STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wedgewood Manor	804 Main St W Cavalier, ND 58220

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46963 Based on review of the facility reported incident (FRI) investigation, review of facility policy, and staff interviews, the facility failed to immediately implement safeguards for all residents after suspected sexual abuse occurred for 1 of 1 sampled resident (Resident #1). Failure to immediately protect all residents from the potential of sexual abuse placed them at risk for mental and emotional distress, and/or physical injury. During the on-site FRI survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 10/07/24. The IJ was identified during an interview with three administrative staff members (#1, #2, and #5) and a staff nurse (#4) on 10/07/24 at approximately 9:55 p.m. The interview confirmed the results of a urinalysis sample, collected 09/30/24, from Resident #1, an [AGE] year old female who was not sexually active, contained non-motile sperm, confirmed by three laboratorians and a Medical Doctor (MD). The interview also confirmed the facility had not provided adequate protection from all potential perpetrators. This finding placed all residents at risk for mental and emotional distress, and/or physical injury. *10/08/24 at 11:08 a.m. The survey team notified the Chief Executive Officer and Director of Nursing (DON) of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. *10/08/24 at 2:30 p.m. The survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: - No additional male travelers will be utilized for staffing until investigation is completed. - In addition, all male staff on duty or scheduled, including non direct care staff, certified nurse aides (CNAs), and licensed staff will have a female staff member with them while in a resident's room. - All staff meeting held on 10/08/24 at 2:00 p.m. informed staff of the changes in procedures for care provided by male caregivers and reviewed the abuse and neglect policy. Staff not present at the meeting will read, review, and sign the information provided prior to their next shift. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*10/08/24 at 2:45 p.m. The survey team verified the implementation of the removal plan as of 10/08/24 and the IJ removal. The deficient practice remained at a G scope and severity following the removal of the immediate jeopardy. Findings include: Review of the facility policy titled Resident Abuse & Neglect occurred on 10/08/24. This policy, revised 06/23/21, stated, . No resident shall be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident . Abuse: is defined as the willful infliction of injury . with resulting physical harm, pain or mental anguish. It includes . sexual abuse . Sexual Abuse: is defined as non-consensual sexual contact of any type with a resident. Ongoing education on abuse will be offered no less that [sic] yearly. Should it be necessary, it will be offered more frequently. Investigation of Alleged Abuse . Any employee who sees or suspects abuse will report immediately to the charge nurse . The charge nurse will assure immediate safety and mental well-being of the resident; investigate the extent of harm to the resident; and provide facts through the investigation. The charge nurse will contact the DON . The . DON . will contact the Administrator . ND [North Dakota] Dept. [Department] of Health . Physician . Responsible Party . Police Department . No attempt is made to disturb the area in anyway. If it is an employee who is being suspected for abuse, the employee is informed and suspended while the investigation is conducted by the DON . Local authorities will direct further follow-up and investigations . Written Report Identify person sending report and/or contact person, facility sending report, all information listed above in initial report, describe measures taken to protect the resident during investigation, describe measures taken to prevent re-occurrence of the incident . Review of the facility's final investigation occurred on 10/07/24 and identified facility staff collected a urine specimen on 09/30/24 at 12:20 p.m. The description of the event stated, . CNA [#6] stated, I heard [Resident #1] screaming for help and I went into the room to help her. [Resident #1] was trying to get out of bed and stated she had to go pee. I assisted [Resident #1] to the bathroom . I remembered she needed her urine collected. I took the hat that was in the room and placed it on the toilet. After she did the sample into the hat, I finished washing her up and assisted her to the nurse's station. I informed the nurse of the sample, and she went in and got the sample. Nurse [#9] . states the hat was full of urine and sitting in the toilet. I grabbed a clean new specimen cup and poured urine into the cup. The urine was transferred to the lab, and I received a call from the lab stating the specimen cup was not labeled. Nurse [#9] . went to the lab and labeled the specimen with [Resident #1's] name. Nurse [#9] reports, I