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	8099	A. BUILDING: _____ B. WING _____	C 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MANDAN, LLC	2801 39TH AVE SE MANDAN, ND 58554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	INITIAL COMMENTS For the unannounced complaint survey, started on 02/19/26 and completed on 02/24/26, the sample included 2 residents for review. Tier II citations included B910, B925, B950, B1240, B1320, and B2403.	B 000	See attached.	
B 910	33-03-24.1-09,1 GOVERNING BODY 1. The governing body is legally responsible for the quality of resident services; for resident health, safety, and security; and to ensure the overall operation of the facility is in compliance with all applicable federal, state, and local laws. This State Licensing Rule is not met as evidenced by: 1. Based on information received from the complainant, record review, and staff interview, the facility failed to ensure the safety and security for 1 of 1 memory care resident (Resident #1) who left the facility with an unknown male. Failure to ensure the overall safety and security of residents jeopardizes the safety of all residents. Upon request, the facility failed to provide a policy regarding visitation/signing out residents in the memory care unit. Review of Resident #1's medical record occurred on 02/19/26 and identified diagnoses of dementia and major depressive disorder. A nursing progress note on 02/08/26 at 1:40 a.m. stated,	B 910		

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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B 910	Continued From page 1	B 910		

"Missing Resident Nurses Note - Staff notified me via phone call at 10:04 pm that resident had left around 5:10 pm with a man. The resident or man didn't speak to staff or say where they were going. Resident was not signed out. I notified GAPS [Guardian and Protective Services] and they were not aware of her leaving with anyone. [Name] from GAPS sent me residents son [name] number. I called [son name] and he did not know where resident was or that she was leaving. Notified residents friend [name] and she was also not aware of her being out with anyone. Friend [name] thought she could have gone with a male friend by the name of [male name]. Friend [name] does not know his last name or have a contact for him but thinks his phone number starts with a Montana area code. [Friend name] also sent me granddaughter [name] number to call. [Granddaughter's name] did not answer, left a voicemail to give me a call back. Code grey initiated. Had staff check residents room to see if phone number was wrote down anywhere. CSD [Clinical Service Director] and ED [Executive Director] contacted. RND [Regional Nursing Director] and RVP [Regional Vice President] notified. [Nurse name] and myself searched residents room and were able to find a number with a Montana area code. I called the number and it was [male name]. Asked [male name] if resident was with him and he said yes and that they were visiting her brother. Explained to [male name] she was not signed out and staff was not notified that resident had left. [Male name] apologized. Asked [male name] when [Resident #1] would be returning and he said tonight or in the morning. I let him know this needed to be approved by GAPS. I called GAPS and they would like him to bring [Resident #1] back to Edgewood. Called [male name] and said he would bring her back. Contacted GAPS, son

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B 910	Continued From page 2 [name], and friend [name] that resident was with [male name] and that he is bringing her back to Edgewood. [Male name] dropped resident off at the front doors and did not escort her in. . . ." During an interview on the morning of 02/19/26 an administrative staff member (#1) confirmed the resident's guardian, family, and staff did not know the man who escorted Resident #1 out of the memory care unit and the facility. The facility failed to ensure Resident #1's safety and security by allowing an unknown male to escort her out of the facility. 2. Based on review of the North Dakota Century Code (NDCC) Chapter (Ch.) 23-09.3 for Basic Care, and staff interviews, the facility failed to appropriately utilize 12 of 21 rooms (Room #302, #303, #304, #305, #307, #308, #309, #311, #312, #313, #316, and #318) licensed for basic care. Failure to utilize rooms for the licensed designated level of care is a violation of North Dakota law. Findings include: Review of the NDCC Ch. 23-09.3 for Basic Care 23-09.3.1 Definitions, stated, "'Basic care facility' means a residence . . . that provides room and board to five or more individuals . . . who, because of impaired capacity for independent living, require health, social, or personal care services, but do not require regular twenty-four-hour medical or nursing services and: . . . Is attached to a nursing home or assisted living facility and its staff are available to meet the needs of all residents and comply with state and federal regulations . . ."	B 910		

