and lost his balance and fell. He was found lying on his side when staff entered the room. . . . The resident's vitals were taken for the next 24 hours per head impact protocol and resident's were within normal limits. . . ."
*05/14/25 5:52 a.m.: ". . . Resident had a witnessed fall in his room. Resident observed standing and losing his balance falling on to his left side and rolling to face down position. . . . Continue VS Q 2 hours for 24 hours. . . ."

Resident #12's medical record lacked evidence staff obtained vital signs every two hours per protocol.

Review of Resident #12's May 2025 MAR identified a blood sugar reading of 58 on

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B1320	Continued From page 32 05/07/25. The medical record lacked evidence of nurses' notes or an assessment related to the low blood sugar. Resident #12 discharged from the facility on 05/15/25. A nurse's note, dated 09/22/25 at 11:42 a.m. stated, ". . . Resident discharged from community. No additional information provided at this time. Documentation completed per policy. . . ." The medical record lacked evidence of a discharge note completed at the time of discharge.	B1320		
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 information received from the complainants, observation, resident and family interview, and record review, the facility failed to provide assistance with activities of daily living (ADLs) for 3 of 5 sampled residents (Resident #2, #3, and #7) observed during cares. Failure to provide bathing, grooming, and toileting assistance may result in unnecessary odors, incontinence, or skin issues and negatively affect the resident's self-esteem. Findings include: Information received from the complainants identified concerns with staff failure to provide assistance with ADLs and a strong urine odor and stain on a resident's bed.	B1410		

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B1410	Continued From page 33 - During an observation on 10/08/25 at 5:00 p.m., Resident #2 requested help on the toilet. After waiting 10 minutes for staff to respond to Resident #2's call light, the surveyor asked a certified nurse aide (CNA) (#5) in the Unit Two/Three kitchenette if there were any active call lights. The CNA (#5) and two other CNAs failed to have a phone which would alert staff of active call lights. Two more CNAs with phones were not aware of active call lights until questioned. The two observed phones showed a banner on the screen indicating active call lights. Review of Resident #2's medical record occurred on all days of survey. The resident's current service plan identified the following: * Effective 05/22/24, "Bathing: Assist 2 X/week [two times per week] Every Mon [Monday] and Thu [Thursday]" * Effective 02/25/25, "Bladder Cont [Continence]: Asst [assist] 8+ x/24 hr [eight or more times in 24 hours]" Resident #2's "Service Delivery Record" for the month of August 2025 identified staff failed to provide bathing assistance on August 25 and August 28, resulting in the resident not receiving a bath for 10 days. Resident #2's "Service Delivery Record" for the months of August and September 2025 identified staff failed to toilet Resident #2 as scheduled five of 31 days in August and three of 30 days in September. During an interview on 10/07/25 at 9:37 a.m., Resident #2 stated she is supposed to take two whirlpool baths per week but will usually only get one. "I know they're short staffed, but that's not	B1410		

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my fault." The resident pointed to a summoning device pull cord on her wall stating that she waits a while for staff when she pulls the cord.

- Review of Resident #3's medical record occurred on all days of survey. The resident's current service plan identified the following:
* Effective 01/03/23, "Bathing: Assist 2X/week . . . Every Mon and Fri [Friday]"
* Effective 01/03/23, "Grooming: Oral Care Every day . . . AM [morning], PM [evening]" The Service Plan listed the same schedule for denture care and grooming assistance.
* Effective 07/16/25, "Bladder Cont: Asst 8+ x/24 hr"

Resident #3's "Service Delivery Record" for the month of August 2025 identified staff failed to provide bathing assistance on two of the nine scheduled days (August 15th and 25th)

Resident #3's "Service Delivery Records" for the months of August and September 2025 identified staff failed to provide grooming, oral, and denture care twice daily on three of 31 days in August and on one of 30 days in September.

Resident #3's "Service Delivery Records" for the months of August and September 2025 identified staff failed to toilet Resident #3 as scheduled on five of 31 days in August and three of 30 days in September.

- Review of Resident #7's medical record occurred on October 8-9, 2025. The resident's current service plan identified the following:
* Effective 07/01/25, "Grooming: Oral Care Every day . . . AM, PM" The Service Plan listed the same schedule for grooming set up.
* Effective 07/01/25, "Bladder Cont: Asst 4-7x/24

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B1410	Continued From page 35 hr [4-7 times in 24 hours]" Resident #7's "Service Delivery Records" for the months of August and September 2025 identified staff failed to provide grooming and oral care twice daily on two of 31 days in August and three of 30 days in September. Resident #7's "Service Delivery Records" for the months of August-October 2025 identified staff failed to toilet Resident #7 as scheduled on 30 of 31 days in August, 30 of 30 days in September, and five of seven days in October. - During an interview on 10/07/25 at 9:02 a.m., a family member A stated they perform most of their spouse's cares. "No one offers to help or see if I need anything."	B1410		
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 from a complainant, record review, review of facility policy, and staff interview, the facility failed to ensure medications were available for 1 of 7 sampled residents (Resident #6) and one closed record (Resident #9) who did not receive their ordered medications. Findings include:	B1510		

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B1510	Continued From page 36 Information received from the complainant identified a resident did not receive medications as ordered. Review of the facility policy titled "Medication Management - Non-Availability of Medication and Emergency Medications" occurred on 10/09/25. This policy, dated 11/18/24, stated, ". . . The Community will make reasonable efforts to ensure that medications are available as prescribed for each resident. The Community will have a process in place to obtain medications unavailable from a standard cycle refill or medications provided by a non-preferred provider. . . ." - Review of Resident #6's medical record occurred on all days of survey. A physician's order, dated 09/24/25, identified Gabapentin (an anticonvulsant medication) 300 milligrams (mg) three times a day for pain. The residents' September and October 2025 medication administration records (MARs) identified Resident #6 did not receive the Gabapentin on September 24-30 and October 1-7 (14 days) and identified "New Order - Not Yet Arrived" or "Med [medication] not available." During an interview on 10/08/25 at 4:52 p.m., an administrative nurse (#16) stated, "Pharmacy said they needed to get a hold of the TCU [transition care unit] from [facility's name] and had trouble getting a hold of them" and indicated the pharmacy sent five faxes and made "a few phone calls." When asked if there was a reason a prescription from a different provider could not be obtained, the nurse (#16) stated, "She (Resident #6) would need to be seen," and stated the provider makes rounds every Tuesday. The	B1510		

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B1510	Continued From page 37 administrative nurse (#16) stated the provider was last at the facility on September 30 and confirmed staff could have addressed the Gabapentin with the provider at that time. - Review of Resident #9's medical record occurred on October 8-9, 2025. A physician's order, dated 04/15/25, identified Quetiapine (Seroquel, an antipsychotic medication) 6.25 mg once daily for mood. The residents' April 2025 MAR identified Resident #9 did not receive Seroquel on April 28-30 and "Med not available." A nurse's note, dated 4/29/25 at 2:35 p.m., stated, ". . . Quetiapine refill requested form [sic] [pharmacy name]. It was stated that the prescription has expired, and they will contact provider for new Rx [prescription] . . ." The facility failed to ensure the residents received medications as ordered.	B1510		
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. This State Licensing Rule is not met as evidenced by:	B1540		

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Based on information received from the complainants, observation, record review, review of the facility Med (medication) Passer Guide, and staff interview, the facility failed to follow provider orders, notify the provider regarding low blood sugars, ensure blood sugars were taken before the resident eats, ensure open/expiration dates on insulin pens, and ensure labels on insulin pens match the orders for 2 of 7 sampled residents (Resident #1 and #6) and 2 closed records (Resident #9 and #12). In addition, the facility failed to ensure qualified staff prepared and administered medications to residents. These failures may result in significant medication errors and/or adverse health consequences for all residents who reside in the facility.

Findings include:

Information received from complainants identified a resident received twice the amount of Ativan ordered and medications were administered by unlicensed staff.

Review of the facility's Med Passers Guide occurred on all days of survey. This guide, dated 04/04/24, page 4, stated, ". . . A med passer is defined as an individual licensed, certified, and delegated to administer medication within the scope of appliable law and Company policies and procedures. . . ." 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 . . . Preparing for Medication Administration: 1. With the resident's electronic medication administration record (eMAR) open, compare the medication listed in the eMAR with the medication label to confirm

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NEW PERSPECTIVE - WEST FARGO	645 33RD AVENUE EAST WEST FARGO, ND 58078

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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 . . ." Pages 13-15, stated, "Inhalant . . . provide resident with water and instruct resident to rinse their mouth . . . Nasal . . . remove cap from the nasal spray . . . gently insert the tip of the container into the nostril indicated in the eMAR . . . Nebulized . . . Assemble nebulizer parts . . . squeeze medication into the nebulizer capsule . . . turn nebulizer on . . . Turn nebulizer off when the chamber that holds the medication is empty . . . Rinse mouthpiece/mask and nebulizer parts with warm water; and Lay rinsed equipment on a clean towel to allow equipment to air dry . . ."

- Review of Resident #1's medical record occurred on all days of survey. Physician's orders identified blood sugar checks four times daily prior to mealtimes and at bedtime and NovoLog insulin 2 units three times daily.

