

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Golden Acres Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1 E Main St Carrington, ND 58421	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interviews, the facility failed to provide appropriate treatment and services to prevent the development of a pressure ulcer for 1 of 1 closed record (Resident #65) with pressure ulcers. Failure to ensure adequate monitoring and assessment by a provider resulted in the worsening of a facility acquired pressure ulcer. Findings Include: Review of the facility policy titled Pressure Injury Prevention and Management occurred on 07/29/26. The policy, dated 02/23/18 stated, . Golden Acres Manor shall establish and utilize a systematic approach for pressure injury prevention and management, starting with prompt assessment and treatment, including efforts to identify risk, stabilize, reduce or remove underlying risk factors, monitor the impact of the interventions, and modify the interventions as appropriate . Review of Resident #65's medical record occurred on 07/29/26. Diagnosis included chronic kidney disease, venous insufficiency, a pressure ulcer to the left heel, and a pressure ulcer to the sacral area. The current care plan, initiated on 03/12/26 and revised on 05/29/26, stated, Potential for impaired skin integrity related to: incontinence, impaired mobility . Prefers to lay on her back and not on her side. Unstageable pressure ulcer to left heel and to her sacrum area. Resident #65's physician's orders included the following: * 04/15/26 at 6:47 p.m., Unstageable pressure to sacrum. Cleanse with normal saline. Apply Santyl (helps to remove dead tissue) to wound bed followed by Polymer Wic (non-adhesive foam dressing that absorbs excess fluid) and Mepilex (foam dressing). Change twice weekly. * 04/30/26 at 2:51 p.m., Culture wound.* 04/30/26 at 4:38 p.m., Cleanse the wound with saline. Apply thin layer of Santyl, cover with Polymer Wic, followed by Mepilex twice a week.The progress notes identified the following:* 03/18/26 at 1:38 p.m., . Resident is dependent on staff for . toileting hygiene. She states she has no feeling when she needs to go to bathroom and is incontinent of bowel and bladder. * 03/24/26 at 8:26 a.m., . Sacral area has large red area that does blanch. Air mattress applied to her bed.* 03/30/26 at 4:44 p.m., Residents sacral area is blanchable with peeling red skin. Moderate amounts of drainage present to dressing.* 04/06/26 at 3:13 p.m., . Sacral area remains red but continues to blanch.* 04/15/26 at 2:50 p.m., . New skin Issue. Location: Sacrum. Laterality / Orientation: Middle. Pressure ulcer. new wound. Unstageable pressure ulcer . acquired in-house. Exact date: 04/15/2026. Length (cm) [centimeters]: 1 Width (cm): 1 Depth (cm): 0 Area (cm2) [centimeters squared] . 0% [percent]. Slough [dead tissue] 100%. Eschar [hardened dead tissues] 0%. Exudate [drainage] amount: None. Surrounding tissue: Erythema [skin redness]. Induration [hardening of soft tissue] < [less than] 2cm around wound. * 04/15/26 at 3:09 p.m., [physician name] here this morning and saw resident on rounds . No new orders received.* 04/16/26 at 4:09 p.m., Unstageable pressure ulcer to sacrum: Cleanse with area with normal saline. Apply thin layer of Sanyl [topical enzyme to remove dead or damaged tissue] to wound bed followed by small piece of Polymer cavity filler covered with a Mepilex every day shift every Mon [Monday], Thu (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0686 Level of Harm - Actual harm Residents Affected - Few	[Thursday] . Wound to sacrum has no signs of infection. Resident did c/o [complain of] pain to area.* 04/21/26 at 8:58 a.m., . Sacrum. Laterality . Middle . Pressure ulcer . Improving: overall wound characteristics improved. Unstageable ulcer due to slough and / or eschar. Wound acquired in-house . 04/15/2026. Did not measure as resident wanted assessment completed in EZ stand and could not tolerate that long. Slough is lessening and becoming thinner. Area is cleaner looking. Slough: 100%. Exudate amount: None. Surrounding tissue: Normal in color . * 04/28/26 at 1:47 p.m., . Location: Sacrum. Laterality . Middle . Pressure ulcer . wound characteristics deteriorated. Unstageable ulcer due to slough and / or eschar. Size has increased. Increased exudate. Painful. Sharp [pain]. Length (cm): 2.2 Width (cm): 2.3 Depth (cm): 0.1 . Slough: 40%. Eschar: 60%. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Surrounding tissue: Erythema . Fragile . Excoriated [skin that has been traumatized, red, and inflamed]. Induration > [greater than] 4 cm in any area around wound. Periwound [tissue surrounding a wound] temperature: Warm. Dressing saturation: Moderate 26-75%.