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B 910	Continued From page 3 On the morning of 02/19/26, an administrative staff member (#2) presented a list of residents residing in the Memory Care Unit. This list contained names and room numbers of 21 residents. All the rooms in Memory Care are licensed as basic care beds. Nine residents are identified as basic care residents (rooms #301A, #301B, #306A, #306B, #310A, #310B, #315, #317A and 317B). This staff member identified the remaining residents as assisted living residents (rooms #302, #303, #304, #305, #307, #308, #309, #311, #312, #313, #316, and #318). The facility failed to ensure beds licensed for basic care were occupied by basic care residents and not assisted living residents.	B 910		
B 925	33-03-24.1-09,2,e GOVERNING BODY e. Prohibition of resident abuse, neglect, and misappropriation of resident property, including investigation, reporting, and follow-up action. This State Licensing Rule is not met as evidenced by: Based on information received by the complainant, record review, review of facility policy, review of missing resident/elopement procedure, and staff interviews, the facility failed to ensure staff monitored 1 of 1 sampled resident (Resident #1) in the memory care unit. Failure of the facility to protect a resident from leaving the facility with an unknown male and implement immediate follow up interventions jeopardized Resident #1's safety and resulted in neglect.	B 925		

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B 925	Continued From page 4 Findings include: Review of the facility policy titled "Abuse Prevention, Intervention, Reporting and Investigation" occurred on 02/19/26. This policy, dated February of 2026, stated, . . . Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. . . ." A clinical services education form attached to this policy stated, . . . "Types of Abuse . . . Neglect . . . Definition . . . Not providing for an individuals needs . . . Examples . . . Lack of monitoring . . ." Review of the facility policy titled "Elopement Risk Prevention/Missing Resident" occurred on 02/19/26. This policy, dated February of 2026, stated, . . . When a resident is determined to be missing: a. The time that the resident is/was missing is noted. b. The staff members assigned to the unit where the resident resides verifies that the resident has not signed out. c. The staff notifies the Licensed Nurse and Executive Director. d. Staff members conduct a thorough search to locate the resident. If the resident is not located, proceed with the following: i. Staff members search the entire Community and grounds. . . ii. If the resident has not been found, the Executive Director or designee calls law enforcement and reports the resident missing. . . ." Review of the facility policy titled "Safety Checks" occurred on 02/19/26. This policy dated January 2023, stated, ". . .MC [Memory Care] residents will be checked at a minimum every two hours. These 'safety checks' should be documented in the electronic health record. This protocol is in place to ensure safety of residents. . . . Staff are	B 925		

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B 925	Continued From page 5 expected to make "visual" contact with a resident . . . Review of Resident #1's medical record occurred on 02/19/26 and included diagnoses of vascular dementia with mood disturbance and major depressive disorder. The record indicated Resident #1 has a guardian and therefore not legally able to make decisions for herself. A nursing progress notes dated, 02/08/26 at 1:40 a.m. stated, "Missing Resident Nurses Note - Staff notified me [Assistant Clinical Service Director] via phone call at 10:04 pm that resident had left around 5:10 pm with a man. The resident or man didn't speak to staff or say where they were going. Resident was not signed out. I notified GAPS [Guardian and Protective Services: the agency legally responsible for Resident #1] and they were not aware of her leaving with anyone. [Name] from GAPS sent me residents son [name] number. I called [son name] and he did not know where resident was or that she was leaving. Notified residents friend [name] and she was also not aware of her being out with anyone. Friend [name] thought she could have gone with a male friend by the name of [male name]. Friend [name] does not know his last name or have a contact for him but thinks his phone number starts with a Montana area code. [Friend name] also sent me granddaughter [name] number to call. [Granddaughter's name] did not answer, left a voicemail to give me a call back. Code grey [missing person] initiated. Had staff check residents room to see if phone number was wrote down anywhere. CSD [Clinical Service Director] and ED [Executive Director] contacted. RND [Regional Nursing Director] and RVP [Regional Vice President] notified. [Nurse name] and myself searched residents room and were able to find a number with a Montana area code. I called the	B 925		

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B 925	Continued From page 6	B 925		

number and it was [male name]. Asked [male name] if resident was with him and he said yes and that they were visiting her brother. Explained to [male name] she was not signed out and staff was not notified that resident had left. [Male name] apologized. Asked [male name] when [Resident #1] would be returning and he said tonight or in the morning. I let him know this needed to be approved by GAPS. I called GAPS and they would like him to bring [Resident #1] back to Edgewood. Called [male name] and said he would bring her back. Contacted GAPS, son [name], and friend [name] that resident was with [male name] and that he is bringing her back to Edgewood. [Male name] dropped resident off at the front doors and did not escort her in. Myself and [nurse name] escorted her back to her room. Asked resident where she went and she stated they were visiting a friend and playing cards. Resident then stated they were at her granddaughter [name]. While walking back to her room, resident asked if she lived here. Reminded resident she lives here and helped her to her room. . . ."