Observation on 10/07/25 at 8:20 a.m. showed a medication passer (#6) performed Resident #1's blood sugar check after the resident ate the majority of his breaksfast. The medication passer then prepared Resident #1's Novolog insulin pen for administration. The pen failed to include an open or expiration date. The medication passer (#6) stated, "I know the pen is not expired because I just opened it the other day and it [the insulin] runs out before it expires." When asked how she can ensure all other medication passers know when the pen was opened or expired without the notations on the pen, the medication passer stated, "They can't."

- Review of Resident #6's medical record

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B1540	Continued From page 40	B1540		

occurred on all days of survey. Physician's orders identified blood sugar checks three times daily prior to meals and NovoLog insulin r units three times a day.

Observation on 10/07/25 at 8:30 a.m. showed a medication passer (#6) performed Resident #6's blood sugar check after the resident ate the majority of her breakfast. The medicaion passer then prepared resident #6's NovoLog insulin pen for administration. The label on the pen indicated to administer the insulin three times daily per sliding scale. The medication passer (#6) stated, "Only nurses can administer sliding scale. There is not a nurse here all the time. So, the order is 4 units three times a day." The medication passer (#6) confirmed Resident #6's insulin pen label did not match the physician's order or the eMAR.

- Review of Resident #9's medical record occurred on October 8-9, 2025. A physician's order, dated 04/17/25, stated, "Discontinue scheduled Ativan [an antianxiety medication] [and] continue previously ordered PRN [as needed] Ativan." A second physician's order, dated 04/22/25, stated, "Start lorazepam [Ativan] 0.5 mg [milligrams] PO [by mouth]. Give 0.5 mg at 1500 [3:00 p.m.] for anxiety and restlessness."

Resident #9's April 2025 medication administration record (MAR) identified a duplicate order entered for Ativan, 0.5 mg in the morning and 0.5 mg at 3:00 p.m. As a result, the resident received two doses of Ativan daily from April 24-30, 2025 (seven days), instead of once daily dose at 3:00 p.m. as ordered.

- Review of Resident #12's medical record occurred on October 8-9, 2025. The record identified a physician's order for Novolin (insulin)

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22 units with supper, and the instructions, "HOLD FOR BS [blood sugar] < [less than] 90 AND IF BS <75 OR > [greater than] 450 CALL NURSE . . ." The May 2025 MAR identified staff obtained a blood sugar reading of 58 on 05/07/25 at 4:15 p.m. and administered 22 units of Novolin with the evening meal. Staff also obtained a one-time order for 5 units of Novolin and administered it at 6:55 p.m. on 05/07/25.

The record lacked evidence of notification of the nurse or clarification regarding Resident #12's low blood sugar and administration of insulin.

- Observation on 10/09/25 at 8:43 a.m., showed a medication passer (#6) prepared medications and gave them to a certified nurse aide (CNA) (#4) and the unsupervised CNA administered them to an unidentified resident seated in the dining room.

- Observation on 10/09/25 at 8:55 a.m. showed a medication passer (#6) prepared medications and gave them to a CNA (#4) to administer. The medication passer (#6) and the CNA (#4) entered an unidentified resident's room. The CNA (#4) administered the oral medications, inserted a capped nasal spray bottle into the resident's nostril, and administered the spray. The resident stated he did not feel the spray. The CNA (#4) realized the cap was still on the bottle, removed the cap, and readministered the spray. The resident again stated he did not feel the spray. The CNA (#4) shook the bottle, stated it was empty, and the medication passer (#6) stated they will have to get a new bottle. The CNA (#4) prepared and handed the resident an inhalation diskus and the resident inhaled the medication. The medication passer (#6) stated, "He [the resident] needs water," exited the resident's

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B1540	Continued From page 42 room, and returned with a glass of water. The medication passer (#6) handed the water to the resident without instructions, and the resident sipped and swallowed the water. The CNA (#4) stated "You [the resident] were supposed to swish and spit the water back out [into the cup]." While preparing the resident's nebulizer treatment, the medication passer (#6) noticed the nebulizer parts were not cleaned from the previous treatment, and rinsed the parts before administering the treatment. After the medication passer (#6) and the CNA (#4) exited the resident's room, the surveyor asked the CNA (#4) if she was a medication assistant (MA). The CNA (#4) stated, "I have had my MA [certification] for about one month." The medication passer (#6) stated the CNA (#4) has a MA license but is in training. Review of the North Dakota Nurse Aide Registry (ND NAR) on 10/09/25 showed the CNA (#4) did not have active status as an MA. Refer to B950.	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. This State Licensing Rule is not met as evidenced by: Based on information received from the	B1700		

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complainants, observation, record review, policy review, and staff interview, the facility failed to provide nursing services to meet the medical and health needs for 2 of 7 sampled residents (Resident #3 and #6) and 3 of 6 closed records (Resident #9, #12, and #13) reviewed. Failure to provide nursing services in accordance with acceptable professional standards in regards to ensuring medication assistants (MAs) notify the nurse of abnormal blood sugar and blood pressure results (Resident #3, #6, and #12), clarifying medication orders (Resident #9 and #12), approving administration of as needed (PRN) medications by MAs (Resident #9, #12, and #13), clarifying blood glucose parameters and ensure MAs follow orders (Resident #12), and ensuring MAs attempt non-pharmacological interventions prior to giving psychotropic medications (Resident #12) placed the residents at risk for complications and illness and may result in negative health outcomes for residents.

Findings include:

Information received from the complainant identified concerns with improper PRN medication use, failure to follow blood glucose protocols, and medications not administered as per physician order.

- Resident #3's vital sign record, dated 10/01/25 at 9:27 a.m., showed a blood pressure reading of 90/51. The record lacked evidence facility staff notified the nurse and received follow up instructions.

- Review of Resident #6's blood glucose readings from 10/01/25 through 10/06/25 showed a glucose reading of 65 on 10/05/25 at 8:19 a.m. The record lacked evidence facility staff notified

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B1700	Continued From page 44 the nurse and received follow up instructions. - Review of Resident #9's medical record occurred on October 8-9, 2025. A physician's order, dated 04/17/25, stated, "Discontinue scheduled Ativan [an antianxiety medication] [and] continue previously ordered PRN Ativan." A second physician's order, dated 04/22/25, stated, "Start lorazepam [Ativan] 0.5 mg [milligrams] PO [by mouth]. Give 0.5 mg at 1500 [3:00 p.m.] for anxiety and restlessness." Resident #9's April 2025 medication administration record (MAR) identified a duplicate order entered for Ativan, 0.5 mg in the morning and 0.5 mg at 3:00 p.m. As a result, the resident received two doses of Ativan daily from April 24-30, 2025 (seven days), instead of a once daily dose at 3:00 p.m. as ordered. The nurse failed to ensure clarification of the Ativan order, which resulted in Resident #9 receiving double the amount of ordered Ativan for one week. The MAR for April and May 2025 identified a medication passer administered PRN Ativan twice on 04/30/25 and once on 05/02/25 and 05/12/25 without contacting a nurse for direction. The facility failed to ensure the availability of nursing services to provide direction and instruction for medication assistants to administer PRN medications. - Review of Resident #12's medical record occurred on October 8-9, 2025. Physician's orders included Novolin (insulin) 22 units with supper, and the instructions, "HOLD FOR BS	B1700		

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[blood sugar] < [less than] 90 AND IF BS <75 OR > [greater than] 450 CALL NURSE . . ."

On 05/07/25 at 4:15 p.m., staff obtained a blood sugar reading of 58 and administered 22 units of Novolin with the evening meal. Staff also obtained orders for a one-time dose of 5 units of Novolin and to monitor Resident #12's blood sugar every two hours. The staff administered the additional 5 units of Novolin at 6:55 p.m. The medical record lacked evidence staff obtained additional blood sugar readings every two hours as ordered.

The record lacked evidence staff sought clarification from the nurse regarding Resident #12's low blood sugar reading and the order for additional insulin.

Review of Resident #12's medical record for the time period of May-July 2024 showed an order for blood glucose monitoring which identified, ". . . Check blood sugar three times daily before meals. HOLD Novolin if blood sugar is LESS THAN 90. Call nurse for blood sugar LESS than 75 or GREATER than 450." Resident #12's insulin orders (three times daily with meals) contained instructions to hold the insulin if the blood sugar was less than 70. Review of Resident #12's May-July 2024 MARs identified seven occasions the blood sugar was less than 90. Staff administered insulin on six of the occasions, and held the insulin on one occasion. The nurse failed to clarify blood sugar parameters related to holding an insulin dose.

Resident #12's May and June 2024 MAR included an order for PRN lorazepam 0.5 mg twice daily with the instructions, "Nurse to instruct the MP [medication passer] to use olanzapin [sic] [olanzapine, an antipsychotic medication] first and

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if not effective then may use lorazepam. Must call nurse before administering. Attempt to utilize three non-medication interventions before calling. . . ." Resident #12's May and June 2024 MAR lacked an order for olanzapine but contained an order for PRN quetiapine (Seroquel, an antipsychotic).

Review of Resident #12's May and June 2024 MARs showed the following:
*May 21: administered lorazepam, no nurse notification
*May 30: administered lorazepam, only one non-pharmacological intervention documented
*June 4: administered lorazepam, no nurse notification and only one non-pharmacological intervention documented
*June 5: administered Seroquel, only one non-pharmacological intervention documented
*June 19: administered Seroquel, no nurse notification, only one non-pharmacological intervention documented

Staff failed to notify the nurse prior to giving PRN psychotropic medications and failed to attempt non-pharmacological interventions prior to administration. This practice may result in residents receiving unnecessary psychotropic medications.

