

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Wedgewood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interviews, the facility failed to provide housekeeping services to maintain a safe, clean, comfortable and homelike environment for 3 of 3 sampled residents (Residents #11, #12, and #14's) and 1 of 1 commons area (Hall B) with circulating fans. Failure to ensure the residents' environment and equipment (fans) are kept clean and sanitary does not promote a homelike living environment. Findings include: Observations on 07/07/26 showed the following: * At 1:59 p.m., the grates of a black pedestal fan coated with dust and debris next to an oxygen concentrator in Resident #14's room. * At 4:42 p.m., the grates of table fan coated with dust and debris located in the common area of Hall B. Observations on all days of survey showed the following:* Resident #11's fan with visible dust debris. * Resident #12's fan grate coated with dust debris and hanging fuzz. On 07/08/26 at 3:05 p.m., a nurse (#5) placed nebulizer equipment directly in front of the blowing fan to air dry. During an interview on 07/09/26 at 10:30 a.m., a housekeeping staff (#7) stated the certified nurse aides and housekeeping staff were expected to identify dirty fans and inform maintenance staff for cleaning and confirmed the fans in Hall B common area and in residents' rooms needed cleaning.		

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, review of facility policy, and staff interviews, the facility failed to notify the resident's medical provider for 1 of 1 sampled resident (Resident #15) with high blood glucose readings. Failure to notify the provider of high blood glucose levels as ordered may result in adverse outcomes for the resident and delay in treatment. Findings include: Review of the facility policy titled Physician Notification occurred on 07/09/26. This policy, dated 05/29/24 stated, . The facility must timely notify the attending physician or practitioner on call of change in condition, lab results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per ordering physician's orders. Examples of timely Notification Orders: Blood glucose levels outside the individual resident parameters. Guidelines: . Immediate notifications . Document notification of result and condition . Review of Resident #15's medical record occurred on all days of survey and included a diagnosis of type 2 diabetes mellitus. A physician's order, dated 01/22/26 stated, Parameters for blood glucose-Call physician if BS [blood sugar] below 70 mg/dl [milligrams per deciliter] and above 400 mg/dl. Review of Resident #15's Blood Sugar Summary, dated April 10 - July 9, 2026, showed the following blood glucose readings: * 05/19/26 at 9:42 p.m. - 445.0 mg/dL * 06/12/26 at 4:45 p.m. - 412.0 mg/dL * 06/18/26 at 4:39 p.m. - 453.0 mg/dL The medical record lacked documentation the facility notified Resident #15's provider of the elevated blood glucose levels. During an interview on 07/09/26 at 11:30 a.m., an administrative nurse (#2) confirmed staff failed to notify the physician of Resident #15's high blood sugar levels on the above dates. During an interview on 07/09/26 at 11:46 a.m., an administrative nurse (#1) stated she expected staff to follow orders and notify the physician of Resident #15's high blood sugar levels.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 14 sampled residents (Resident #8). Failure to develop a comprehensive care plan that includes opioid medication use and pain may negatively impact the resident's quality of care. Findings include: Review of Resident #8's medical record occurred on all days of survey. Medications included hydrocodone-acetaminophen (an opioid) 5-325 milligrams (mg) every four hours as needed for pain and hydrocodone-acetaminophen 7.50-325 mg three times a day for pain. The admission Minimum Data Set (MDS) dated [DATE], identified Resident #8 received opioid medication, non-medication intervention for pain, and experienced pain almost constant during the assessment period. Resident #8's care plan lacked goals and interventions related to opioid use and pain. During an interview on 07/09/26 at 11:50 a.m., an administrative staff nurse (#1) confirmed staff failed to include opioid medication risks/side effects and interventions for pain management in Resident #8's care plan.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to utilize the assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #6) observed during a transfer. Failure to use a gait belt during transfers placed residents at risk for injuries and falls. Findings include: Review of the facility policy titled Use of Gait Belt occurred on 07/09/26. This policy, dated 03/16/23, stated, . Use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. Review of Resident #6's medical record occurred on all days of survey. The care plan, stated, Assist of 1 with transfers with gait belt, toileting, dressing, bathing, and personal hygiene. Observation on 07/08/26 at 9:35 a.m. showed a certified nurse aide (CNA) (#4) assisted Resident #6 to the bathroom without using a gait belt. During an interview on 07/08/26 at 10:11 a.m., Resident #6 stated, Therapy uses the gait belt when they are working with me, but the CNA's typically do not. During an interview on 07/09/26 at 11:47 a.m., an administrative nurse (#1) stated she expected staff to use a gait belt during transfers.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #11) receiving oxygen. Failure to administer oxygen according to the physician's order may result in complications and compromise the resident's respiratory status. Findings include: Review of the facility policy titled Oxygen Administration occurred on 07/09/26. This policy, dated March 2023, stated, . Oxygen is administered under orders of a physician . Equipment setting for the prescribed flow rates. Review of Resident #11's medical record occurred on all days of survey. Diagnoses included acute and chronic respiratory failure with hypoxia (inadequate oxygen reaching the body's tissues) and chronic obstructive pulmonary disease with acute exacerbation. A physician's order, dated 05/18/26, stated, Continuous oxygen via NC [nasal cannula] set at 3 LPM [liters per minute] in use. The current care plan stated, . observe for s/s [signs and symptoms] of sob [shortness of breath]. Oxygen at 3L/min via Nasal Cannula . Review of the nurse's progress notes from February 1 through July 7, 2026, identified 30 times Resident #11 complained of shortness of breath. Observations on all days of survey showed Resident #11's room oxygen concentrator setting at 2 LPM. During an interview on 07/09/26 at 8:35 a.m., Resident #11 stated the oxygen concentrator should be set at 3 LPM. During an interview on 07/09/26 at 8:47 a.m., a nurse (#5) confirmed the physician's order stated oxygen at 3 LPM. During an interview on 07/09/26 at 8:55 a.m., an administrative nurse (#1) stated she expected staff to administer oxygen at the rate ordered by the physician.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, record review, and staff interview, the facility failed to ensure the safety of equipment for 1 of 2 sampled resident (Resident #12) observed with a nebulizer machine. Failure to maintain equipment in safe operating conditions may result in equipment short circuiting, fires, and injuries to the residents or staff. Findings include: The facility was unable to provide a policy on equipment maintenance. Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, . I self-administer my nebulizer after set up by nurse .Observation on all days of survey showed the power cord to Resident #12's nebulizer machine damaged and the insulated conductor wires exposed.During an interview on 07/09/2026 at 11:16 a.m., an administrative nurse (#1) stated she expected all equipment to be in proper working order and immediately removed the nebulizer machine from Resident #12's room.		