STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	**1 E MAIN ST , CARRINGTON, North Dakota, 58421**

(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 and complaint survey started on 07/27/26 and concluded on 07/30/26. During the complaint investigation the facility was found noncompliant with regulatory requirements.	F0000		08/11/2026
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the facility reported incident (FRI) investigation, review of facility policy, and staff interviews, the facility failed to ensure residents remained free from abuse for 3 of 16 sampled residents (Resident #47, #56, and #57) who exhibited and/or were subjected to physical/verbal abuse. Failure to prevent resident-to-resident physical/verbal abuse resulted in hitting, emotional distress (crying), and fear. These actions placed all residents at risk for serious injury, pain, and mental/emotional harm. Findings include:	F0600	Immediate corrective action for residents involved included separating individuals immediately, close monitoring of the individuals, providing emotional support, and providing an option to relocate to a different wing. A medication review was also completed on resident #57. The facility has determined that all residents have the potential to be affected by this practice. the facility had recognized the need for additional staff in the evening hours related to increased behaviors due to sundowning. An additional staff member was assigned starting 5/1/26 to care for residents recognized to have these increased behaviors or for others that needed more individualized care. Education of the Golden Acres Manor Abuse and Neglect Policy was provided to facility and agency staff on 7/28/26 emphasizing types of abuse and reporting requirements. The policy was reviewed and updated on 8/17/26. A structured progress note type was added to PCC labeled "Resident-to-Resident altercation" to more readily identify resident-to-resident altercations in which a timelier review of the incident can occur. An online course on "Abuse, neglect and Exploitation: Mandatory Reporter" was assigned to all facility staff to be completed by 8/19/26. An additional course "Conducting Abuse and Neglect Investigations" was assigned to the facility nurses. Education was provided to direct care staff on 8/18/26 on the revised Abuse and Neglect Policy and how to use the new structured progress note. The Director of Nursing or designee will monitor progress notes daily X 4 weeks, weekly X 4, and monthly X 4, and quarterly X 2 to review	08/21/2026

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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F0600 SS = G	Continued from page 1 Review of the facility policy titled "Abuse and Neglect Policy and Procedure" occurred on 07/29/26. This undated policy stated, ". . . each resident has the right to be free from abuse, . . . Residents must not be subjected to abuse by anyone, including, but not limited to . . . other residents. . . ." Review of the initial FRI, dated 07/27/26, identified two nursing staff members (#2 and #3) witnessed a verbal altercation between Resident #56 and Resident #57 on 07/25/26. The staff members immediately intervened. -Review of Resident #56's medical record occurred on all days of survey. Diagnoses included borderline personality disorder, mild intellectual disabilities, Post-Traumatic Stress Disorder, major depressive disorder, and mood disorder. The current care plan stated, "Post Traumatic Stress Disorder. . . Goal: patient will acknowledge and feel that they are safe and cannot be harmed. . .. Interventions: acknowledge the resident's feelings and show understanding, monitor for avoidances of places, people, or situations. . . ." During an interview on 07/27/26 at 2:04 p.m., Resident #56 expressed fear for her life. During an interview on 07/27/26 at 6:19 p.m., Resident #56 verbalized fear of Resident #57 and stated she will not go to activities or places where Resident #57 is present. During an interview on 07/30/26 at 8:19 a.m., Resident #56's guardian stated the resident called to inform her of the incident on 07/26/26. The guardian indicated Resident #56 stated she was terrified to sleep, but did not mention the altercation later in the day. - Review of Resident #57's medical record occurred on all days of survey. Diagnoses included schizophrenia, psychosis, anxiety, Alzheimer's disease, bipolar disorder, and Post-Traumatic Stress Disorder. The current care plan stated, ". . . Mood and Behavior may vary. . . Current behaviors of swearing, yelling out, and interrupting staff. . . ."	F0600	Continued from page 1 documentation of investigations and follow-up. If non-compliance is found immediate re-education and further interventions will be implemented.	08/21/2026