- Review of Resident #13's medical record occurred on October 8-9, 2025 and identified a physician's order, dated 11/10/24, for Olanzapine 2.5 mg every four hours PRN. A progress noted, dated 01/24/25 at 7:30 a.m., stated, "MP [medication passer] called stating that resident was exit seeking. . . . MP requesting to give PRN for agitation/restlessness. Writer gave ok. . . ." Review of Resident #13's MAR showed the Olanzapine signed out by the medication passer

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B1700	Continued From page 47 as given to the resident at 4:25 a.m. (Three hours and five minutes before receiving permission from the nurse to administer the medication). Refer to B910, B921, B922, B924, B950, B1220, B1240, B1320, B1420, B1510, B1540, B2302, B2305, B2404, B2405, and B2408.	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: Based on information from the complainant, observation, 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 3 of 3 kitchenettes (Unit One, Unit Two/Three, and Unit Four). Failure to discard potentially hazardous food by its best by date, label food items with an open date, cover foods to prevent contamination, and ensure the kitchenette food service areas, equipment, refrigerators, and floors are clean may result in unsanitary conditions and/or foodborne illness. Findings include: The complainant stated the facility had no kitchen staff in the memory care unit "for months."	B1800		

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B1800	Continued From page 48 Review of the facility policy titled "Person-in-Charge of Food Preparation and Service" occurred on 10/08/25. This policy, dated 06/30/25, stated, "The Community will have a designated person in charge (PIC) within the Culinary Services department. . . . The CSD [culinary service director] or ED [executive director] will: Designate an appropriate number of PIC's to ensure coverage during meal preparation and service times (e.g., breakfast, lunch, and dinner) . . . Ensure a PIC is present during meal preparation and service times. Ensure the PIC has a current ServSaf certification [food safety course] or is in the process of obtaining a certification. . . ensure team members working as part of the Culinary Services department are properly trained in food safety . . . Prevent cross-contamination of . . . foods . . . by properly using suitable utensils such as . . . tongs . . ." Review of facility policies from a booklet titled "2025 Culinary Department Policy Revisions," dated 02/28/25, included the following policies: * "General Culinary Department Management," stated, ". . . Team member's beverages must be . . . stored in an area away from food prep . . . to prevent contamination. . . ." * "Proper Storage of Food, Chemical, and Equipment," stated, ". . . All food must be stored in . . . sanitary areas. . . . All stored foods must be covered, labeled, and dated. . . ." * "Maintaining Proper Logs in the Foodservice Setting," stated, ". . . The following logs must be completed daily . . . Kitchen and Dining Room Checklist . . . must include all daily and deep-cleaning tasks for food prep areas, equipment, storage, and dining spaces. . . . The Kitchen and Dining Room Closing Duties . . . must cover: Proper food storage and labeling.	B1800		

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B1800	Continued From page 49 Equipment shutdown procedures. Cleaning and sanitizing of surfaces, floors . . . Trash removal and disposal. . . . Each task must be checked off, and the assigned team member must initial next to their completed items. The supervisor or manager on duty must review and sign off the checklist . . ." * "Proper Handwashing, Glove Usage, and Hair Restraints," stated, ". . . protocols to prevent cross-contamination and the spread of foodborne illnesses . . . When to change gloves . . . After touching any non-food surface . . ." * "General Cleaning and Sanitizing of the Kitchen and Dining Room," stated, ". . . All kitchen . . . areas must be cleaned and sanitized regularly throughout the day and at the end of each shift. . . . Surfaces, equipment, and food contact areas must be free of food debris, grease, and residue to prevent contamination. Countertops, shelving . . . appliances . . . must be kept clean and free of visible dirt . . . grease. Floors must be 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 . . . Trash disposal: Empty trash can regularly and replace liners. . . . Ice machine: Clean per manufacturer guidelines . . . appliances . . . Cleaned and sanitized after each shift to prevent buildup. . . ." - Observations on the morning of 10/07/25 in the kitchenettes showed the following: * Unit One, Greasy residue on the microwave door and handle, a toaster with several crumbs inside and a sticky substance and burnt food marks on the outside, and a large trash can contained trash without a liner. The refrigerator shelves and drawers contained food debris and spillage, an uncovered bowl of grapes, and an undated, unlabeled half full closed bottle of water	B1800		

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and an open energy drink. A management staff member (#1) removed the items from the fridge, identified the energy drink and water as staff items, and stated "these [water and energy drink] should not be in here. They [staff] have their own fridge in the staff breakroom."
* Unit Two/Three, Greasy residue on the microwave door and handle, a shelf with dust and food particles, an ice machine with dried food/liquids on the opening lid and entire front, and a majority of the cabinet doors dirty and sticky. The refrigerator shelves and drawers contained food debris and spillage, a gallon of milk with a best by date of 10/04/25, and an undated, unlabeled, covered plate of food. The freezer contained an uncovered, unlabeled Styrofoam cup of ice cream. The management staff member (#1) removed the items from the refrigerator and freezer.
* Unit Four, The entire inside of the microwave with dried food splatter and greasy residue on the door and handle.
* All units, The bottom cabinets, which had an open bottom shelf with the floor exposed, showed dried liquid spills, dust, and dry and fresh food particles.

Observation on 10/08/24 at 8:30 a.m. on Unit Two/Three showed a caregiver (#4) opened the refrigerator door and touched the handles of a serving cart multiple times with gloved hands. Without changing gloves, the caregiver (#4) reached into a food warmer and placed waffles onto the resident's breakfast plates.

Observation on 10/08/25 at 8:37 a.m. showed a duties checklist, dated June 2025, located on the refrigerator door in the Unit Two/Three kitchenette and no duty checklists found in Units One and Four.

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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
B1800	Continued From page 51 During an interview on 10/07/25 at 10:19 a.m., a management staff member (#1) agreed all the kitchenettes needed cleaning attention. During an interview on 10/08/25 at 2:54 pm, a culinary manager (#19) stated he expected staff to use utensils when plating foods and staff use the staff refrigerator to store their personal food items.	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, review of the menu, and staff interview, the facility failed to ensure no more than a 14-hour span between the evening meal and breakfast on 3 of 4 days of survey (October 7-9, 2025). Failure to provide meals no greater than 14 hours apart or provide a substantial evening snack may result in unresolved hunger and/or weight loss. Findings include: On the morning of 10/07/25, the facility staff provided the menu for the week of October 6-12, 2025. Staff wrote the time the meals started, "Breakfast 8:15 -8:30 a.m., Lunch 11:30 a.m., Dinner 4:30 p.m., Snacks 2 p.m. [and] 7 p.m." at the top of the menu. The facility meal times resulted in a 15.75 - 16 hour difference between supper and breakfast.	B1820		

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B1820	Continued From page 52 During an interview on 10/08/25 at 2:50 p.m., a dietary manager (#19) stated the facility provided resident snacks at 7 p.m. He stated they offered snacks like pretzels, chips, snack bar, pudding and agreed the evening snacks are not substantial snacks and should include protein. During an interview on the morning of 10/07/25, a management staff member (#1) stated "Evening snacks have not happened for months until sometime last week."	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, policy review, review of the menu, and staff interview, the facility failed to provide snacks between all meals and in the evenings and failed to post the menu including the snacks on the daily menu for 3 of 4 days of survey (October 7-9, 2025). Failure to provide regular snacks (between meals in the morning and afternoon, and in the evening) and keep residents informed of snack choices may result in unresolved hunger and/or weight loss. Findings include: Review of the facility policy titled "2025 Culinary Department Policy Revisions" occurred on 10/09/25. This policy, dated 02/28/25, stated, ". . . Culinary Standards and Compliance . . . Menus	B1830		

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B1830	Continued From page 53 must be posted weekly . . ." On the morning of 10/07/25, the facility staff provided the menu for the week of October 6-12, 25. The menu listed the breakfast as "Made To Order Breakfast" and the specific food items for the lunch and supper menus. Staff wrote the time the meals started and "Snacks 2 p.m. [and] 7 p.m." at the top of the menu. The menu failed to include a snack between breakfast and lunch and failed to list the food item to be served for each snack for each day. Observation throughout the survey showed the weekly breakfast menu posted in the main kitchen/dining area, but no menu posted for lunch and supper meals and no snacks identified. During an interview on 10/08/25 at 8:20 a.m., a caregiver (#4) stated "no" when asked if there was any other menu posted in the Memory Care Unit. During an interview on 10/08/25 at 2:50 p.m., a dietary manager (#19) agreed the facility needed to post the weekly menu and thought the care staff posted it. The manager stated he was unaware food items for snacks needed to be listed on the menu, but knew the facility needed to offer snacks in the afternoon and evening, and stated the facility provided resident snacks at 2 p.m. and 7 p.m. During an interview on the morning of 10/07/25, a management staff member (#1) stated "Evening snacks have not happened for months until sometime last week." The facility failed to post the daily menu, including snacks, and provide snacks between all three	B1830		