then got a call from Laboratorian [#7] at the lab requesting another specimen because they had concerns with the first specimen. Administrative staff [#2] . contacted Laboratorian [#7] at the lab and Laboratorian [#7] reported that sperm was found in the urine specimen. Administrative staff [#2] . contacted [Resident #1's] PCP [primary care provider] and the PCP requested [Resident #1] be brought to the clinic for further evaluation. CNA [#6] was removed from service at this time. During an interview on 10/07/24 at approximately 9:55 p.m., three administrative staff members (#1, #2, and #5) and a staff nurse (#4) confirmed they terminated the male CNA (#6) who assisted Resident #1 to the toilet but continued to allow other male staff members to provide personal cares to all residents in the facility by themselves except for Resident #1, who required two staff members present. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to ensure all residents were protected from sexual abuse. When the facility received notification of sperm identified in Resident #1's urine sample, the facility failed to implement measures to protect residents from sexual abuse by all potential male perpetrators and follow established policies and procedures.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46963 Based on review of the facility reported incident (FRI) investigation, review of facility policy, and staff interviews, the facility failed to report potential sexual abuse to law enforcement for 1 of 1 sampled resident (Resident #1) with cognitive impairment. Failure to report potential sexual abuse placed Resident #1 and all other residents at risk for possible abuse and/or injury. During the on-site survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 10/07/24. The IJ was identified during an interview with three administrative staff members (#1, #2, and #5) and a staff nurse (#4) on 10/07/24 at approximately 9:55 p.m. The interview confirmed the results of a urinalysis sample, collected 09/30/24, from Resident #1, an [AGE] year old female who was not sexually active, contained non-motile sperm, confirmed by three laboratorians and a Medical Doctor (MD). The interview confirmed the facility failed to notify law enforcement. These findings placed all residents in immediate danger for abuse, mental and emotional distress, and/or physical injury. *10/08/24 at 11:08 a.m. The survey team notified the Chief Executive Officer and Director of Nursing (DON) of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. *10/08/24 at 2:30 p.m. The survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: - Chief of Police notified via phone at 11:24 a.m. on 10/08/24 of potential sexual abuse of resident regarding potential improper contents of female urine specimen. - Facility will cooperate with reporting and investigation per law enforcement. - All staff meeting held on 10/08/24 at 2:00 p.m. informed staff of the changes in procedures for care provided by male caregivers and reviewed the abuse and neglect policy. Staff not present at the meeting will read, review, and sign the information provided prior to their next shift. *10/08/24 at 2:45 p.m. The survey team verified the implementation of the removal plan as of 10/08/24 and the IJ removal. The deficient practice remained at an E scope and severity following the removal of the immediate jeopardy. Findings include: Review of the facility policy titled Resident Abuse & Neglect occurred on 10/08/24. This policy, revised 06/23/21, stated, . Investigation of Alleged Abuse/Neglect . The . DON . will contact . the . Police Department . No attempt is made to disturb the area in anyway. Local authorities will direct further follow-up and investigations . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's final investigation occurred on 10/07/24. A progress note, dated 09/30/24, stated . An order from MD [#12] was obtained for a urinalysis Sunday night, 9/29. A urine sample was brought to the lab, without a name on it. Nurse [#9] . had poured the urine from the hat, to the collection cup, and forgot to place a label on it. The nurses' aide had gotten the urine from [Resident #1] . The urine sample showed bacteria, and sperm, which were non-motile, seen by all 4 personnel in the lab, and myself [MD #13]. During an interview on 10/07/24 at approximately 9:55 p.m., an administrative staff member (#5) confirmed the facility failed to notify law enforcement regarding the alleged sexual abuse.