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F0600 SS = G	Continued from page 2 A progress noted, dated 07/25/26 at 5:07 p.m., stated, "Resident [Resident #57] was ambulating near the nurses' station toward her room when she became verbally upset with another resident [Resident #56] after believing the resident [Resident #56] was talking about her. Resident [Resident #57] stated, '[profanity] you,' to the other resident. The other resident [Resident #56] responded with the same statement, after which the resident became increasingly agitated, walked toward the other resident, and stated, 'Do you want to [profanity] fight?' Writer immediately intervened by positioning self between both residents to prevent further escalation. Resident [Resident #57] was given clear verbal redirection, instructed to stop using inappropriate language and making threats, and directed to disengage from the interaction and return to her room. Resident initially complied and began walking away. As the resident [Resident #57] was walking toward her room, the other resident [Resident #56] stated to nursing staff that she believed the resident 'should be at the state hospital.' Upon hearing this comment, the resident turned and yelled, 'If I had a knife, I will cut your [profanity] throat.' Writer immediately redirected the resident again, instructed her to stop making threatening statements, and reinforced expectations for appropriate behavior. Resident [Resident #57] complied with redirection, continued to her room, and no further verbal or physical aggression was observed. Both residents were separated for the remainder of the shift and monitored closely to prevent further interaction. No physical contact or injuries occurred. Resident [Resident #57] remained in her room following the incident, and no additional behaviors were observed during the remainder of the shift. Continued monitoring and behavioral observation will be maintained." During an interview on 07/27/26 at 5:34 p.m., a nurse (#2) stated after the incident, staff redirected Resident #57, visited with Resident #56 and her guardian, completed daily monitoring for Resident #57, and informed the next shift about the incident. The nurse also stated she has not witnessed any altercations between Resident #57 and other residents. During an interview on 07/28/26 at 1:55 p.m., a nurse (#3) stated the incident occurred in the front lobby and Resident #57 thought Resident #56 was	F0600		08/21/2026

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F0600 SS = G	Continued from page 3 talking about her and Resident #56 cried for a few minutes after the incident. The nurse also stated Resident #57 has shown agitation in the past but not directed towards a specific resident. - Review of Resident #47 medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, anxiety, dementia with psychotic disturbance, and depression. The current care plan stated, ". . . Alteration in mood and behaviors . . . Tends to wander/follow other residents at times, may attempt to hold their hand at times. Likes to hang around . . . front lounge. Periods of increased restlessness, delusions . . . Redirect as able away from other residents if appears unwanted attention attempted. . . . When resident is anxious, take her for a walk outside . . . or 1:1 . . ." Resident #47's progress note, dated 06/22/26 at 1:58 p.m., stated, ". . . Resident was involved in a physical altercation with another resident. Writer observed both residents striking each other. Staff intervened immediately and separated the residents. Resident was assessed for injuries, no injuries was [sic] noted." During an interview on 07/29/26 at 5:30 p.m., an administrative staff member (#1) confirmed staff failed to recognize "two residents striking each other" as resident-to-resident physical abuse and failed to report the abuse in a timely manner.	F0600		08/21/2026
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to ensure that 1 of 1 sampled resident (Resident #1) with a non-pressure	F0684	Facility staff recognized the need for additional documentation on wounds on 7/21/26. Special requirements were added to the ETAR to capture additional documentation on resident #1 and other residents with skin concerns. All residents with wounds have the potential to be affected. The facility "Pressure Injury Prevention and Management" was reviewed and updated on 8/17/26 to include a weekly evaluation by a provider or wound care specialist as well as a weekly skin assessment on non-pressure and pressure wounds. These assessments will trigger under the User Defined Assessments. Orders were entered to complete these assessments as scheduled. Education was provided on 8/18/26 to nursing staff	08/21/2026