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B1830	Continued From page 54 meals and in the evening.	B1830		
B1910	33-03-24.1-19,1 ACTIVITY SERVICES 1. Be developed based on the activity needs and interests of each resident identified through the initial and ongoing assessments. This State Licensing Rule is not met as evidenced by: Based on review of the October 2025 memory care unit activity calendar and record review, the facility failed to develop an activity program based on the needs and interests of 7 of 7 sampled residents (Resident #1, #2, #3, #4, #5, #6 and #7). Failure to identify and utilize residents' interests to develop the program may result in boredom, increased behaviors, and decreased quality of life. Findings include: Review of Resident's #1, #2, #3, #4, #5, #6 and #7's service agreements/plans failed to identify specific activities of interest. Review of the October 2025 activity calendar showed a generic schedule for each day of the week. The facility failed to develop an effective and meaningful activity program based on the interests of the individual residents' needs and interests.	B1910		
B1920	33-03-24.1-19,2 ACTIVITY SERVICES 2. Develop and post a monthly group activity	B1920		

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B1920	Continued From page 55 calendar, based on the individual interests identified, which lists social, recreational, and other events available to residents. This State Licensing Rule is not met as evidenced by: Based on review of the October 2025 memory care unit activity calendar and staff interview, the facility failed to implement an activity calendar that meets individual interests of residents and include a variety of activities for all residents who reside in the unit. Findings include: Review of the October 2025 memory care unit activity calendar showed a generic set of activities for each day of the week and included activities of daily living (ADLs). On the morning of 10/07/25, the surveyor and activity staff member (#20) reviewed the October 2025 memory care unit activity calendar and the staff member identified the following: * 8:00 a.m., "Rise & Shine": getting the residents up for the day. * 8:30 a.m., "Morning Meet and Greet": getting the residents out to breakfast. * 8:45 a.m., "Daily Chronicles & Current Events": turning on the TV. * 11:30 a.m., "Lunch." * 1:00 p.m., "Life Skills": residents help with tasks such as placing chairs under the dining room tables. * 1:00 p.m., "Bingo,": those residents that can leave the unit and join others residents from the assisted living outside the memory care unit. * 2:00 p.m., "Tasty Treats & Coffee": afternoon coffee and snack.	B1920		

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B1920	Continued From page 56 * 4:30 p.m., "Dinner." * 6:00 p.m., "Walking Club": the staff member (#20) couldn't identify what this activity is. * 7:00 p.m., "Evening snack." During an interview on 10/09/25 at 4:45 p.m. a regional director (#8) stated the activity calendar "looks more like a daily schedule than an activity calendar" and agreed several items on the calendar are not activities.	B1920		
B1930	33-03-24.1-19,3 ACTIVITY SERVICES 3. Activities must be available and provided 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, review of the activity calendar, and family and staff interview, the facility failed to provide/offer activities that meet the needs of residents on 3 of 3 days (October 7-9, 2025) of survey. Failure to provide activities that meet the needs of the residents may result in boredom, increased behaviors, and decreased quality of life. Findings include: A family member A stated the memory care unit activity calendar is seldom followed, residents lack stimulation, residents are set in front of the television "a lot," and the Walking Club activity had not occurred in the evenings. Review of the October 2025 memory care unit activity calendar occurred on all days of survey.	B1930		

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B1930	Continued From page 57	B1930		

The calendar identified the Walking Club scheduled at 6:00 p.m. seven days a week.

During interviews, the staff stated the following:
* The morning of 10/07/25, when asked what the Walking Club activity was, an activity staff member (#20) stated, "I am not sure what that is. I leave at 4:30 [p.m.]. They [memory care unit caregivers] do this."
* 10/08/25 at 2:25 p.m., caregivers (#3 and #4) stated they were unsure what the evening Walking Club activity was and stated they do not perform this activity with the residents.
* 10/08/25 at 3:18 p.m., when asked about the walking club, the activity staff member (#20) again stated she leaves at 4:30 p.m., the caregivers complete this activity, and stated "Our goal is to have the residents walk at least once around [the unit hallways]."

The activity calendar showed an activity titled "Garden Club" at 2:30 p.m. held on Wednesdays and Fridays. During an interview on 10/08/25 at 3:18 p.m., when asked about the Garden Club, the activity staff member (#20) stated "We planted peas outside. No one wanted to go outside today because it is too cold." The outdoor temperature was noted to be 68-degrees Fahrenheit and breezy.

On 10/07/25 the activity calendar showed a 10:00 a.m. activity called Fun Facts. Observation showed 7 to 8 residents sat in the activity room watching television. The television screen was not visible from four different angles due to high glare on the screen. The residents appeared disengaged.

During an interview the morning of 10/07/25, an administrative staff member (#1) stated "I have to

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B1930	Continued From page 58 initiate most of the activities, or they would not happen in the memory care unit." The facility failed to provide/offer activities that meet the needs of all residents.	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 information received from the complainants, observation, review of professional reference, review of facility policy, review of chemical Safety Data Sheets (SDSs), and staff interview, the facility failed to ensure a clean environment for 2 of 7 sampled residents (Resident #2 and #4) and ensure chemicals stored in locked cabinets. Failure to ensure chemicals are kept in locked cabinets placed all residents at risk of injury and failure to ensure resident rooms are clean and odor free does not promote a homelike atmosphere. Findings include: Information received from complainants identified a strong urine odor and visibly dirty residents' bathrooms. Review of CDC (Centers for Disease Control and Prevention) at	B2000		

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B2000	Continued From page 59 https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html, dated 03/19/24, titled "Environmental Cleaning Procedures," stated, "4.3 Patient area toilets. Toilets in patient care areas . . . have high patient exposure (i.e., high-touch surface) and are frequently contaminated. Therefore, they pose a higher risk of pathogen transmission than in general patient areas. . . . Toileting practices vary . . . In some cases, more than twice daily cleaning and disinfection may be warranted. . . ." Review of the facility policy titled "Proper Storage of Food, Chemicals, and Equipment" occurred on 10/08/25. This policy, revised 02/28/25, stated, ". . . Chemical Storage Guidelines . . . Chemicals must be stored in a locked storage space . . ." Review of the SDS for Comet Disinfecting Sanitizing Bathroom Cleaner, issued 02/12/15, stated, ". . . Causes eye irritation. Harmful if swallowed . . ." Review of the SDS for Spic and Span Disinfecting All-Purpose Spray and Glass Cleaner, issued 02/09/15, stated, ". . . Causes severe skin burns and eye damage . . ." - Observations on the morning of 10/07/25 showed chemicals in unlocked cabinets under the kitchenette sinks in the following units: * Unit One, one spray bottle containing a liquid labeled Spic and Span Disinfecting All Purpose Spray and Glass Cleaner. A management staff member (#1) removed the bottle from the cabinet. * Unit Two/Three, one spray bottle containing a liquid labeled Comet Disinfecting-Sanitizing Bathroom Cleaner and one spray bottle containing a liquid labeled Spic and Span	B2000		

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B2000	Continued From page 60 Disinfecting All Purpose Spray and Glass Cleaner. The staff member (#1) removed the bottles from the cabinet. * Unit Four, one spray bottle containing a liquid labeled Comet Disinfecting-Sanitizing Bathroom Cleaner. An unidentified housekeeping staff member removed this bottle and five empty bottles labeled either Comet or Spic and Span from the cabinet. During an interview on 10/08/25 at 2:52 p.m., a culinary manager (#19) stated he expected all chemicals located in kitchen areas accessible to residents be stored in locked cabinets. - Observations on all days of survey showed Resident #2 and #4's bathrooms odorous and their toilets soiled with bowel movement. During an interview on 10/07/25 at 9:05 a.m., a housekeeping staff member (#18) stated hard surfaces in the resident's rooms are wiped down and bathrooms cleaned daily. At 10:37 a.m., a management staff member (#1) stated she expects staff to clean resident toilets 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.	B2302		

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B2302	Continued From page 61	B2302		

This State Licensing Rule is not met as evidenced by:
Based on observation, policy review, and record review the facility failed to provide nurse oversight related to resident care for 1 of 1 sampled residents (Resident #4) receiving end-of-life services. Failure to provide nurse oversight resulted in a worsening condition of a resident's leg ulcer.

Findings include:

Review of the facility policy titled "Skin and Nail Management" occurred on 10/09/25. This policy, revised 05/01/25, stated, " . . . The nurse in charge is responsible for ensuring that appropriate interventions for wound management are documented in the resident's service plan and where applicable progress notes. Interventions will include an at least weekly wound evaluation and documentation by a licensed nurse until the wound is resolved. . . ."

Observation on 10/08/25 at 10:22 a.m. showed an unbandaged quarter-sized recessed wound on Resident #4's right lower leg. The dry dark red wound bed contained minimal moisture around the perimeter and reddened skin surrounding the wound.

Review of Resident 4's medical record occurred on October 8 - 9, 2025. The progress notes stated the following:
* 08/21/25 at 11:15 a.m., " . . . injury . . . to the inside oft he [sic] resident's right leg was a small abrasion with redness and bruising around it that staff state was not present earlier. No intervention needed for site, continue to monitor. . . ."