Review of the facility's "Missing Resident/Elopement Procedure" form (completed for this incident) identified the following timeline:
* 02/07/26:
8:15 p.m. Staff check the sign out book
11:08 p.m. Nurse notified Executive Director that resident is missing.
11:10 p.m. Nurse contacted Guardian and Protective Services
11:14 p.m. Code Gray called by Assistant Clinical Service Director
11:15 p.m. Assign staff to search every room and space in the facility.
11:15 p.m. Assign staff to begin searching the outside perimeter of building.

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If resident is not found during initial search, notify the police. (left blank)
11:15 p.m. When instructed by the Executive Director, notify the resident's representative and/or emergency contact.
11:18 p.m. Contact Regional Nursing Director and Regional Vice President
* 02/08/26 (after the resident returned):
12:30 a.m. Assess the resident's physical condition - call physician if appropriate
12:30 a.m. Notify family
12:30 a.m. Contact Regional Nursing Director and Regional Vice President

Review of the Resident's care plan identified the following:
Safety - resident is at risk to be abused - Resident of a memory care unit and considered a vulnerable adult.
Mental status: Resident has confusion
Safety check: Resident is on every two hour safety checks.

Review of the Saint Louis University Mental Status (SLUMS) exam, dated 01/12/26, identified a score of 8, indicating dementia.

Review of safety checks for 02/07/26 show staff documented safety checks completed at 6:21 p.m., 8:29 p.m. and 9:40 p.m. (Resident #1 out of the building at those times)

During interviews on the morning and afternoon of 02/19/26 an administrative staff member (#1) confirmed the resident's guardian, family, and staff did not know the man who escorted Resident #1 out of the memory care unit and facility. She stated security cameras showed an unknown male and Resident #1 left the memory care area at approximately 5:15 p.m. on 02/07/26

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B 925	Continued From page 8 and returned to the facility on 02/08/26 at 12:27 a.m. She confirmed staff did not contact the police and documented safety checks while the resident was out of the facility. A phone interview occurred on 02/23/26 at 2:07 p.m. with a staff member (#4). This staff member reported cleaning tables after supper on 02/07/26 and saw Resident #1 and a man leave the memory care area. She had not seen this man before. She saw him again the next day (02/08/26) around 1:00 p.m. in Resident #1's room holding hands and kissing her. The staff member (#4) stated staff alerted the nurse at this time and they were instructed Resident #1 and the male visitor could only visit in the commons area and could not leave the building.	B 925		
B 950	33-03-24.1-09,5 GOVERNING BODY 5. The governing body shall ensure sufficient trained and competent staff are employed to meet the residents' needs. Staff must be in the facility, awake and prepared to assist residents twenty-four hours a day. This State Licensing Rule is not met as evidenced by: Based on review of the Nurse Aid (NA) registry, and staff interviews, the facility failed to comply with North Dakota Administrative Code (NDAC) Chapter 33-43-01-08 "Nurse Aide Training, Competency Evaluation, and Registry," for 1 of 1 staff (Staff A) not on the NA registry. Failure to	B 950		