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F0684 SS = G	Continued from page 4 skin wound received treatment and care in accordance with professional standards of practice. Failure to perform regular wound monitoring and assessments and document the progression of a wound resulted in delayed healing and worsening of the wound. Findings include: Observation on 07/28/26 at 8:52 a.m. showed an open area on Resident #1's mid-back. Resident #1 stated, "They think it [the open area] is from the sling [ceiling lift sling]." During an interview on 07/30/26 at 10:42 a.m., Resident #1 stated she has had the open area for "about a month." Review of Resident #1's medical record occurred on all days of survey. Physician's orders included: *07/20/26, "Check placement of dressing to mid/lower back-change if off or strikethrough drainage noted, every day and night shift." *07/21/26, "Cleanse wound to mid/lower back with wound cleanser, pat dry. Apply xeroform [medical gauze used for wounds] dressing to wound bed and cover with gauze dressing and secure with Medi pore [brand of medical tape] tape on all 4 sides. Change 2x [times] /wk [week] on bath days (Tues [Tuesday]/Fri [Friday]) and as needed." Review of nursing progress notes identified the following: *06/30/26 at 1:08 p.m., "Open area to mid back has improved slightly since yesterday. Redness present in a linear line in the fold that has decreased since yesterday. Treatment changed to sacral Mepilex [brand of medical dressing] . . . " The medical record failed to contain documentation of a wound assessment on 06/29/26, despite the progress note referencing improvement "since yesterday." *07/20/26 at 10:26 a.m., "Wound committee in to assess wound to lower back. It has declined since committee last assessed. No drainage or odor present. Dressing was rolled up and not in correct position. Has two liner open areas. Left one measures 0.5 cm [centimeters] x 1.8 cm and the right one measures 1.8 cm x 4 cm. Complains of discomfort at dressing only. Area is difficult to keep a dressing on due to . . . constant moisture. Dressing applied to assist with friction as the skin	F0684	Continued from page 4 on the updated pressure Injury Prevention and Management Policy as well as the requirements of completing the weekly skin assessments on non-pressure and pressure injuries. They were also educated on the special requirements added to residents who have other skin concerns. The Director of Nursing or designee will audit residents with non-pressure and pressure wounds weekly X 4, monthly X 3, and quarterly X 3 to ensure these residents have a weekly wound assessment completed appropriately and are seen by a practitioner or wound care specialist weekly or more frequently if indicated. If non-compliance is found, immediate re-education and further interventions will be implemented.	08/21/2026

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F0684 SS = G	Continued from page 5 folds rub against each other. She has limited air circulation due to area." The medical record failed to show any further wound assessments or progress notes regarding Resident #1's back wound between 06/30 and 07/19/26 (19 days). On 07/20/26, the wound committee documented the wound had "declined since committee last assessed," despite the absence of documentation describing the wound's progression or ongoing assessments. During an interview on 07/30/26 at 11:33 a.m., an administrative nurse (#10) state she expected staff to document the wound status during dressing changes. The nurse (#10) confirmed the medical record lacked documentation of assessments and monitoring of Resident #1's wound, and the facility began to document the wound condition on 07/21/26 on the Treatment Administration Record (TAR). The facility failed to perform and document regular wound monitoring and assessments from 06/30/26 through 07/19/26.	F0684		08/21/2026
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interviews, the facility failed to provide appropriate treatment and services to prevent the	F0686	No immediate corrective action was taken for resident #65 as they are no longer a resident at the facility. All residents with pressure injuries have the potential to be affected by this practice. Resident identified as having a pressure injury were seen by a practitioner on 8/10/26. The Pressure Injury and Prevention Policy was reviewed and updated on 8/16/26 to include weekly evaluations by a provider or a skin and wound specialist for those diagnosed with pressure injuries. Education was provided on 8/18/26 to nurses on the updated policies "Pressure Injury and Prevention" and "Notification of Change". The Director of Nursing or designee will complete audits on all residents diagnosed to have pressure injuries to ensure that weekly visits are being completed by a health care provider or skin and wound specialist. This will be done weekly X 4 weeks, monthly X 3, and quarterly x 3. Monitoring and further interventions will be put into place if evidence that further education or interventions are	08/21/2026