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B2302	Continued From page 62 * 09/04/25 at 9:52 a.m., " . . . She [Resident #4] continues to have a healing wound to the back of her right leg which does have redness surrounding the area, but does not appear infected. . . ." * 09/16/25 at 11:25 a.m., ". . . late entry for 09/15/25 8:00 AM [morning]: CG [caregiver] noted change in wound . . .gotten worse. . . . Was noted it was scabbed over yesterday. Today . . . med passer noticed the [wound] is now a hole. RN [registered nurse] assessed . . . wound . . . notified [hospice agency] nurse so that assessment can be completed and orders given on dressing. . . . Will continue to monitor." * 09/17/25 at 1:13 p.m., "New order per [provider] . . . Wound to left [right] leg: apply saline wash to clean, then calcium alginate dressing, then cover with mepilex [type of foam dressing] and change daily. Update in 2 weeks. . . ." * 09/29/25 at 11:37 a.m., ". . . The wound to her right calf is still present and is open. . . . This nurse covered the wound with a Mepilex. . . . Will report out to [hospice agency] and provider tomorrow on status of wound." Review of hospice visit report occurred on 10/09/25. This report dated 10/07/25, stated, " . . . was informed that they [basic care] wanted hospice to perform wound cares daily for patient as their med aide [medication passer] is not supposed to be doing this. Nursing team made aware and changes will be made to wound care order at next visit." The medical record lacked documentation the a nurse responded to the resident needs timely, care planned wound care interventions, and provided oversight and care related to Resident 4's individual needs.	B2302		

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B2305	Continued From page 63	B2305		
B2305	33-03-24.1-23,5 End-of-Life Services 5. The facility, in consultation with the resident or resident's designee, shall develop and implement an interdisciplinary care plan that identifies how the resident's needs are met and includes delineation of the roles of facility staff and others in the provision of care and services for the resident in need of end-of-life care and a list of medications the resident receives related to end-of-life care and who is authorized to administer the medications. This State Licensing Rule is not met as evidenced by: Based on observation and record review, the facility failed to develop, update and implement an interdisciplinary care plan that identified how the resident's needs are met and include delineation of the roles of the facility staff and others in the provision of care and services for 1 of 1 sampled resident (Resident #4) receiving end-of-life services and 1 of 1 closed record (Resident #9) reviewed for end-of-life services. Lack of interdisciplinary care plan and delineation of specific roles may result in unmet needs for resident's receiving end-of-life services. Observation on 10/08/25 at 10:22 a.m., showed a wound on Resident #4's right lower leg. - Review of Resident 4's medical record occurred on October 8 - 9, 2025. The progress notes stated the following: * 08/21/25 at 11:15 a.m., " . . . injury . . . to the inside oft he [sic] resident's right leg was a small	B2305		

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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
B2305	Continued From page 64	B2305		

abrasion with redness and bruising around it that staff state was not present earlier. No intervention needed for site, continue to monitor. . . ."
* 09/04/25 at 9:52 a.m., " . . . She [Resident #4] continues to have a healing wound to the back of her right leg which does have redness surrounding the area, but does not appear infected. . . ."
* 09/16/25 at 11:25 a.m., ". . . late entry for 09/15/25 8:00 AM [morning]: CG [caregiver] noted change in wound . . .gotten worse. . . . Was noted it was scabbed over yesterday. Today . . . med passer noticed the [wound] is now a hole. RN [registered nurse] assessed . . . wound . . . notified [hospice agency] nurse so that assessment can be completed and orders given on dressing. . . . Will continue to monitor."
* 09/17/25 at 1:13 p.m., "New order per [provider] . . . Wound to left [right] leg: apply saline wash to clean, then calcium alginate dressing, then cover with mepilex [type of foam dressing] and change daily. Update in 2 weeks. . . ."
* 09/29/25 at 11:37 a.m., ". . . The wound to her right calf is still present and is open. . . . This nurse covered the wound with a Mepilex. . . . Will report out to [hospice agency] and provider tomorrow on status of wound."

Review of the hospice visit report occurred on 10/09/25. This report dated 10/07/25, stated, " . . . was informed that they [basic care] wanted hospice to perform wound cares daily for patient as their med aide [medication passer] is not supposed to be doing this. Nursing team made aware and changes will be made to wound care order at next visit."

- Review of Resident #9's medical record occurred on October 8-9, 2025. The resident's care plan failed to include end-of-life services and

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	8201	A. BUILDING: _____ B. WING _____	C 10/13/2025

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B2305	Continued From page 65 interventions related to end-of-life care. The facility failed to include end-of-life cares and specific delineation of roles in the residents' care.	B2305		
B2404	33-03-24.1-24,4 Optional Alzheimer's, Demential, Special Mem The facility shall develop a written policy related to resident rights and provide the policy to the resident or designee, verbally and in writing. The facility shall ensure each resident's right to privacy, dignity and respect, and freedom from coercion and restraint by promoting individual initiative, autonomy, and independence in making life choices related to daily activities, physical environment, and with whom to interact. The facility or unit must comply with residents' rights in North Dakota Century Code chapter 50-10.2, and: a. Residents must be provided privacy in their sleeping or living area, including entrance doors lockable by the individual, with only appropriate staff having keys to the doors; b. Residents sharing a room with another resident must have a choice of roommate in that setting; c. Residents must be granted the freedom to furnish and decorate their sleeping unit or living area to the extent allowable based on facility policy and fire code requirements; d. Residents must have the freedom and support to control their schedules and activities and have access to food any time and eat where they choose; e. Residents are allowed to have visitors of their choosing at any time; f. Must have access to the community; and g. Residents must have access to outdoor space.	B2404		

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B2404	Continued From page 66 Residents in a secured facility or unit must have access to a secured outdoor space. This State Licensing Rule is not met as evidenced by: Based on observation, the facility failed to provide care in a manner that maintained the resident's dignity for 2 of 2 sampled residents (Resident #1 and #6) observed during insulin administration. Failure to maintain bodily privacy during insulin administration does not promote the resident's self-esteem, preserve the resident's personal dignity, or enhance their quality of life. Findings include: Observations on 10/07/25 at 8:20 a.m. and 8:30 a.m. showed a medication passer (#6) administer insulin to Resident's #1 and #6 while seated at their tables in the dining room with other resident's seated at the tables and staff/residents present throughout the dining room. The medication passer (#6) failed to administer insulin in a private area.	B2404		
B2405	33-03-24.1-24,5 Optional Alzheimer's, Demential, Special Mem The facility shall develop a person-centered care plan for each resident. The care plan must be completed following the functional assessment and be based on input from the resident or designee. This State Licensing Rule is not met as	B2405		

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B2405	Continued From page 67	B2405		

evidenced by:
Based on record review and review of facility policy, the facility failed to develop a person-centered care plan related to behaviors for 1 of 6 closed records reviewed (Resident #9). Failure to develop a care plan and implement interventions regarding behaviors may result in unmet resident needs.

Findings include:

Review of the facility policy titled "Behavioral Expressions Management" occurred on 10/09/25. This policy, dated December 29, 2024, stated, ". . . Interventions are designed to improve the ability for a resident to meet the goals associated with service plan [care plan] objectives. . . ."

Review of the facility policy titled "Resident Service Plan" occurred on 10/09/25. This policy, dated 12/30/24, stated, ". . . The service plan will: a. Identify the program services, frequency, and approaches the Community will provide under applicable law, to include . . . behavior management . . . It will be updated to reflect changes to the services provided to the resident . . ."

Review of Resident #9's nurses' notes identified the following:
*04/13/25 7:35 a.m.: ". . . resident has increased behaviors and s/sx [signs and symptoms] of agitation . . ."
*04/21/25 11:59 p.m.: ". . . the resident was yelling, crying, hitting at staff, blocking staff in their office, stating people were going to kill her et [and] the team couldn't get the resident to re-direct. . . ."
*05/15/25 9:40 p.m.: ". . . Med [medication] passer called to report that resident is very

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B2405	Continued From page 68 agitated and restless, resident keeps removing her clothes and ambulating naked in common areas . . ." *05/22/25 12:35 a.m.: ". . . the resident continues to have multiple behaviors this evening et has been unable to re-direct . . ." *05/23/25 1:05 a.m.: ". . . The MP [med passer] called requesting PRN [as needed] Ativan stating the resident is agitated, taking off her clothing in common areas et tearful. . . ." *05/28/25 12:50 a.m.: ". . . call received from the MP stating the resident is yelling, tearful, difficult to re-direct, has removed all of her clothing despite the team encouraging her to keep her clothing on et is walking around the common areas nude. . . ." *05/28/25 12:54 a.m.: ". . . Call placed to [Hospice nurse] to discuss resident's progression s/p [status post] starting medications to assist with behavioral expressions. . . . This writer requested medications be reviewed et increased or additional medication for behavioral expressions be added. . . ." *07/04/25 5:00 a.m.: ". . . Staff report that resident is agitated, pacing the halls, rummaging through things and unable to be redirected. . . ." The resident's care plan lacked information related to behaviors, including identification of behaviors and interventions to help manage those behaviors.	B2405		
B2408	33-03-24.1-24,8 Optional Alzheimer's, Demential, Special Mem Each nursing or personal care staff member shall receive annually a minimum of four hours of educational training in two or more of the topics identified in subsection 7.	B2408		

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B2408	Continued From page 69 This State Licensing Rule is not met as evidenced by: Based on review of employee files and job description review, the facility failed to ensure a minimum of four hours of dementia education annually for 3 of 10 employees reviewed (Employee #9, #10, and #11). Findings include: The facility job description titled "Caregiver" occurred on 10/09/25. This document stated, ". . . RESPONSIBILITIES . . . Complete and or attend, all annual required training, team meetings, town hall meetings, online learning resources, including New Perspective and state regulations. . . ." Review of employee files occurred on 10/09/25. Review of Employee #9, #10, and #11's annual education showed the employees failed to obtain a minimum of four hours of dementia education within the past year.	B2408		

B910 – Plan of Correction

Resident #13 is no longer residing in the community, having discharged on 01/28/25; a full review of the resident's record and the elopement history was completed on 11/18/25. Between 11/18/25 and 11/22/25, the Health and Wellness Director reviewed all memory care residents' assessments, behavior plans, and elopement risk documentation, and updated interventions for any residents exhibiting wandering or exit-seeking behaviors. On 11/20/25, the Governing Body, Regional Director of Operations, Executive Director, and HWD reviewed the deficiency and added monthly oversight of elopement events, alarm logs, and environmental safety to the facility's governance agenda. Staff were retrained between 11/21/25 and 11/23/25 on elopement policies, alarm response, identification of exit-seeking behaviors, and required documentation. The HWD was re-educated on care planning and updating the care plan when elopement risk is identified. All secured egress points were tested 11/19–11/21/25, and daily alarm checks were added to shift handoff procedures. To maintain compliance, weekly audits of care plans, risk assessments, and alarm response documentation will occur from 12/12/25 through 03/20/26, with daily door-alarm reviews through 12/12/25, then weekly through 03/20/26. Audit results will be reviewed monthly by QA/QAPI and the Governing Body. Full compliance will be achieved by 12/12/2025.

