

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  355059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/21/2025
NAME OF PROVIDER OR SUPPLIER  Missouri Slope		STREET ADDRESS, CITY, STATE, ZIP CODE  2425 Hillview Ave Bismarck, ND 58501	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review, review of the facility investigation, review of facility policy, and staff interview, the facility failed to ensure all alleged violations involving possible abuse and/or neglect were reported immediately to officials including the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #1) who sustained significant bruising to the left lower leg. Failure to immediately report alleged violations to the SSA placed Resident #1 and other residents at risk for possible abuse and/or neglect and further injury.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse occurred on 05/21/25. This policy, dated September 2024, stated, . Neglect: Failure to provide goods and services necessary to avoid physical harm . The [NAME] President of Resident Services, or his/her designee shall immediately (within 24 hours) report all allegations of staff resident abuse, neglect . to the Stote [sic] Survey and Certification Agency and will report the results of the investigation to the State Survey and Certification Agency within tive [sic] (5) working days of [sic] the incident.</p> <p>Review of Resident #1's medical record occurred on all days of survey. Diagnoses included atrial fibrillation and localized edema (swelling that occurs when fluid builds up in the body's tissues). Physician's orders, dated April 24-May 1, 2025, included aspirin (helps prevent blood clots from forming) 81 milligrams (mg) daily and enoxaparin (an anticoagulant) 70 mg every 12 hours for 25 days.</p> <p>Resident #1's care plan, dated 04/24/25, stated, . use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface .</p> <p>A progress note, dated 05/01/25, stated, 3:14 a.m., Resident requested PRN [as needed] pain medication r/t [related to] left leg pain. this nurse came to bedside for assessment and to discuss intervention options. Upon assessment it was noted that the LEFT Calf was with new localized onset edema, hot to the touch, pain rated by resident as 'the worst,' significant bruising was noted to interior left mid-calf to knee bend. MD [medical doctor] [was] contacted . and gave the order to send to ER [emergency room] by ambulance at this [sic] is the non-surgical leg with no previous known issues .</p> <p>A progress noted, dated 05/01/25 at 8:15 a.m., stated, Called [hospital], resident has been admitted . It was found that [the] resident has an active bleed in the left, lower extremity .</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Final Investigation Report, dated 05/05/25, stated, . Day CNA [certified nurse aide] on 04/30/25 indicates that the resident reported her leg got twisted the night before . CNA does not remember seeing any bruising to the left leg that day.</p> <p>During an interview on 05/21/25 at 4:30 p.m., an administrative nurse (#4) confirmed the facility failed to report this incident to the SSA.</p>		