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B 950	Continued From page 9 ensure only qualified staff performed cares increases the risk for adverse consequences for residents. Findings include: The North Dakota Administrative Code (NDAC) Chapter 33-43-01-08 "Nurse Aide Training, Competency Evaluation, and Registry" stated, . . . "A record of successful completion of the competency evaluation for individuals seeking registration as a certified nurse aide, home health aide, or nurse aide must be included in the nurse aide registry within fourteen days of the date the individual was found to be competent." During an interview on the afternoon of 02/19/26 an administrative staff (#3) identified Staff A as a patient care assistant (PCA). Review of the NA registry occurred on 02/23/26 and showed Staff A not on the registry. During a phone interview on the morning of 02/23/26, an administrative staff (#1) confirmed a PCA is a NA. An email received on 02/23/26 from an administrative staff (#1) stated, "[Staff A] has not been registered as a nurse aide with the state as she just recently took on this role. She has completed her direct care orientation with her department. She transitioned from a dining aide to a PCA (nurse's aide) on 01/05/2026." Record review showed Staff A signed safety checks on 02/07/26 as completed in a resident record.	B 950		

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B1240	Continued From page 10	B1240		
B1240	33-03-24.1-12,4 RESIDENT ASSESSMENTS/CARE PLANS 4. The care plan must be updated as needed, but no less than quarterly. This State Licensing Rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current needs for 1 of 1 sampled resident (Resident #1) reviewed. Failure to revise the care plan limited staffs' ability to communicate care needs and ensure safety for the resident. Findings include: Review of Resident #1's medical record occurred on 02/19/26. Diagnoses included dementia and major depressive disorder. A nursing progress note on 02/08/26 at 1:40 a.m. stated, "Missing Resident Nurses Note - Staff notified me via phone call at 10:04 pm that resident had left around 5:10 pm with a man. The resident or man didn't speak to staff or say where they were going. Resident was not signed out. I notified GAPS [Guardian and Protective Services] and they were not aware of her leaving with anyone. . . ." Review of an email dated 02/09/26 from the facility to GAPS stated, ". . . Going forward, as we talked today, we posted pictures of what he looks like to staff. We posted/educated staff that she is not to be alone with him and not in her room with him. . . ." Observation in the nurses station showed two pictures of a male with notes informing staff of	B1240		

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B1240	Continued From page 11 visitor's name and cannot leave or be alone with Resident #1. Review of the resident's care plan failed to identify Resident #1 could not leave or be alone with this male visitor. During an interview on the morning of 02/19/26 an administrative staff member (#1) confirmed the resident's guardian, family, and staff did not know the man who escorted Resident #1 out of the memory care unit and the facility. During an interview on the afternoon of 02/19/26, an administrative staff member (#3) confirmed nursing staff failed to update Resident #1's care plan.	B1240		
B1320	33-03-24.1-13,2 RESIDENT RECORDS 2. Resident records must include: a. The resident's name, social security number, marital status, age, sex, previous address, religion, personal licensed health care practitioner, dentist, and designated representative or other responsible person. b. The licensed health care practitioner's orders and report of an examination of the resident's current health status. c. An admission note. d. A copy of an initial and current assessment and care plan. e. Documentation of resident observations by authorized staff.	B1320		

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B1320	Continued From page 12 f. Documentation of death, including cause and disposition of the resident's personal effects, money, or valuables deposited with the facility. g. A quarterly progress note documenting the resident's current health condition, level of functioning, activity involvement, nutritional status, psychosocial interactions, and needs. h. Documentation of review of prescribed diets. i. Transfer forms that are completed, signed, and sent with the resident when transferred to another facility. j. A medication administration record documenting medication administration consistent with applicable state laws, rules, and practice acts. k. Documentation of an annual medication regimen review. l. A written report of any funds kept at a resident's request. Such record shall show deposits to and withdrawals from the fund. m. Documentation of a fire drill walk-through within five days of admission. n. All agreements or contracts entered into between the facility and the resident or legal representative.	B1320		