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46963 Based on review of the facility reported incident (FRI) investigation, review of facility policy, and staff interviews, the facility failed to conduct a thorough investigation of potential sexual abuse for all residents after suspected sexual abuse for 1 of 1 sampled resident (Resident #1). Failure to investigate alleged violations of sexual abuse and ensure all residents were protected during the investigation, placed Resident #1 and all other residents at risk for possible abuse, mental and emotional distress, and/or physical injury. During the on-site survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 10/07/24. The IJ was identified during an interview with three administrative staff members (#1, #2, and #5) and a staff nurse (#4) on 10/07/24 at approximately 9:55 p.m. following the submission of the final investigation report. The report contained the results of a urinalysis sample, collected 09/30/24, from Resident #1, an [AGE] year old female who was not sexually active. The urinalysis sample contained non-motile sperm, confirmed by three laboratorians and a Medical Doctor (MD). The interview confirmed the following: - Male facility staff members continued to provide cares to all residents, except Resident #1, - Male residents, visitors, and non-resident care staff members were not included in the facility's investigation, and - Education had not been provided by the facility to all staff regarding sexual abuse. The facility failed to thoroughly investigate an incident of potential sexual abuse for Resident #1 which placed all residents at risk for abuse, mental and emotional distress, and/or physical injury. *10/08/24 at 11:08 a.m. The survey team notified the Chief Executive Officer and Director of Nursing (DON) of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. *10/08/24 at 2:30 p.m. The survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: - During investigation all male staff will be accompanied by another female at all times during cares and behind closed doors. - A camera was placed in Resident #1's room on 09/28/24 and is stationed at the nurses station. - All staff meeting held on 10/08/24 at 2:00 p.m. informed staff of the changes in procedures for care provided by male caregivers and reviewed the abuse and neglect policy. Staff not present at the meeting will read, review, and sign the information provided prior to their next shift. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*10/08/24 at 2:45 p.m. The survey team verified the implementation of the removal plan as of 10/08/24 and the IJ removal. The deficient practice remained at an E scope and severity following the removal of the immediate jeopardy. Findings include: Review of the facility policy titled Resident Abuse & Neglect occurred on 10/08/24. This policy, revised 06/23/21, stated, . Investigation of Alleged Abuse/Neglect . Any employee who sees or suspects abuse will report immediately to the charge nurse . The charge nurse will assure immediate safety and mental well-being of the resident; investigate the extent of harm to the resident; and provide facts through the investigation. No attempt is made to disturb the area in anyway. The charge nurse will complete a variance report. The report will be reviewed by the DON and Administrator to determine the direction of the investigation, and to identify occurrences for patterns, and trends that constitute abuse. The investigation will include interviews with the resident reported to have been abused . anyone witnessing the abuse, the individual suspected of committing the abuse, or other pertinent persons. A report of the investigation is written, including summaries of all interviews, and any other investigation activities . When the investigation is finished, the investigator will meet with Administrator, and a decision shall be made regarding the validity of the reported abuse or need for further investigation. Local authorities will direct further follow-up and investigations as needed. Written Report Identify person sending report and/or contact person, facility sending report, all information listed above in initial report, describe measures taken to protect the resident during investigation, describe measures taken to prevent re-occurrence of the incident, include a written statement clearly identifying the result of the investigation and actions taken, include copies of written and signed statements of CNA, witness(es), and resident, include copies of any other documents, or pictures . resulting from investigation. Review of the facility's final investigation occurred on 10/07/24. A progress note, dated 09/30/24, stated . An order from MD [#12] was obtained for a urinalysis Sunday night, 9/29. A urine sample was brought to the lab, without a name on it. Nurse [#9] . had poured the urine from the hat, to the collection cup, and forgot to place a label on it. The nurses' aide had gotten the urine from [Resident #1] . The urine sample showed bacteria, and sperm, which were non-motile, seen by all 4 personnel in the lab, and myself [MD #13]. During an interview on 10/07/24 at approximately 9:55 p.m., three administrative staff members (#1, #2, and #5) and a staff nurse (#4) confirmed male direct care staff performed cares alone on all residents with the exception of Resident #1. The staff members confirmed the investigation failed to include wandering male residents. The facility lacked evidence of investigations of all potential perpetrators of sexual abuse and failed to protect all residents during the investigation.