B920 – Plan of Correction

Resident #13 is no longer in the community, having discharged on 01/28/25; however, their full record, service agreement, elopement assessments, and progress notes were reviewed on 11/18/25 to identify gaps in the implementation of elopement policies, behavior interventions, and room placement considerations. Between 11/18/25 and 11/22/25, the Health and Wellness Director reviewed all memory care residents' elopement risk assessments, service agreements, and behavior plans to confirm that interventions are in place and consistently implemented. Residents with wandering or exit-seeking behaviors received updated care plans and individualized interventions. On 11/20/25, the Governing Body, RDO, ED, and HWD reviewed the cited deficiencies and implemented monthly oversight of elopement policies, alarm logs, documented interventions, and any identified trends. Staff received retraining between 11/07/25 and 11/23/25 on elopement policies, exit-seeking triggers, required therapeutic interventions, and documentation expectations, including when to consider room changes and when to initiate assessment for a higher level of care. Room placement reviews for all memory care residents were completed on 11/22/25 to confirm that residents at increased risk are located away from exit doors when appropriate. To maintain compliance, weekly audits of behavior plans, elopement assessments, intervention documentation, room placement appropriateness, and alarm

response records will occur from 12/12/25 through 03/20/26, with findings reviewed monthly by QA/QAPI and the Governing Body. The facility will reach full compliance by 12/12/2025.

B921 – Plan of Correction

Resident #4's complete medical record, wound orders, progress notes, and hospice communications were reviewed on 11/18/25. A late referral for wound care services was identified, and the resident is now receiving appropriate wound care through an outside agency with updated orders and documentation. Between 11/18/25 and 11/22/25, the Health and Wellness Director reviewed all residents with wounds or skin impairments to confirm that treatment orders are active, referrals are in place, and documentation is current. Nursing staff were re-educated on 11/21/25 regarding the facility's responsibility to obtain timely referrals, follow physician orders, notify providers of changes, and document wound assessments and interventions according to policy and state rules. A standardized wound referral and follow-up process was implemented on 11/22/25, including same-day provider notification and documented confirmation of service acceptance by the outside agency. The ED and HWD reviewed all wound-related policies with the Regional Director of Operations on 11/20/25 and added monthly Governing Body review of all active wounds, referral timeliness, and wound-care documentation. To maintain compliance, weekly audits of all wounds, treatment orders, referrals, and charting will occur from 12/12/25 through 03/20/26, with any variances corrected immediately. Audit results will be reviewed monthly by QA/QAPI and the Governing Body. The facility will achieve full compliance by 12/12/2025.

B922 – Plan of Correction

The medical records for Residents #3, #6, and #12 were reviewed on 11/18/25 to address missed notifications to licensed nursing staff for vital signs and blood glucose values outside established parameters. All three residents received updated service plans and clear provider-established notification thresholds, and nursing staff were notified of any changes in their current status. Between 11/18/25 and 11/22/25, the Health and Wellness Director audited all residents with ordered vital-sign or blood-glucose monitoring to verify that notification parameters were documented in the record and that results outside those parameters were consistently communicated to the nurse. Staff were re-educated between 11/21/25 and 11/23/25 on the requirements for notifying licensed nursing staff immediately when abnormal blood pressure or blood glucose values occur, including when

provider-specific parameters differ from standard ranges. Training also reinforced use of the Med Passer Guide, documentation expectations, and the requirement to notify the on-call nurse when licensed personnel are not onsite. On 11/20/25, the ED and HWD reviewed the deficiency with the Regional Director of Operations and added monthly Governing Body review of abnormal vital-sign logs, eMAR documentation, staff notifications, and timeliness of licensed-professional involvement. To maintain compliance, weekly audits of vital-sign documentation, notification records, and follow-up actions will be completed from 12/12/25 through 03/20/26, with corrective action taken immediately for any missed notifications. Audit results will be reviewed monthly by QA/QAPI and the Governing Body. Full compliance will be achieved by 12/12/2025.

B924 – Plan of Correction

On 11/18/25, the facility reviewed the infection control practices observed during survey, including insulin pen preparation, glucometer handling, glove use, and hand hygiene expectations for staff involved in direct care and blood glucose monitoring. Residents #1, #6, and #14's records were reviewed to confirm that no adverse outcomes resulted from the observed lapses. Between 11/18/25 and 11/22/25, the Health and Wellness Director completed an audit of all insulin-dependent and blood-glucose–monitored residents to verify that proper supplies were labeled, stored appropriately, and sanitized according to facility policy and manufacturer guidelines. Staff were re-educated between 11/14/25 and 11/23/25 on infection control procedures, including required hand hygiene before and after glove use, proper glove removal, sanitizing glucometers between residents, disinfecting insulin pen rubber seals prior to attaching needles, and policies regarding storage and labeling of diabetic equipment. The ED and HWD reviewed infection control policies with the Regional Director of Operations on 11/7/25 and added infection control practices—including glove use, hand hygiene compliance, equipment sanitization, and insulin pen preparation—to the monthly Governing Body review agenda. Beginning 12/12/25 through 03/20/26, the facility will conduct weekly audits of infection control practices during medication administration, glucometer use, and personal care. Audit findings will be reviewed monthly by QA/QAPI and the Governing Body. Full compliance will be achieved by 12/12/2025.

B950 – Plan of Correction

Between 11/18/25 and 11/22/25, the Executive Director and Health and Wellness Director reviewed staffing schedules, job descriptions, call-light response data, MA registration

status, and memory care assignments following survey findings of inadequate staffing presence, delayed assistance, and unlicensed personnel performing medication tasks. Immediate corrective action included removing unregistered staff from medication-passing duties, updating the MA roster with the ND Department of Health, reassigning staff to ensure adequate presence across all four memory care units, and confirming that all caregivers are awake, available, and carrying functioning communication devices during their shifts. The ED and HWD conducted staff re-education between 11/21/25 and 11/23/25 on resident supervision, distribution of staff throughout the unit, call-light response expectations, communication device requirements, and scope of practice related to medication passing. Starting 11/20/25, the Regional Director of Operations joined the ED and HWD in reviewing memory care staffing patterns and competency concerns, and monthly Governing Body agendas now include review of staffing levels, call-light response times, MA registration, and unassigned-time observations. Beginning 11/20/25 through 02/20/26, weekly audits will be completed to verify caregiver presence in all units, proper call-light device usage, MA registration accuracy, and timely response to resident needs. Findings will be reviewed monthly at QA/QAPI and Governing Body meetings. The facility will reach full compliance by 12/12/2025.

B1220 – Plan of Correction

On 11/18/25, the facility completed a full review of Resident #3's record, including the fracture diagnosis, orthopedic recommendations, service plan, and progress notes. The resident was reassessed immediately, and the care plan was updated to address brace usage, skin integrity, pain management, and follow-up needs. Between 11/18/25 and 11/22/25, the Health and Wellness Director reviewed all residents who experienced recent falls, injuries, or significant changes in condition to confirm that a reassessment by a licensed nurse was completed and documented according to policy. The ED and HWD conducted staff re-education between 11/21/25 and 11/23/25 on reassessment requirements, fracture and injury follow-up, documentation expectations, and the obligation to consult with the resident's licensed provider before discontinuing treatment interventions. Starting 11/20/25, the Regional Director of Operations joined the ED and HWD in reviewing all resident changes in condition and the timeliness of reassessments as part of monthly Governing Body oversight. To maintain compliance, weekly audits of all fall-related injuries, orthopedic follow-up, brace usage, and reassessment documentation will occur from 12/12/25 through 03/20/26. Audit results will be reviewed monthly at QA/QAPI and Governing Body meetings. The facility will achieve full compliance by **12/12/2025**.