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F0686 SS = G	Continued from page 6 development of a pressure ulcer for 1 of 1 closed record (Resident #65) with pressure ulcers. Failure to ensure adequate monitoring and assessment by a provider resulted in the worsening of a facility acquired pressure ulcer. Findings Include: Review of the facility policy titled "Pressure Injury Prevention and Management" occurred on 07/29/26. The policy, dated 02/23/18 stated, ". . . Golden Acres Manor shall establish and utilize a systematic approach for pressure injury prevention and management, starting with prompt assessment and treatment, including efforts to identify risk, stabilize, reduce or remove underlying risk factors, monitor the impact of the interventions, and modify the interventions as appropriate . . ." Review of Resident #65's medical record occurred on 07/29/26. Diagnosis included chronic kidney disease, venous insufficiency, a pressure ulcer to the left heel, and a pressure ulcer to the sacral area. The current care plan, initiated on 03/12/26 and revised on 05/29/26, stated, "Potential for impaired skin integrity related to: incontinence, impaired mobility . . . Prefers to lay on her back and not on her side. Unstageable pressure ulcer to left heel and to her sacrum area. . . ." Resident #65's physician's orders included the following: * 04/15/26 at 6:47 p.m., Unstageable pressure to sacrum. Cleanse with normal saline. Apply Santyl (helps to remove dead tissue) to wound bed followed by Polymer Wic (non-adhesive foam dressing that absorbs excess fluid) and Mepilex (foam dressing). Change twice weekly. * 04/30/26 at 2:51 p.m., Culture wound. * 04/30/26 at 4:38 p.m., Cleanse the wound with saline. Apply thin layer of Santyl, cover with Polymer Wic, followed by Mepilex twice a week. The progress notes identified the following: * 03/18/26 at 1:38 p.m., ". . . Resident is dependent on staff for . . . toileting hygiene. She states she has no feeling when she needs to go to bathroom and is incontinent of bowel and bladder. . . . "	F0686	Continued from page 6 needed.	08/21/2026

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F0686 SS = G	Continued from page 7 * 03/24/26 at 8:26 a.m., ". . . Sacral area has large red area that does blanche. . . . Air mattress applied to her bed. . . ." * 03/30/26 at 4:44 p.m., "Residents sacral area is blanchable with peeling red skin. Moderate amounts of drainage present to dressing." * 04/06/26 at 3:13 p.m., ". . . Sacral area remains red but continues to blanch. . ." * 04/15/26 at 2:50 p.m., ". . . New skin Issue. Location: Sacrum. Laterality / Orientation: Middle. . . . Pressure ulcer. . . . new wound. . . . Unstageable pressure ulcer . . . acquired in-house. Exact date: 04/15/2026. . . . Length (cm) [centimeters]: 1 Width (cm): 1 Depth (cm): 0 Area (cm2) [centimeters squared] . . . 0% [percent]. Slough [dead tissue] 100%. Eschar [hardened dead tissues] 0%. Exudate [drainage] amount: None. . . . Surrounding tissue: Erythema [skin redness]. . . . Induration [hardening of soft tissue] < [less than] 2cm around wound. . . . " * 04/15/26 at 3:09 p.m., "[physician name] here this morning and saw resident on rounds . . . No new orders received. * 04/16/26 at 4:09 p.m., "Unstageable pressure ulcer to sacrum: Cleanse with area with normal saline. Apply thin layer of Sanyl [topical enzyme to remove dead or damaged tissue] to wound bed followed by small piece of Polymer cavity filler covered with a Mepilex every day shift every Mon [Monday], Thu [Thursday] . . . Wound to sacrum has no signs of infection. Resident did c/o [complain of] pain to area. . . ." * 04/21/26 at 8:58 a.m., ". . . Sacrum. Laterality . . . Middle . . . Pressure ulcer . . . Improving: overall wound characteristics improved. . . . Unstageable ulcer due to slough and / or eschar. Wound acquired in-house . . . 04/15/2026. . . . Did not measure as resident wanted assessment completed in EZ stand and could not tolerate that long. Slough is lessening and becoming thinner. Area is cleaner looking. . . . Slough: 100%. Exudate amount: None. . . . Surrounding tissue: Normal in color . . . " * 04/28/26 at 1:47 p.m., " . . . Location: Sacrum. Laterality . . . Middle.. . . Pressure ulcer . . . wound characteristics deteriorated. . . . Unstageable ulcer due to slough and / or eschar. . . . . Size has increased. . . . Increased exudate. Painful. . . . Sharp [pain]. . . . Length (cm): 2.2 Width (cm): 2.3 Depth (cm): 0.1 . . . Slough: 40%. Eschar: 60%. Exudate amount: Moderate. Seropurulent: mixture of	F0686		08/21/2026

