STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355128	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE	4916 N WASHINGTON ST , BISMARCK, North Dakota, 58503

(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) COMPLETION DATE
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 05/11/26 and concluded 05/14/26.	F0000		05/22/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F0880	Staff caring for Residents #30, #50, #61, #139, and #154 were re-educated on infection control standards related to glove use, hand hygiene, catheter care, equipment disinfection, and enhanced barrier precautions (EBP). All residents have the potential to be affected. Nursing staff received re-education on infection control standards related to glove use, hand hygiene, catheter care, equipment disinfection, and EBP on June 10, 2026. The Unit Directors, Charge Nurses, Lead CNA, and Mentor CNAs will be responsible to monitor/audit. The Infection Preventionist/QAPI Director and Vice President of Resident Services will compile QAPI data and monitor to ensure infection control standards related to glove use, hand hygiene, catheter care, equipment disinfection, and EBP are followed. The first quality assurance monitor will be completed on May 29, 2026. QAPI monitoring will be performed weekly for four weeks, monthly for three months, and then quarterly thereafter for one year. After that time, continuation of monitoring will be determined by facility performance. Monitoring will continue until performance demonstrates sustained compliance and discontinuation is approved by the QAPI committee and medical director. If concerns are identified, immediate action will be taken to re-educate staff. Monitoring results will be reviewed by the QAPI committee at each scheduled meeting.	06/10/2026

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 reverse for further 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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F0880 SS = E	Continued from page 1 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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: Review of the facility policy titled “Isolation,	F0880		06/10/2026

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F0880 SS = E	Continued from page 2 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 . . ." 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 . . ." 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. . . ." - 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. . . ." 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. 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	F0880		06/10/2026

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F0880 SS = E	Continued from page 3 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 does not come in contact with the floor. - 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. - 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. - 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. - 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	F0880		06/10/2026

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F0880 SS = E	Continued from page 4 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. 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.	F0880		06/10/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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	F0689	Staff caring for Residents #61 were re-educated on securing leg strap and abdominal strap of the PAL lift. All residents who use a PAL lift for transfers have the potential to be affected. Nursing staff received re-education on securing leg strap and abdominal strap on the PAL lift on June 10, 2026. The Unit Directors, Charge Nurses, Lead CNA, and Mentor CNAs will be responsible to monitor/audit. The Infection Preventionist/QAPI Director and Vice President of Resident Services will compile QAPI data and monitor to ensure leg strap and abdominal strap on the PAL lift are being secured. The first quality assurance monitor will be completed on May 29, 2026. QAPI monitoring will be performed weekly for four weeks, monthly for three months, and then quarterly thereafter for one year. After that time, continuation of monitoring will be determined by facility performance. Monitoring will continue until performance demonstrates sustained compliance and discontinuation is approved by the QAPI committee and medical director. If concerns are identified, immediate action will be taken to re-educate staff. Monitoring results will be reviewed by the QAPI committee at each scheduled meeting.	06/10/2026

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F0689 SS = D	Continued from page 5 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.	F0689		06/10/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F0761	Resident #24’s daughter was provided education on not storing medications at bedside and storing them per facility guidelines. Resident #109 was provided re-education on not keeping medications in her room and storing them per facility guidelines. Staff caring for Residents #24 and #109 were re-educated on ensuring medications are stored properly. All residents have the potential to be affected. Nursing staff received re-education on proper medication storage on June 10, 2026. The Unit Directors, Charge Nurses, Lead CNA, and Mentor CNAs will be responsible to monitor/audit. The Infection Preventionist/QAPI Director and Vice President of Resident Services will compile QAPI data and monitor to ensure medications are stored correctly. The first quality assurance monitor will be completed on May 29, 2026. QAPI monitoring will be performed weekly for four weeks, monthly for three months, and then quarterly thereafter for one year. After that time, continuation of monitoring will be determined by facility performance. Monitoring will continue until performance demonstrates sustained	06/10/2026

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F0761 SS = D	Continued from page 6 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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.	F0761	Continued from page 6 compliance and discontinuation is approved by the QAPI committee and medical director. If concerns are identified, immediate action will be taken to re-educate staff. Monitoring results will be reviewed by the QAPI committee at each scheduled meeting.	06/10/2026