B1240 – Plan of Correction

Between 11/18/25 and 11/22/25, the Health and Wellness Director reviewed all residents' service plans following survey findings that care plans were not updated to reflect current needs, mobility status, fall risk, activity interests, assistive devices, and brace use. Resident #3's care plan was updated immediately to reflect fracture follow-up, brace requirements, pain management, and monitoring. Resident #7's service plan was modified to reflect use of a four-wheel walker. Resident #5's service plan was updated to reflect current DME use, mobility status, and transfer needs. Activity care plans were also updated to include resident-specific interests identified through assessment. Staff were re-educated between 11/21/25 and 11/23/25 on quarterly and as-needed service plan revisions, documentation expectations after condition changes, and the requirement to reconcile assessment findings with the face sheet, service plan, and activity plan. On 11/20/25, the ED and HWD reviewed the deficiency with the Regional Director of Operations and added quarterly review of service plans, including cross-checks with mobility assessments, fall risk tools, dietary notes, and activity assessments, to the Governing Body agenda. To maintain compliance, the HWD or designee will complete weekly audits of service plans for accuracy, updates following changes in condition, correct DME specifications, and alignment with interdisciplinary assessments from 12/12/25 through 03/20/26. Audit results will be reviewed monthly by the QA/QAPI committee and the Governing Body. Full compliance will be achieved by **12/12/2025**.

B1320 – Plan of Correction

Between 11/18/25 and 11/22/25, the Health and Wellness Director completed a full audit of all active records of residents, focusing on missing or incomplete documentation such as code status forms, progress notes, nursing assessments, vital sign monitoring, transfer forms, discharge summaries, fall evaluations, and death documentation. Immediate corrective action was taken on each open record to update code status forms, enter missing notes, reconcile physician orders, add fall follow-up assessments, and complete transfer or discharge documentation. Staff were re-educated between 11/21/25 and 11/23/25 on required components of the medical record, including documentation of advance directives, changes in condition, vital signs, nursing assessments, transfer forms, death disposition forms, and discharge notes, as well as the requirement to enter timely, objective, complete health record entries according to policy and the ND administrative code. On 11/20/25, the ED and HWD reviewed the deficiency with the Regional Director of Operations and added monthly Governing Body review of resident records, including spot audits of code status forms, fall assessments, MARs, transfer documentation, death documentation, and discharge summaries. To sustain compliance, weekly audits will be

completed from 12/12/25 through 03/20/26 to verify that all required documentation elements are present in new admissions, changes in condition, falls, emergency room transfers, low blood sugar readings, and discharges. Any missing or incomplete information will be corrected immediately. Audit findings will be reviewed monthly by QA/QAPI and the Governing Body. Full compliance will be achieved by **12/12/2025**.

B1410 – Plan of Correction

Between 11/18/25 and 11/22/25, the Care Team Manager audited all ADL service delivery records following survey findings of missed bathing, grooming, toileting, and continence assistance. Immediate corrective action included updating each resident's service plan to reflect current ADL needs, reviewing bath and toileting schedules with assigned caregivers, and completing any overdue ADL care on the date identified. Staff were re-educated between 11/21/25 and 11/23/25 on timely provision of ADL supports, documentation requirements, call-light response expectations, and the need to proactively assist residents who rely on staff for hygiene, grooming, toileting, and continence care. The ED and HWD reviewed the deficiency with the Regional Director of Operations on 11/20/25 and added monthly Governing Body review of ADL compliance reports, call-light responsiveness, and caregiver assignment accuracy. To sustain compliance, weekly audits from 12/12/25 through 03/20/26 will review ADL delivery records, missed care logs, toileting schedules, and bathing frequency, with immediate correction of any omissions. Audit results will be presented monthly to QA/QAPI and the Governing Body. The facility will reach full compliance by 12/12/2025.

B1510 – Plan of Correction

On 11/18/25, the Health and Wellness Director reviewed the medication records for Residents #6 and #9 following survey findings that ordered medications were not available or administered as prescribed. Resident #6's pain medication orders were reconciled, the pharmacy was contacted for immediate fulfillment, and the resident's medication profile was updated to reflect receipt of all current orders. Resident #9's antipsychotic medication was reviewed, with updated orders obtained and refilled, and documentation corrected. Between 11/18/25 and 11/22/25, the HWD completed an audit of all residents with "med not available," "new order not yet arrived," or delayed fill indicators on MARs for the previous 60 days to ensure all issues were resolved. Staff were re-educated between 11/21/25 and 11/23/25 on the Medication Management and Non-Availability of Medication Policy, including timely provider notification, required follow-up when medications are not delivered, coordination with off-cycle fills, and documentation expectations when using non-preferred pharmacies. The ED and HWD reviewed this deficiency with the Regional Director of Operations on 11/20/25 and added monthly Governing Body review of

medication availability, refill timeliness, communication logs with pharmacy, and provider notification responsiveness. From 12/12/25 through 03/20/26, weekly audits will be completed to verify no resident has gaps in medication availability, with immediate corrective action for any missed or delayed orders. Audit results will be reviewed monthly at QA/QAPI and Governing Body meetings. The facility will reach full compliance by 12/12/2025.

B1540 – Plan of Correction

On **11/18/25**, the Health and Wellness Director (HWD) reviewed the medication administration events for the residents involved in the survey findings related to medication administration by an unregistered med passer, improper insulin labeling, duplicate MAR orders, and incorrect inhaler instruction. The med passer who administered medications without being listed on the North Dakota Medication Assistant Registry was immediately added to the registry. On **11/18/25**, the HWD verified that the staff member had completed the required training and submitted all necessary documentation to the registry. The HWD confirmed the individual was added to the ND registry on **11/19/25**, and no further medication administration occurred prior to registry confirmation.

On **11/18/25**, the HWD audited the insulin pens for the residents involved, ensuring all pens were labeled with required "date opened" and calculated expiration dates. Any unlabeled or outdated insulin was discarded and immediately replaced. The HWD conducted a review of all residents receiving insulin between **11/18/25 and 11/20/25** to ensure all insulin pens in use contained proper labeling, were within expiration parameters, and that blood glucose checks were being completed prior to meals and as ordered.

On **11/19/25**, the HWD provided immediate re-education to the staff member who instructed the resident incorrectly regarding rinsing after inhaler use. Proper inhaler administration steps—including prompting residents to swish and spit when required—were reviewed and validated.

Between **11/20/25 and 11/22/25**, the HWD conducted a full medication systems audit that included registry status verification for all medication passers, insulin inventory and labeling review, MAR accuracy review, and observation of medication administration practices. Corrections were made immediately when issues were identified.

The ED and HWD reviewed this deficiency with the Regional Director of Operations on **11/21/25**. Monthly Governing Body review has been expanded to include verification that:

- All medication passers remain active on the ND registry
- All insulin pens are labeled and within expiration
- MARs contain no duplicate or conflicting orders
- Medication administration observations are conducted and documented
- Blood glucose monitoring is completed per physician order

The facility will reach full compliance by **12/12/2025**.

B1700 – Plan of Correction

The facility immediately reviewed the medication records for all residents and corrected all issues involving missing nurse notification, unclear parameters, duplicate PRN orders, missed non-pharmacological interventions, and insulin administration without clarification. All active residents with orders involving blood glucose monitoring, insulin parameters, and PRN psychotropic and anxiolytic medications were audited to confirm correct parameters, proper nurse notification requirements, and accurate MAR entries. No additional residents were found to be at risk. The facility revised its Nursing Services and PRN Medication Protocols to require real-time RN notification before all PRN psychotropic or anxiolytic medications, before administering insulin when blood glucose is <90 or out of the prescribed range, and before administering any PRN medication without clear parameters. All nurses, medication assistants, and medication passers were retrained on blood glucose parameters, insulin HOLD instructions, duplicate-order reconciliation, PRN administration rules, and required documentation of non-pharmacologic interventions prior to PRN psychotropics. A new RN-on-call escalation flow sheet and PRN Decision Support Tool were implemented to guide MA practice. Nursing leadership will complete daily audits of PRN and insulin administrations for 14 days, weekly audits for eight weeks, and monthly audits for three months to confirm parameters, documentation, and nurse notifications are consistently completed. Completion date: **12/12/25**, with monitoring through **March 2026**.

B1800 – Plan of Correction

The facility immediately cleaned and sanitized all three kitchenettes, discarded all undated, unlabeled, or expired food items, and removed all staff beverages and personal items from resident food-service areas. All refrigerators, microwaves, shelving, ice machines, and food-contact surfaces were deep cleaned, and a Culinary Manager inspected each unit to verify completion. All residents' dietary areas were reviewed across all four units and no additional concerns were identified. The Person-in-Charge (PIC)

coverage schedule was corrected to ensure a certified PIC is present during all meal periods, and all culinary and caregiving staff were reeducated on food safety requirements, including proper food labeling, dating, utensil use, hand hygiene, glove changes, and prevention of cross-contamination. A new Kitchenette Daily Sanitation Checklist was implemented requiring cleaning and supervisory sign-off every shift, and weekly spot audits will be completed by the Executive Director or designee. To prevent recurrence, the Culinary Manager or PIC will conduct daily checks for 14 days, weekly inspections for eight weeks, and monthly inspections for three months to ensure sustained compliance with ND sanitary requirements. Completion date: **12/12/25**, with monitoring through **March 2026**.

B1820 – Plan of Correction

The facility immediately corrected meal and snack service schedules to ensure no more than a 14-hour span occurs between the evening meal and breakfast. Substantial evening snacks are now provided nightly and include a protein component such as cheese, yogurt, peanut butter, or protein-based snacks rather than solely carbohydrate items. All dietary staff and caregivers were reeducated on the requirement for substantial evening snacks and the 14-hour rule. The weekly posted menu now includes documented snack times, and the Evening Snack Distribution Log was implemented for staff to record snack delivery and resident acceptance. The Culinary Manager or PIC will verify snack preparation and delivery each evening for 14 days, conduct weekly meal-span audits for eight weeks, and review monthly for three months to confirm sustained compliance. Completion date: **12/12/25**, with monitoring through **March 2026**.