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F0686 SS = G	Continued from page 8 purulent and serous, usually watery, yellow, green, tan or brown. . . . Surrounding tissue: Erythema . . . Fragile . . . Excoriated [skin that has been traumatized, red, and inflamed]. Induration > [greater than] 4 cm in any area around wound. . . . Periwound [tissue surrounding a wound] temperature: Warm. . . . Dressing saturation: Moderate 26-75%. . . ." * 04/28/26 at 2:05 p.m., "Sacrum and right buttock wounds have both deteriorated since last week when they were healing nicely. Both areas now have drainage, redness surrounding wound, moderate drainage present to Polymer [dressing] when it was changed this morning, increase in size with black eschar present . . . Wound committee will re-evaluate again in the morning." The wound committee failed to evaluate the next day, 04/29/26. * 04/30/26 at 12:22 p.m., "Wound committee into assess wounds. They are stable since noted deterioration on 4/28/26. . . . [physician name] will be contacted to request a wound culture of sacral area due to increased drainage, increased slough and eschar since last week. . . ." * 04/30/26 at 12:34 p.m., ". . .Sacrum. Laterality . . . Middle. . . . Pressure ulcer . . . Deteriorating: wound characteristics deteriorated. . . . Unstageable ulcer due to slough and / or eschar. Wound acquired in-house . . . 04/15/2026 . . . Increased exudate. . . . Non-healing. . . . Length (cm): 3.1 Width (cm): 2 Depth (cm): 0.1 . . . Slough: 100%. Eschar: 20%. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. . . . Surrounding tissue: Erythema. . . . Dressing saturation: Moderate 26-75%. . . . " The wound committee assessed Resident #65 on 04/30/26 and determined the pressure ulcer as "stable". The nurse's assessment at 12:34 p.m. on the same day contradicts the wound committee's assessment as stable. * 05/02/26 at 3:57 a.m., ". . . Dressing was changed for soilage and break through drainage. Resident tolerated procedure well." * 05/02/26 at 3:16 p.m., ". . . wound culture results . . . positive for Staphylococcus Aureus [bacteria]. . . . Ciprofloxacin [antibiotic] 500mg [milligrams] PO [oral] BID [twice a day] x 5days. . . . [physician name] would like for resident to be re-evaluated by	F0686		08/21/2026

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F0686 SS = G	Continued from page 9 [physician assistant name] during rounds on Monday 5/4/26." * 05/03/26 at 3:57 p.m., ". . . Wound Infection (Sacrum) . . . small amount of serosanguineous [pink and watery] drainage was observed on the previous dressing. The wound bed contains area of necrotic [dead tissue] tissue. The site is tender upon palpation . . ." * 05/04/26 at 5:33 a.m., ". . . Wound Infection (Sacrum) . . . drainage with a foul odor. The wound bed area was reddened with dark tissue to the wound bed. * 05/04/26 at 9:34 a.m., ". . . RT [restorative therapy] did place a different cushion in wheelchair." RT assessed Resident #65 for a new cushion approximately 19 days after the pressure ulcer was first noted. * 05/04/26 at 10:12 a.m., ". . . Sacrum. Laterality . . . Middle. . . . Size has increased. . . . Smell increased. Painful . . . Pain description: Sharp. . . . Length (cm): 2.1 Width (cm): 3.5 Depth (cm). . . . Slough: 60%. Eschar: 40%. Exudate amount: Light. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Odor after cleansing: Moderate. . . . Surrounding tissue: Excoriated. . . . Erythema. . . . Induration > [greater than] 4 cm in any area around wound. . . . " * 05/05/26 at 5:37 p.m., ". . . Wound Infection (Sacrum) . . . Resident continues on Cipro BID for treatment of wound infection to sacrum. Old dressing removed with moderate amount of serosanguineous drainage noted . . . Aprox [approximately] 50% of wound bed is slough and 50% has appearance of necrotic tissue that is tender with palpation. . . ." * 05/06/26 at 8:46 p.m., "Wound Infection (Sacrum) . . . Previous dressing has a moderate amount of serosanguineous drainage with a foul odor. The wound bed area has some slough and necrotic tissue noted. . . ." * 05/10/26 at 9:53 a.m., ". . . Wound Infection (Sacrum) . . . Wound has increased in size since last observed. Area is tender to touch. . . ." * 05/11/26 at 9:21 a.m., ". . . Resident continues with unstageable pressure ulcer to sacral area with wound bed covered in slough/eschar. A New stage 2 pressure ulcer noted right below it that is a stage	F0686		08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026