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B1320	Continued From page 13 o. A discharge note. This State Licensing Rule is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a complete and accurate medical record for 1 of 1 sampled resident (Resident #1). Failure to accurately document safety checks has the potential to jeopardize the safety of all residents. Findings include: Review of the facility policy titled "Safety Checks" occurred on 02/19/26. This policy dated January 2023, stated, ". . .MC [Memory Care] residents will be checked at a minimum every two hours. These "safety checks" should be documented in the electronic health record. This protocol is in place to ensure safety of residents. . . . Staff are expected to make "visual" contact with a resident . . ." Review of Resident #1's medical record occurred on 02/19/26 and identified diagnoses of dementia and major depressive disorder. A nursing progress note on 02/08/26 at 1:40 a.m. stated, "Missing Resident Nurses Note - Staff notified me via phone call at 10:04 pm that resident had left around 5:10 pm with a man. . . ." Review of the safety checks documented on 02/07/26 showed staff completed safety checks at 6:21 p.m., 8:29 p.m., and 9:40 p.m. During an interview on the afternoon of 02/19/26 an administrative nurse (#1) confirmed Resident #1 left the building on 02/07/26 around 5:15 p.m. and returned on 02/08/26 at 12:27 a.m. and	B1320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8099	A. BUILDING: _____ B. WING _____	C 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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B1320	Continued From page 14 facility staff documented safety checks completed on three occasions while Resident #1 was out of the facility.	B1320		
B2403	33-03-24.1-24,3 Optional Alzheimer's, Demential, Special Mem The facility or unit licensed to provide specialized care and services to residents under this section shall provide: a. Care of residents with chronic moderate to severe memory loss or an individual who has significant emotional, behavioral, or cognitive impairments and needs services that may include independent living skills, support and training to promote and develop relationships, participate in the social life of the community, and develop behavioral skills as determined necessary based on assessment and care plan; b. Protective oversight and supervision in a structured environment that is staffed with sufficient personal care and intermittent licensed nursing staff to monitor, evaluate, and accommodate an individual's changing needs; c. Service in which assistance with activities of daily living and independent activities of daily living, therapeutic, social, and recreational programming is provided; and d. Care furnished in a way that fosters the maintenance or improvement, as appropriate, to promote independence of the resident. This State Licensing Rule is not met as evidenced by: Based on record review, review of facility's	B2403		

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B2403	Continued From page 15	B2403		

license, and staff interview, the facility failed to ensure specialized care and services included protection oversight and supervision for 1 of 1 sampled resident (Resident #1) in the memory care unit. Failure to ensure a memory care resident does not leave the facility with an unknown visitor has the potential to jeopardize all residents' safety.

Findings include:

Upon request, the facility failed to provide a policy regarding visitation/signing out residents in the memory care unit.

Review of the facility's license found this facility has opted to provide Alzheimer's, Dementia, or Special Memory Care services. The license application designated 22 beds under this specialized service. Resident #1 resides in this secured memory care unit.

Review of Resident #1's medical record occurred on 02/19/26 and included a diagnoses of vascular dementia with mood disturbance and major depressive disorder. The record indicated Resident #1 has a legal guardian. A nursing progress notes dated, 02/08/26 at 1:40 a.m. stated, "Missing Resident Nurses Note - Staff notified me [Assistant Clinical Director] via phone call at 10:04 pm that resident had left around 5:10 pm with a man. The resident or man didn't speak to staff or say where they were going. Resident was not signed out. I notified GAPS [Guardian and Protective Services] and they were not aware of her leaving with anyone. [Name] from GAPS sent me residents son [name] number. I called [son name] and he did not know where resident was or that she was leaving. Notified residents friend [name] and she was also not aware of her

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B2403	Continued From page 16	B2403		

being out with anyone. Friend [name] thought she could have gone with a male friend by the name of [male name]. Friend [name] does not know his last name or have a contact for him but thinks his phone number starts with a Montana area code. [Friend name] also sent me granddaughter [name] number to call. [Granddaughter's name] did not answer, left a voicemail to give me a call back. Code grey [missing resident] initiated. Had staff check residents room to see if phone number was wrote down anywhere. CSD [Clinical Service Director] and ED [Executive Director] contacted. RND [Regional Nursing Director] and RVP [Regional Vice President] notified. [Nurse name] and myself searched residents room and were able to find a number with a Montana area code. I called the number and it was [male name]. Asked [male name] if resident was with him and he said yes and that they were visiting her brother. Explained to [male name] she was not signed out and staff was not notified that resident had left. [Male name] apologized. Asked [male name] when [Resident #1] would be returning and he said tonight or in the morning. I let him know this needed to be approved by GAPS. I called GAPS and they would like him to bring [Resident #1] back to Edgewood. Called [male name] and said he would bring her back. Contacted GAPS, son [name], and friend [name] that resident was with [male name] and that he is bringing her back to Edgewood. [Male name] dropped resident off at the front doors and did not escort her in. Myself and [nurse name] escorted her back to her room. Asked resident where she went and she stated they were visiting a friend and playing cards. Resident then stated they were at her granddaughter [name]. While walking back to her room, resident asked if she lived here. Reminded resident she lived here and helped her to her room. . . ."

