| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355128 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Missouri Slope | 4916 N Washington St<br>Bismarck, ND 58503 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 4 of 21 sampled residents (Resident #50, #61, #139, #154) and 1 supplemental resident (Resident #30) observed during cares. Failure to practice infection control standards related to glove use, hand hygiene, catheter care, equipment disinfection, and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include:<br><br>Review of the facility policy titled Isolation, Standard Precautions, and Enhanced Barrier Precautions occurred on 05/14/26. This policy, revised December 2025, stated, . Perform hand hygiene with hand sanitizer or soap and water upon entering and leaving a resident's room . remove gloves after use, before touching noncontaminated items and environmental surfaces and environmental surfaces . Wash hands immediately after [glove] removal to avoid transfer of microorganisms . Linen should be bagged at the point of use. Enhanced Barrier Precautions . Use gowns and gloves for high contact direct cares including . device care . examples of devices include . feeding tubes .<br><br>Review of the facility policy titled Foley Catheter Care, Suprapubic Catheter Care, Drainage Bag, Leg Bag occurred on 05/14/26. This policy, revised in November 2025, stated, . Leg Bag Catheter System . Leg bags are attached directly to the catheter and are secured to the resident's leg with the Velcro straps. When drainage bag is emptied, care must be taken to avoid contamination of the spout. Keep drainage bag from touching the floor .<br><br>Review of the facility policy titled Hand Hygiene, Artificial Nails occurred on 05/14/26. This policy, revised August 2025, stated, . Indications for Hand Hygiene: . Before and after resident care. After removing gloves.<br><br>- Review of Resident #30's medical record occurred on all days of survey. The current care plan stated, . Resident has an indwelling medical device . Gown and gloves are used for high contact direct cares . including . device care . Resident is on Enhanced Barrier Precautions.<br><br>Observation on 05/11/26 at 12:07 p.m. showed an EBP sign on Resident #30's door. A nurse (#7) entered the room, performed hand hygiene, applied gloves, flushed the resident's feeding tube with water and reattached the enteral feeding tube to the pump. The nurse (#7) failed to apply a gown prior to high-contact resident cares.- Review of Resident #50's medical record occurred on all days of survey and identified recurrent UTIs and required a Foley catheter.<br><br>Observation on 05/11/26 at 12:40 p.m. showed Resident #50's urine collection bag slid along the floor as he drove his motorized wheelchair. Staff greeted the resident, but failed to secure the collection bag until the resident reached his room.During an interview on 05/14/26 at 9:46 a.m., an administrative staff member (#4) stated she expected staff to secure catheter bags to ensure the bag<br>(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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | does not come in contact with the floor.<br><br>- Observation on 05/11/26 at 11:39 a.m. showed two CNAs (#8 and #9) completed morning cares for Resident #61. The CNAs removed the soiled brief, the CNA (#8) washed the resident's perineal area, removed the soiled gloves and asked the CNA (#9) for a clean pair of gloves. Wearing soiled gloves, the CNA (#9) reached into a box of clean gloves, removed two gloves and handed them to the CNA (#8). Without performing hand hygiene, the CNA (#8) applied the new gloves, placed a barrier cream on the resident's abdominal folds and removed the soiled gloves. The CNAs (#8 and #9) completed the brief change, dressed the lower body, and transferred the resident into a wheelchair. The CNA (#8) failed to complete hand hygiene between glove changes. The CNA (#9) failed to remove the soiled gloves and complete hand hygiene prior to reaching into a clean box of gloves and failed to change the gloves after providing perineal cares and before assisting with other cares.<br><br>- Observation on 05/13/26 at 9:00 a.m. showed a CNA (#5) completed morning cares for Resident #61. The CNA (#5) used three separate washcloths to cleanse the abdominal fold and perineal areas and placed each soiled washcloth directly on the bedside table. Upon completion, the CNA (#5) placed the soiled washcloths into a linen bag, set a cup of ice water on the bedside table and positioned the bedside table in front of Resident #61. The CNA (#5) failed to place soiled washcloths directly in a linen bag and failed to disinfect the bedside table after use.