* 04/28/26 at 2:05 p.m., Sacrum and right buttock wounds have both deteriorated since last week when they were healing nicely. Both areas now have drainage, redness surrounding wound, moderate drainage present to Polymer [dressing] when it was changed this morning, increase in size with black eschar present . Wound committee will re-evaluate again in the morning.The wound committee failed to evaluate the next day, 04/29/26. * 04/30/26 at 12:22 p.m., Wound committee into assess wounds. They are stable since noted deterioration on 4/28/26. [physician name] will be contacted to request a wound culture of sacral area due to increased drainage, increased slough and eschar since last week.* 04/30/26 at 12:34 p.m., .Sacrum. Laterality . Middle. Pressure ulcer . Deteriorating: wound characteristics deteriorated. Unstageable ulcer due to slough and / or eschar. Wound acquired in-house . 04/15/2026 . Increased exudate. Non-healing. Length (cm): 3.1 Width (cm): 2 Depth (cm): 0.1 . Slough: 100%. Eschar: 20%. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Surrounding tissue: Erythema. Dressing saturation: Moderate 26-75%. The wound committee assessed Resident #65 on 04/30/26 and determined the pressure ulcer as stable. The nurse's assessment at 12:34 p.m. on the same day contradicts the wound committee's assessment as stable. * 05/02/26 at 3:57 a.m., . Dressing was changed for soilage and break through drainage. Resident tolerated procedure well.* 05/02/26 at 3:16 p.m., . wound culture results . positive for Staphylococcus Aureus [bacteria]. Ciprofloxacin [antibiotic] 500mg [milligrams] PO [oral] BID [twice a day] x 5days. [physician name] would like for resident to be re-evaluated by [physician assistant name] during rounds on Monday 5/4/26.* 05/03/26 at 3:57 p.m., . Wound Infection (Sacrum) . small amount of serosanguineous [pink and watery] drainage was observed on the previous dressing. The wound bed contains area of necrotic [dead tissue] tissue. The site is tender upon palpation . * 05/04/26 at 5:33 a.m., . Wound Infection (Sacrum) . drainage with a foul odor. The wound bed area was reddened with dark tissue to the wound bed.* 05/04/26 at 9:34 a.m., . RT [restorative therapy] did place a different cushion in wheelchair.RT assessed Resident #65 for a new cushion approximately 19 days after the pressure ulcer was first noted. * 05/04/26 at 10:12 a.m., . Sacrum. Laterality . Middle. Size has increased. Smell increased. Painful . Pain description: Sharp. Length (cm): 2.1 Width (cm): 3.5 Depth (cm). Slough: 60%. Eschar: 40%. Exudate amount: Light. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Odor after cleansing: Moderate. Surrounding tissue: Excoriated. Erythema. Induration > [greater than] 4 cm in any area around wound. * 05/05/26 at 5:37 p.m., . Wound Infection (Sacrum) . Resident continues on Cipro BID for treatment of wound infection to sacrum. Old dressing removed with moderate amount of serosanguineous drainage noted . Aprox [approximately] 50% of wound bed is slough and 50% has (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	appearance of necrotic tissue that is tender with palpation.* 05/06/26 at 8:46 p.m., Wound Infection (Sacrum) . Previous dressing has a moderate amount of serosanguineous drainage with a foul odor. The wound bed area has some slough and necrotic tissue noted.* 05/10/26 at 9:53 a.m., . Wound Infection (Sacrum) . Wound has increased in size since last observed. Area is tender to touch.* 05/11/26 at 9:21 a.m., . Resident continues with unstageable pressure ulcer to sacral area with wound bed covered in slough/eschar. A New stage 2 pressure ulcer noted right below it that is a stage 2 with partial thickness skin loss with red/pink wound bed. Mepilex applied to the stage 2 pressure ulcer. She was added to [physician assistant] rounds this after [afternoon] for review due to continues [sic] worsening of wound. Antibiotics for wound infection was completed on 5/8/26. She continues to be at risks [sic] for ongoing pressure and delay in wound healing. See skin assessment for measurements. * 05/11/26 at 9:56 a.m., . Sacrum. Laterality . Middle. Pressure ulcer . Size has increased. New or satellite areas of breakdown. Length (cm): 4.3 Width (cm): 4.2 Depth (cm): 0.1 . * 05/11/26 at 10:00 a.m., . New skin Issue. Location: Right gluteus. Right upper buttock . Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis [middle layer of skin]. Wound acquired in-house. Wound is new. Pain description: Sharp. Length (cm): 2.8 Width (cm):1.5 Area (cm2) . Exudate type: None. Odor after cleansing: None. Surrounding tissue: Intact. Surrounding tissue: Erythema. Induration > 4 cm in any [sic] area around wound.* 05/12/26 at 2:33 p.m., . Resident was given convoluted [pressure relieving] cushion for W/C last week to try out for comfort. She stated it feels more comfortable where her wound is when sitting in W/C. A convoluted cushion will also be placed in her recliner, so she gets out of W/C during the day for more frequent repositioning.* 05/13/26 at 10:55 a.m., . Wound Infection (Sacrum) . Foul odor present when dressing changed this shift. Copious [large] amounts of drainage present to superior sacral dressing, Polymer completely saturated. Area cleansed with Vashe [wound cleanser], dressing applied as ordered.