B1830 – Plan of Correction

The facility immediately updated the weekly posted menu to include all required snacks—morning, afternoon, and evening—and added the specific food item offered for each snack. Substantial snacks are now listed directly on the menu in accordance with the dietary policy. All dietary staff and caregivers were reeducated on the requirement to provide snacks between all meals and in the evening, and on posting the full weekly menu in every resident dining area, including Memory Care. The Evening and Between-Meal Snack Log was implemented for staff to document snack delivery, the food item offered, and any refusals. The Culinary Manager or PIC now verifies that menus are posted weekly in all required locations and that daily snacks are prepared and served as scheduled. To ensure sustained compliance, daily audits of snack delivery and menu posting will occur for 14 days, weekly audits for eight weeks, and monthly audits for three months. Completion date: **12/12/25**, with monitoring through **March 2026**.

B1910 – Plan of Correction

Plan of Correction:
The Executive Director and Health & Wellness Director immediately reviewed all memory care resident service agreements on 11/24/2025 and identified missing documentation of activity interests for all residents. Beginning 11/25/2025, the Life Enrichment Coordinator (LEC) will conduct individualized interest interviews with each memory care resident and/or their family/legal representative, document at least five meaningful interests per resident, and update the service agreement and activity plan accordingly. The LEC will revise the October activity calendar format to reflect individualized programming tied to documented interests rather than a generic weekly schedule and will begin implementing individualized and small-group programming no later than 12/05/2025. The Executive Director will educate the LEC and all activity staff on regulatory requirements for interest-based activity programming and documentation by 12/01/2025. To maintain compliance, the LEC will complete and document monthly resident interest reviews and update activities when resident needs or preferences change. The Executive Director will audit 100% of memory care activity plans weekly for four weeks, then biweekly for the next eight weeks, ensuring activities reflect documented interests and that calendars include individualized programming. Any missing or incomplete documentation will be corrected immediately and coaching provided. This monitoring plan will continue for 12 weeks to verify sustained compliance. Completion date: **12/12/25**, with monitoring through **March 2026**.

B1920 – Plan of Correction

Plan of Correction:
The Executive Director and Life Enrichment Coordinator (LEC) reviewed the October 2025 memory care activity calendar on 11/24/2025 and confirmed it did not reflect individualized interests or offer a variety of meaningful activities. Beginning 11/25/2025, the LEC will revise the memory care activity calendar format to ensure it reflects group and individualized programming, incorporates resident-specific interests identified through assessments, and eliminates routine care tasks (e.g., "Rise & Shine," mealtimes, ADLs) from activity listings. The revised calendar will include social, recreational, cognitive, sensory, and physical activities offered throughout each day, and will be posted monthly in accordance with regulation. The Executive Director will provide education to the LEC and all activity staff by 12/01/2025 on regulatory requirements for meaningful, interest-based

activity calendars and documentation standards. Effective 12/05/2025, the LEC will post the updated calendar monthly and ensure residents and families have access to it. To maintain compliance, the Executive Director will audit the activity calendar weekly for four weeks, then biweekly for eight weeks, verifying activities correspond to documented resident interests and are not duplicative of daily care tasks. Any gaps will be corrected immediately and additional staff coaching provided. Monitoring will continue for 12 weeks to ensure sustained compliance. Completion date: **12/12/25**, with monitoring through **March 2026**.

B1930 – Plan of Correction

The facility immediately revised the memory care activity schedule to ensure activities are available and implemented throughout the day, evening, and weekends in accordance with residents' assessed needs and interests. The Activity Director and Memory Care Coordinator updated each resident's activity profile, integrated individualized and meaningful activities into the daily and weekly calendars, and removed non-activity entries such as routine care tasks. All activity staff and caregivers were reeducated on their responsibility to initiate, lead, and document scheduled activities, including the evening Walking Club and weekend programming. The Daily Activity Implementation Log was reinstated for staff to record start time, participation, and resident engagement, and the Activity Director or designee will verify completion of scheduled activities twice daily for 14 days, conduct weekly calendar-to-implementation audits for eight weeks, and complete monthly reviews for three months to ensure sustained compliance. Completion date: 12/12/25, with monitoring through March 2026.

B2000 – Plan of Correction

The facility immediately secured all chemicals in locked cabinets in every kitchenette and resident-accessible area. All housekeeping, culinary, and caregiver staff were reeducated on the facility's Chemical Storage Guidelines and the requirement that all cleaning agents and hazardous products remain locked when not in direct staff use. The Housekeeping Supervisor implemented twice-daily environmental rounds to verify chemicals are locked, resident bathrooms are clean, and odors are addressed promptly. A Resident Bathroom Cleaning Log was implemented for daily documentation of toilet and hard-surface sanitation. The Environmental Services Manager will conduct weekly audits for eight weeks and monthly audits for three months to ensure sustained compliance with cleaning

frequency expectations and chemical safety requirements. Completion date: **12/12/25**, with monitoring through **March 2026**.

B2302 – Plan of Correction

The facility immediately assessed Resident #4's wound on 10/09/25 and ensured appropriate cleansing and application of the ordered dressing. All licensed nursing staff were reeducated on the "Skin and Nail Management" policy, including the requirement for **at least weekly wound evaluations** and documentation of wound progression in both the service plan and progress notes until healed. An audit tool was implemented for all residents with active wounds to verify that dressing changes, weekly evaluations, and provider/hospice communication are documented accurately. The nurse in charge will complete wound audits three times weekly for four weeks, weekly for eight weeks, and monthly for three months to ensure continued compliance. Any missed documentation or deviations from wound orders will be corrected immediately and addressed through staff coaching. Completion date: 12/12/25, with monitoring through March 2026.

B2305 – Plan of Correction

The facility immediately updated Resident #4's and Resident #9's care plans to include complete end-of-life care interventions, interdisciplinary involvement, and clearly defined roles of facility staff, hospice personnel, and other providers. All current residents receiving end-of-life services were reviewed to ensure their care plans identify how needs are met, list all end-of-life medications, and specify who is authorized to administer each medication. Nursing staff and care team members were reeducated on the requirements of 33-03-24.1-23, including the need for timely interdisciplinary care plan development and continuous updates when conditions change. A Coordination of Care form was implemented to document communication, care plan updates, medication lists, and role delineation for any resident enrolled in end-of-life services. The DON or designee will audit all residents receiving end-of-life care twice weekly for four weeks, weekly for eight weeks, and monthly for three months to ensure ongoing compliance and immediate correction of any deficiencies. Completion date: 12/12/25, with monitoring through March 2026.

B2404 – Plan of Correction

The facility immediately reeducated all nursing and medication-passing staff on resident rights related to privacy, dignity, and bodily autonomy, emphasizing that all insulin and

other injections must be administered in a private area rather than in communal dining spaces. Medication administration practices for Residents #1 and #6 were corrected at the time of the survey, and all staff were instructed to escort residents to a designated private location for injections unless the resident specifically requests an alternative that still maintains dignity. The Resident Rights Policy was reviewed and revised to include explicit guidance on maintaining privacy during medication administration in memory care. All caregivers, nurses, and medication passers received same-day reeducation on the requirements of 33-03-24.1-24, including bodily privacy, dignity, and appropriate use of shared areas. The DON or designee will conduct random observations of medication administration twice daily for 14 days, weekly for eight weeks, and monthly for three months to ensure continued compliance. Completion date: **12/12/25**, with monitoring through **March 2026**.

B2405 – Plan of Correction

The facility immediately reviewed Resident #9's record and updated the care plan to include a complete, person-centered behavioral profile identifying specific behaviors, triggers, interventions, and appropriate staff responses. All current residents with behavioral expressions were reviewed to confirm their service plans included individualized behavioral supports, approaches, and documentation consistent with the "Behavioral Expressions Management" and "Resident Service Plan" policies. Nursing staff, medication passers, and caregivers were reeducated on the requirement to develop and update behavior care plans promptly when new behaviors occur, and to document non-pharmacological and environmental interventions attempted prior to PRN medication use. A Behavioral Care Plan Audit Tool was implemented to ensure all residents with reported behaviors have up-to-date, person-centered service plans reflecting behaviors, associated interventions, and interdisciplinary input. The Health & Wellness Director or designee will audit behavior-related care plans twice weekly for four weeks, weekly for eight weeks, and monthly for three months to verify sustained compliance and immediate correction of any missing or outdated care plan content. Completion date: **12/12/25**, with monitoring through **March 2026**.

B2408 – Plan of Correction

The facility immediately reviewed all employee training records and confirmed that Employees #9, #10, and #11 had not completed the required minimum of four hours of annual dementia education. These staff were scheduled for and completed the missing

dementia training modules, and their files were updated accordingly. All other employee files were audited to ensure completion of the annual dementia training requirement, and any gaps identified were immediately addressed. The Caregiver job description and orientation checklist were updated to clearly outline the mandatory annual four-hour dementia training requirement in accordance with 33-03-24.1-24. All nursing, caregiving, and personal care staff were reeducated on the annual dementia training requirement and deadlines during a staff meeting held the week of the survey. To sustain compliance, the Executive Director or designee will complete monthly audits of training completion reports for three months, followed by quarterly audits to verify ongoing adherence, and the training system will auto-generate reminders 30 days prior to annual training due dates. Completion date: **12/12/25**, with monitoring through **March 2026**.

12-1-25