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F0686 SS = G	Continued from page 10 2 with partial thickness skin loss with red/pink wound bed. . . . Mepilex applied to the stage 2 pressure ulcer. She was added to [physician assistant] rounds this after [afternoon] for review due to continues [sic] worsening of wound. Antibiotics for wound infection was completed on 5/8/26. . . . She continues to be at risks [sic] for ongoing pressure and delay in wound healing. See skin assessment for measurements. . . . " * 05/11/26 at 9:56 a.m., ". . . Sacrum. Laterality . . . Middle. . . . Pressure ulcer . . . Size has increased. . . . New or satellite areas of breakdown. . . . Length (cm): 4.3 Width (cm): 4.2 Depth (cm): 0.1 . . . " * 05/11/26 at 10:00 a.m., ". . . New skin Issue. Location: Right gluteus. . . . Right upper buttock . . . Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis [middle layer of skin]. Wound acquired in-house. Wound is new. . . . Pain description: Sharp. . . . Length (cm): 2.8 Width (cm):1.5 Area (cm2) . . . Exudate type: None. Odor after cleansing: None. . . . Surrounding tissue: Intact. Surrounding tissue: Erythema. . . . Induration > 4 cm inany [sic] area around wound. . . ." * 05/12/26 at 2:33 p.m., ". . . Resident was given convoluted [pressure relieving] cushion for W/C last week to try out for comfort. She stated it feels more comfortable where her wound is when sitting in W/C. . . . A convoluted cushion will also be placed in her recliner, so she gets out of W/C during the day for more frequent repositioning." * 05/13/26 at 10:55 a.m., ". . . Wound Infection (Sacrum) . . . Foul odor present when dressing changed this shift. Copious [large] amounts of drainage present to superior sacral dressing, Polymer completely saturated. Area cleansed with Vashe [wound cleanser], dressing applied as ordered. . . ." * 05/13/26 at 4:36 p.m., "[physician] here this morning and saw resident on rounds . . . New orders received." * 05/14/26 at 6:08 p.m., "Wound Infection (Sacrum) . . . new abx [antibiotic] started 5/13/26. Wound assessed and has some serosanguineous drainage with slough and necrotic tissue to upper portion of wound bed. Foul odor noted. No increased warmth but redness around red edges remains. * 05/16/26 at 4:51 a.m., ". . . Wound Infection (Sacrum) . . . Wound beds not visible as they are covered with slough and black eschar. Moderate	F0686		08/21/2026

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F0686 SS = G	Continued from page 11 yellowish drainage noted on the dressing with no granulation tissue. . . ." * 05/18/26 at 9:26 a.m., ". . . Right upper buttock . . . Stage 2 Pressure ulcer . . . partial thickness skin loss with exposed dermis. Wound acquired in-house. Wound is new. . . . Reason measurements not documented as part of this assessment: Area has merged with the sacral ulcer . . ." * 05/18/26 at 9:42 a.m., ". . . Wound Infection (Sacrum) . . . Wound committee into [sic] assess wounds after whirlpool. Sacral and right upper buttock have merged into one large unstageable pressure ulcer. Area has rapidly deteriorated andhas [sic] become larger and deeper. No complaints of pain during dressing change. Redness surrounds the wound but blanchable. Therapy placed a different cushion in wheelchair last week that [Resident #65] states is helping. . . . [physician] ordered a second round of antibiotics last week with no improvement noted to wound bed. She continues withan [sic] air mattress on bed . . . [physician] notified with request for wound clinic referral. . . ." * 05/18/26 at 10:40 a.m., "Cushion provide [sic] behind the back in W/C due to ongoing wound." * 05/19/26 at 3:05 p.m., "Dressing to sacral wound changed again at this time due to drainage and 4x4 Mepilex coming off. Sacral dressing placed along with entire sheet of the Polymer cavity filler. [Resident #65] reports her nurse had already changed her dressing late this morning. She has wound clinic appointment scheduled for Thursday. . . . " * 05/21/26 at 10:31 a.m., "Wound Infection (Sacrum) . . . wound assessed edges of wound appear macerated, wound has slough necrotic tissue in upper portion/center of wound bed no drainage noted at this time. Redness noted to be surrounding wound." * 05/21/26 Resident #65 left for the first scheduled appointment at the wound clinic. * 05/21/26 at 6:06 p.m., "Received call from ER [emergency room] nurse at [hospital] as resident was sent to them from the wound clinic due to severity of her wound. Nurse reports that a CT [computed tomography] scan was done of the wound and it is in to [sic] the bone and the surgeon at [hospital] is making arrangements for [resident] tobe [sic] transferred via ambulance to [hospital] in Fargo. . . ."	F0686		08/21/2026