<br><br>- Observation on 05/12/26 at 8:37 a.m. showed a CNA (#9) completed morning cares for Resident #139. The CNA (#9) cleansed the perineal area, placed the soiled washcloth on the bedside table, dried the excess water on the table with a paper towel, and moved the table next to the resident's bed. The CNA (#9) failed to place the soiled washcloths directly into a linen bag and failed to disinfect the soiled bedside table.<br><br>- Observation on 05/11/26 at 4:05 p.m. showed a CNA (#10) entered Resident #154's room, performed hand hygiene and applied gloves. The CNA removed the resident's soiled brief, completed perineal care, removed the soiled gloves, applied new gloves and placed a clean brief on Resident #154. The CNA (#10) changed gloves, placed the bedside table near the resident, collected the garbage and exited the room. The CNA (#10) failed to perform hand hygiene between glove changes and failed to remove soiled gloves and complete hand hygiene prior to exiting the resident's room.<br><br>During an interview on 05/13/26, an administrative staff member (#4) confirmed staff are expected to wear gowns in EBP rooms during close contact tasks, complete hand hygiene between glove changes and when moving from a dirty to a clean task, dispose of soiled laundry after use, and disinfect contaminated resident equipment. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, record review, review of facility policy and staff interview, the facility failed to ensure adequate assistance for 1 of 1 sampled resident (Resident #61) observed during a mechanical sit to stand lift transfer. Failure to secure the leg strap and the abdominal strap of the lift sling placed the resident at risk for falls.Findings include:Review of the facility policy titled Transfer/Locomotion occurred on 05/14/26. This policy, revised September 2025, stated, . Slings are to be placed according to proper procedure.Review of Resident #61's medical record occurred on all days of survey. Diagnosis included left sided weakness and paralysis, history of falling, unsteadiness on feet and abnormal posture. The current care plan stated, Transfers with PAL [Patient Assist Lift] with assist x 2. Per shared risk agreement, [Resident #61's name] can choose where he wants the hook strap length at and where the abdominal strap is located (prefers it above abdomen).Observation on 05/11/26 at 11:39 a.m. showed two certified nurse aides (CNAs) (#8 and #9) assisted Resident #61 to a sitting position on the edge of the bed, placed the lift sling under Resident #61's arms, and situated the mechanical lift in front of the resident. The CNA (#8) stated the resident did not want the abdominal strap buckled. Resident #61 held onto the lift with only the right hand. Without securing the abdominal strap buckle or securing the leg straps, the CNAs (#8 and #9) raised the resident to a standing position. The CNAs (#8 and #9) provided morning cares while Resident #61 stood connected to the sit to stand lift. The CNAs (#8 and #9) failed to secure the leg strap of the lift and failed to secure the abdominal strap buckle.During an interview on 05/13/26 at 1:45 p.m., an administrative nurse (#4) stated she expected staff to always buckle the abdominal safety straps on the sling and secure the leg straps on the PAL lift. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation and staff interview, the facility failed to ensure drugs and biologicals were stored securely for 1 of 35 sampled residents (Resident #24) and 1 supplemental resident (Resident #109) with medications at the bedside. Failure to securely store medications may result in unauthorized use, adverse reactions, or ineffective treatment. Findings include: - Observation on 05/11/26 at 10:45 a.m. showed a tube of a topical analgesic (pain relief cream) on Resident #24's bedside table. - Observation on 05/12/26 at 8:15 a.m. showed three Refresh Tears eye drop bottles and one Systane eye drop bottle on Resident #24's bedside table. During an interview on 05/14/26 at 7:49 a.m., an administrative staff member (#5) confirmed nursing staff were not aware of the medications in Resident #24's room.- Observation on 05/11/26 at 11:55 a.m. showed a box of Lidocaine patches (topical pain relief patches) and Genteal eyes drops (lubricating eye drops) at Resident #109's bedside.- Observation on 05/12/26 at 10:08 a.m. showed Lidocaine patches, Genteal eyes drops, generic psyllium husk powder (fiber supplement), and generic muscle rub cream (topical pain relief) at Resident 1#09's bedside. During an interview on 05/14/26 at 10:39 a.m., an administrative staff member (#3) confirmed nursing staff were not aware of the medications in Resident #109's room. |