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B2403	Continued From page 17 During interviews on the morning and afternoon of 02/19/26 an administrative staff member (#1) confirmed the resident's guardian, family, and staff did not know the man who escorted Resident #1 out of the memory care unit and facility. She stated security cameras showed Resident #1 left the memory care area with an unknown male at approximately 5:15 p.m., (on 02/07/26) and returned to the facility at 12:27 a.m. (on 02/08/26) (over seven hours) and confirmed staff did not contact the police. This staff member also confirmed a nurse aid falsely documented safety checks completed when the resident was out of the facility. The facility staff failed to provide protective oversight and supervision for Resident #1, a memory care resident by allowing the resident to leave the locked memory care unit and facility with an unknown visitor. Refer to B910 and B925	B2403		

North Dakota Health and Human Services
Health Response & Licensure
1720 Burlington Dr, Suite A
Bismarck, ND 58504-7736

Kelly Beechie, Manager
Health Facilities Unit

Please see below for the Plan of Correction for Edgewood Mandan regarding the February 24, 2026, survey.

Plan of Correction (PoC)
Updated June 4, 2026

B910

Upon request, the facility failed to provide a policy regarding visitation/signing out residents in the memory care unit.

1. Visitation policy was developed and will be disseminated to all residents and families by May 22, 2026.
2. Resident education regarding visitation and signing in and out was completed on May 11, 2026, at resident council. Notes from resident council were distributed to all residents.
3. Staff education was provided regarding signing residents out of memory care including resident sign in/sign out sheets. Verbal training was completed on February 9, 2026, and it was again addressed at the all-staff meeting on February 24, 2026.
4. Executive Director will audit the sign-in/sign out sheets weekly for three months starting May 1, 2026.
5. Compliance date is May 25, 2026.

The facility failed to ensure resident's safety and security by allowing an unknown male to escort her out of the facility.

1. Community updated Resident #1 care plan to reflect guardian's request regarding specific visitors and who is allowed to take the resident out of the community. Staff to notify nursing/leadership team if there are any concerns regarding this. Resident care plan was updated with this information.
2. Community has received specific instructions and information regarding our memory care residents and who they can and cannot leave the community with. Resident care plans have been updated.
3. Staff education regarding visitor preferences and who resident can and cannot leave the community with was completed with staff verbally on February 9, 2026, and it was again addressed at the all-staff meeting on February 24, 2026.
4. Assistant Clinical Services Director will complete chart audits monthly for three months to ensure visitor preferences and restrictions are included in the care plan. Additionally, visitor preferences and restrictions will also be reviewed quarterly during care conferences with guardian/POA/family. Audits will begin on May 1, 2026.
5. Compliance date is May 1, 2026.

Memory Care unit: "The facility failed to ensure beds licensed for basic were occupied by basic care residents and not assisted living residents".

1. Rooms were used appropriately, and all residents residing in the MC unit are basic care residents. There was confusion between license type and payer source when discussed with surveyor.
2. Staff education on proper terminology related to the basic care license has been completed by Executive Director at the all staff meeting on February 24, 2026.
3. Staff education will be completed during new employee orientation and quarterly with the staff during the all-staff meetings by the Executive Director. The Executive Director will audit provide the education with staff weekly for 3 months, then quarterly.
4. Compliance date is May 1, 2026.

B925

"If the resident has not been found, the Executive Director or designee calls law enforcement and reports the resident missing."

1. RVP and RND conducted education with community director staff addressing the Elopement Risk/Missing Resident "Code Grey" policy on February 24, 2026.
2. Edgewood's Clinical Compliance Director provided education on elopement to all North Dakota executive directors on April 29, 2026.
3. Elopement drill was conducted on May 17, 2026. An after-action report has been reviewed with directors, and staff will be educated on findings at all-staff meeting on May 21, 2026.

4. Quarterly elopement drills will be conducted and are documented in TELS for review by the Edgewood corporate compliance team.
5. Compliance date is May 1, 2026.

