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	05/16/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13101 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 5 of 12 sampled residents (#3, #10, #15, #28, and #30). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION J: FALLS The Long-Term Care Facility RAI Manual, revised October 2023, page J-37, states, . If this is not the first assessment . the review period is from the day after the ARD [assessment reference date] of the last MDS assessment to the ARD of the current assessment. Determine the number of falls that occurred since . prior assessment . and code the level of fall-related injury for each. - Review of Resident #30's medical record occurred all days of survey. The record identified a fall with injury (bruising) on 02/28/24 and falls without injury on 02/24/24, 03/18/24, and 03/23/24. Resident #30's annual MDS, dated [DATE], identified no falls since the previous assessment on 01/04/24. During an interview on 05/16/24 at 09:30 a.m., an administrative nurse (#1) agreed Resident #30's 04/04/24 MDS lacked documentation of his falls. SECTION P: RESTRAINTS AND ALARMS The Long-Term Care Facility RAI User's Manual, revised October 2023, pages P-9 through P-11, stated, An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected. Code 2, used daily: if the device was used daily during the look-back period [seven days]. Other alarm includes devices, such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms or seatbelt alarms. - Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], showed the facility coded other alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as other. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Record review for Resident #10 occurred on all days of survey. The quarterly MDS, dated [DATE], showed the facility coded other alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as other alarm during the MDS assessment. - Review of Resident #15's medical record occurred on all days of survey. The annual MDS, dated [DATE], showed the facility coded other alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as other during the look-back period. - Record review for Resident #28 occurred on all days of survey. The quarterly MDS, dated [DATE], showed the facility coded other alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as other alarm during the MDS assessment. 28398 - Review of Resident #30's medical record occurred all days of survey. The annual MDS, dated [DATE], showed the facility coded other alarm used daily. The record lacked evidence the resident used an alarm the RAI manual defined as other. During an interview on 05/16/24 at 09:49 a.m., an administrative nurse (#1) stated staff coded other alarm for the alarm triggered on an exit door when a resident with a wander guard got too close to the exit. The nurse (#1) agreed the exit alarm did not meet the definition of an other alarm. 47896

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13101 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 2 of 12 sampled residents (Resident #15 and #28). Failure to review and revise the care plan limited staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled [NAME] Manor Comprehensive Care Plans occurred on 05/16/24. This policy, dated 10/05/22, stated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment. 28398 - Observation throughout the survey showed Resident #15 with a wanderguard (roam alert device) on his leg and wheelchair frame and frequently wandering throughout the building. Review of Resident #15's medical record occurred on all days of survey. Diagnoses included dementia with behavior disturbance. Resident #15's Elopement Risk Assessment, dated 11/13/19, identified the resident at risk for elopement/wandering with interventions of personal safety alarms, frequent monitoring, music, personalization of room, staff aware of wander risk, and initiation of roam alert. Resident #15's nurses' notes included episodes of exit seeking and/or elopement on at least nine occasions from 01/27/24 to 05/16/24. The facility failed to update the care plan to include interventions to address wandering/elopement. During an interview on 05/16/24 at 10:06 a.m., an administrative nurse (#2) agreed Resident #15's care plan lacked interventions related to wandering/elopement. - Review of Resident #28's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], identified the resident received anticoagulant and diuretic medications, and failed to identify the resident was in isolation for an active infection. The current care plan identified the resident was in isolation related to a communicable disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to update Resident #28's care plan to include side effects and/or interventions related to anticoagulant and diuretic medications and failed to remove isolation after the resident recovered from the disease in December 2023.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 13101 1. Based on record review, facility policy review, and staff interview, the facility failed to follow professional standards of care regarding physician orders for 1 of 5 sampled residents (Resident #17) selected for medication review. Failure to follow professional standards and contact the physician when blood glucose levels are higher than the practitioner's parameter has the potential to prevent the provider from altering medications to control residents blood sugar and/or result in adverse events. Findings include: Review of the facility policy title Notification of Changes occurred on 05/16/24. This policy, dated 12/11/23, stated, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician . when there is a change requiring notification. Potential to require physician intervention. Circumstances that require a need to alter treatment. Record review for Resident #17 occurred on all days of survey. A physician's order, dated 04/09/24, stated, Accucheck [a test for blood sugar] - Obtain accucheck three times daily. Update physician if blood sugar is greater than 400 and if less than 70. Review of Resident #17's blood sugar levels from 05/01/24 to 05/15/24 showed the following: * 05/03/24 at 11:46 a.m. blood sugar 454 milligrams per deciliter (mg/dl) * 05/04/24 at 11:25 a.m. blood sugar 408 mg/dl * 05/04/24 at 4:39 p.m. blood sugar 501 mg/dl * 05/05/24 at 4:00 p.m. blood sugar 401 mg/dl * 05/07/24 at 12:00 p.m. blood sugar 412 mg/dl * 05/08/24 at 11:30 a.m. blood sugar 401 mg/dl * 05/08/24 at 4:38 p.m. blood sugar High * 05/11/24 at 5:04 p.m. blood sugar 430 mg/dl The medical record lacked documentation facility staff notified the provider of blood sugar results over 400 mg/dl. During an interview on the morning of 05/16/24, an administrative nurse (#1) identified the policy provided is the one the administrator expected nursing staff to follow regarding blood sugar levels outside the provider's parameters. 28398 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 4 sampled residents (Resident #30) who experienced a fall. Failure to perform neurological assessments following a fall with actual or suspected head injury may result in delayed identification and treatment of a resident's medical condition. Findings include: Review of the facility policy titled Neurochecks occurred on 05/16/24. This policy, dated 05/29/14, stated, Neurochecks will be initiated in case of actual or suspected head injury to assess changes in vitals, level of consciousness, pupil response and motor function to help identify any nervous system damage. Neurological flow sheet will be completed . The attached Neurological Flow Sheet identified the timeframe for staff to complete vital signs and neurological checks as follows: - q [every] 15 min [minutes] X [times] (1) hr [hour] - q 30 min X (1) hr - q 1 hr X (4) hr - q 2 hr X (4) hr - q 4 hr X (4) hr - q 8 hr X (8) hr - 3 days after occ. [occurrence] Review of Resident #30's medical record occurred on all days of survey. Diagnoses included dementia, other abnormalities of gait and mobility, and repeated falls. Resident #30's nurses' notes showed the following: * 02/28/24 at 8:12 p.m., Resident found on his back in his room. VS [vital signs] taken. Neuros [neurological checks] completed. States he did remember if he hit his head. On left upper buttock a red area had formed with a bruise starting . * 03/01/24 at 7:11 p.m., Resident is alert and orient to person. Able to follow commands. Neuros WNL [within normal limits]. Able to move all extremities. The record lacked documentation of the results of the initial [02/28/24] and subsequent neurological checks except the entry on 03/01/24 above. * 03/20/24 at 4:40 a.m., Fall notes 3/19/24 [03/18/24 per the incident report]: Resident was found in the bathroom of another resident. Suspected head trauma from position after fall. Resident also claims to have hit his head. The neurological flow sheet, started 03/18/24 at 8:30 p.m., identified staff failed to complete eight of the required neurological checks. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/24 at 10:05 a.m., an administrative nurse (#2) stated Resident #30's record lacked a neurological flow sheet for the resident's fall on 02/28/24. The nurse verified staff failed to complete all the required neurological checks for the resident's fall on 03/18/24.