* 05/13/26 at 4:36 p.m., [physician] here this morning and saw resident on rounds . New orders received.* 05/14/26 at 6:08 p.m., Wound Infection (Sacrum) . new abx [antibiotic] started 5/13/26. Wound assessed and has some serosanguineous drainage with slough and necrotic tissue to upper portion of wound bed. Foul odor noted. No increased warmth but redness around red edges remains.* 05/16/26 at 4:51 a.m., . Wound Infection (Sacrum) . Wound beds not visible as they are covered with slough and black eschar. Moderate yellowish drainage noted on the dressing with no granulation tissue.* 05/18/26 at 9:26 a.m., . Right upper buttock . Stage 2 Pressure ulcer . partial thickness skin loss with exposed dermis. Wound acquired in-house. Wound is new. Reason measurements not documented as part of this assessment: Area has merged with the sacral ulcer . * 05/18/26 at 9:42 a.m., . Wound Infection (Sacrum) . Wound committee into [sic] assess wounds after whirlpool. Sacral and right upper buttock have merged into one large unstageable pressure ulcer. Area has rapidly deteriorated and has [sic] become larger and deeper. No complaints of pain during dressing change. Redness surrounds the wound but blanchable. Therapy placed a different cushion in wheelchair last week that [Resident #65] states is helping. [physician] ordered a second round of antibiotics last week with no improvement noted to wound bed. She continues with [sic] air mattress on bed . [physician] notified with request for wound clinic referral.* 05/18/26 at 10:40 a.m., Cushion provide [sic] behind the back in W/C due to ongoing wound.* 05/19/26 at 3:05 p.m., Dressing to sacral wound changed again at this time due to drainage and 4x4 Mepilex coming off. Sacral dressing placed along with entire sheet of the Polymer cavity filler. [Resident #65] reports her nurse had already changed her dressing late this morning. She has wound clinic appointment scheduled for Thursday. * 05/21/26 at 10:31 a.m., Wound Infection (Sacrum) . wound assessed edges of wound appear macerated, wound has slough necrotic tissue in upper portion/center of wound bed no drainage noted at this time. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Redness noted to be surrounding wound.* 05/21/26 Resident #65 left for the first scheduled appointment at the wound clinic. * 05/21/26 at 6:06 p.m., Received call from ER [emergency room] nurse at [hospital] as resident was sent to them from the wound clinic due to severity of her wound. Nurse reports that a CT [computed tomography] scan was done of the wound and it is in to [sic] the bone and the surgeon at [hospital] is making arrangements for [resident] [NAME] [sic] transferred via ambulance to [hospital] in Fargo.* 05/22/26 at 9:27 a.m., Call placed to [hospital] Fargo for a resident update. Nurse [name] reported she arrived on the trauma med surg [medical surgical] unit . with dx [diagnosis] of a sacral ulcer . She is currently being held as NPO [nothing by mouth] until they hear back from provider about a possible procedure.* 05/25/26 at 11:57 a.m., . Call placed to husband [name]. stated [resident] was transferred to Minneapolis to a hospital . regarding her bladder stimulator.* 05/29/26 at 10:00 a.m., Call placed to [hospital] for an update on this resident. Nurse [name] stated she is currently on IV [intravenous] antibiotics . The doctor is recommending 6 weeks of antibiotic therapy following removal of her bladder stimulator on 5/26/29.During an interview on 07/29/26 at 4:30 p.m., a nurse (#8) stated the facility was not aware of the bladder stimulator and the stimulator caused the pressure ulcer to the resident's sacrum. During an interview on 07/29/26 at 5:46 p.m., an administrative nurse (#1) stated because antibiotics were initiated on 05/02/26, the facility staff removed Resident #65 from the physician PA rounds on 05/04/26. The nurse (#1) also stated because Resident #65 was scheduled for routine rounds with the physician on 05/13/26, the facility removed the resident from the PA's rounds schedule on 05/11/26. During a phone interview on 07/30/26 at 10:42 a.m., a PA (#9) stated she sees residents on Mondays, sees any resident the physician did not see, and also sees residents with acute issues. The PA (#9) stated the facility provides a list of residents to be seen. The PA (#9) stated she expected facility staff to schedule an appointment with a provider for residents who have a decline or a significant change to a pressure ulcer. During an interview on 07/30/26 at 11:02 a.m., a nurse (#8) stated nursing staff adds a resident with concerns to the provider list or makes an appointment at the clinic. The nurse (#8) agreed Resident #65 should have been seen at the clinic for the documented decline the end of April. The facility failed to ensure a provider evaluated Resident #65's sacral ulcer between 04/15/26 and 05/13/26. (27 days) during which time the sacral ulcer worsened.		