"Review of safety checks for 02/07/2026 show staff documented safety checks completed at 6:21pm, 8:29pm, and 9:40pm. Resident was out of the building at those times."

1. Staff education regarding safety checks and false charting was completed at the all-staff meeting on February 24, 2026, at the all-staff meeting.
2. Ongoing staff education will be provided by a nurse bi-monthly at the 2:00pm shift change and the lead CNA/CMA will conduct the bi-monthly education at the 10:00pm shift change for three months. Rosters will be maintained of this education. Education will start in the two-week period beginning May 18, 2026.
3. Executive Director will audit the staff education sheets bi-monthly for three months starting the week of May 18, 2026.
4. Compliance date is May 18, 2026.

B950

"The facility failed to comply with "nurse aide training competency, evaluation, and registry."

1. All newly hired clinical services floor staff are added to a tracking spreadsheet at the time of hire. The spreadsheet is reviewed at the beginning of each month to ensure accuracy and ongoing compliance with certification requirements. This corrective action and monitoring process was completed and implemented on May 1, 2026.
2. New process will be implemented for all clinical services floor staff effective May 1, 2026. New hires will be required to obtain licensure through the ND Department of Health and Human Services upon completion of their ULP/new hire orientation.
3. All current staff members are registered with the ND Department of Health and Human Services Nurse Aide Registry.
4. RVP and RND conducted education with community director staff addressing the nurse aide registry on May 18, 2026.
5. Business Office Assistant will review the spreadsheet for new hires weekly for the next three months and will report any new hires to the ACSD to complete nurse's aide registration.
6. Compliance date is May 1, 2026.

B1240

The facility failed to review and revised the comprehensive care plan to reflect the resident's current needs."

1. The assistant clinical services director (ACSD) updated the resident care plans with any specific instructions and information regarding our memory care residents and who they can and cannot leave the community with.
2. Education regarding updating care plans was completed on February 9, 2026, by the RND. Assistant clinical services director attends monthly meetings with the RND as well.
3. ASCD/RN manager will complete chart audits monthly for three months to ensure visitor preferences and restrictions are included in the care plan. Visitors preferences and restrictions will aso be reviewed quarterly during care conference with guardian/POA/family. Audits will begin on May 1, 2026.
4. Compliance date is May 1, 2026.

B1320

"The facility failed to ensure a complete and accurate medical record. Failure to accurately document safety checks has potential to jeopardize the safety of all residents."

1. Staff education regarding safety checks and false charting was completed at the all-staff meeting on February 24, 2026, at the all-staff meeting.
2. Ongoing staff education will be provided by a nurse bi-monthly at the 2:00pm shift change and the lead CNA/CMA will conduct the bi-monthly education at the 10:00pm shift change for three months. Rosters will be maintained of this education. Education will start in the two-week period beginning May 18, 2026.
3. Executive Director will audit the staff education sheets bi-monthly for three months starting the week of May 18, 2026.
4. Compliance date is May 18, 2026.

B2403

"The facility failed to ensure specialized care and services included protection oversite and supervision in the memory care unit."

1. The assistant clinical services director (ACSD) updated the resident care plans with any specific instructions and information regarding our memory care residents and who they can and cannot leave the community with.
2. ACSD/RN manager will complete chart audits monthly for three months to ensure visitor preferences and restrictions are included in the care plan. Visitors preferences and restrictions will aso be reviewed quarterly during care conference with guardian/POA/family. Audits will begin on May 1, 2026.
3. Compliance date is May 1, 2026.

“Upon request, the facility failed to provide a policy regarding visitation/signing out residents in the memory care unit.”

1. Visitation policy was developed and will be disseminated to all residents and families by May 22, 2026.
2. Resident education regarding about visitation and signing in and out was completed on May 11, 2026, at resident council. Notes from resident council were distributed to all residents.
3. Staff education was provided regarding signing residents out of memory care including resident sign in/sign out sheets. Verbal training was completed on February 9, 2026, and it was again addressed at the all-staff meeting on February 24, 2026.
4. Executive Director will audit the sign-in/sign out sheets weekly for three months starting May 1, 2026.
5. Compliance date is May 25, 2026.

Please refer to plan of corrections for B910 and B925.