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F0686 SS = G	Continued from page 12 * 05/22/26 at 9:27 a.m., "Call placed to [hospital] Fargo for a resident update. Nurse [name] reported she arrived on the trauma med surg [medical surgical] unit . . . with dx [diagnosis] of a sacral ulcer.. . . She is currently being held as NPO [nothing by mouth] until they hear back from provider about a possible procedure. . . ." * 05/25/26 at 11:57 a.m., ". . . Call placed to husband [name]. . . stated [resident] was transferred to Minneapolis to a hospital . . . regarding her bladder stimulator. . . ." * 05/29/26 at 10:00 a.m., "Call placed to [hospital] for an update on this resident. Nurse [name] stated she is currently on IV [intravenous] antibiotics . . . The doctor is recommending 6 weeks of antibiotic therapy following removal of her bladder stimulator on 5/26/29. . . ." During an interview on 07/29/26 at 4:30 p.m., a nurse (#8) stated the facility was not aware of the bladder stimulator and the stimulator caused the pressure ulcer to the resident's sacrum. During an interview on 07/29/26 at 5:46 p.m., an administrative nurse (#1) stated because antibiotics were initiated on 05/02/26, the facility staff removed Resident #65 from the physician PA rounds on 05/04/26. The nurse (#1) also stated because Resident #65 was scheduled for routine rounds with the physician on 05/13/26, the facility removed the resident from the PA's rounds schedule on 05/11/26. During a phone interview on 07/30/26 at 10:42 a.m., a PA (#9) stated she sees residents on Mondays, sees any resident the physician did not see, and also sees residents with acute issues. The PA (#9) stated the facility provides a list of residents to be seen. The PA (#9) stated she expected facility staff to schedule an appointment with a provider for residents who have a decline or a significant change to a pressure ulcer. During an interview on 07/30/26 at 11:02 a.m., a nurse (#8) stated nursing staff adds a resident with concerns to the provider list or makes an appointment at the clinic. The nurse (#8) agreed Resident #65 should have been seen at the clinic for the documented decline the end of April. The facility failed to ensure a provider evaluated Resident #65's sacral ulcer between 04/15/26 and 05/13/26. (27 days) during which time the sacral ulcer worsened.	F0686		08/21/2026

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F0689 SS = G	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: 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and/or assistance for 1 of 5 sampled residents (Resident #5) who experienced frequent falls. Failure to provide adequate supervision, assistance, and interventions to prevent falls, resulted in two transfers to the emergency room, pain, lacerations and abrasions, and lethargy. Findings include: Review of the facility policy titled “Fall Policy” occurred on 07/30/26. This policy, dated 2017, stated, “. . . Falls will be discussed in morning meetings. Immediate interventions are discussed as well as any other possible contributing factors that may be mitigated by additional interventions. . . . Weekly prn [as needed] fall reviews will be done by the fall committee in QA [quality assurance] meetings. . . . At the monthly safety meeting, the falls are discussed and patterns evaluated and any safety issues addressed. . . .” Review of Resident #5 medical record occurred on all days of survey. Diagnoses included agitation/restlessness, dementia, and Parkinson’s disease. The annual Minimum Data Set (MDS), dated 06/04/26, identified severely impaired cognition, more than two falls without injury, and more than two falls with injury during the assessment period. A fall assessment, dated 06/19/26, described Resident #5 as disoriented all the time, balance problems while standing/walking, chairbound, and at risk for falls.	F0689	Resident #10 was immediately educated on provide safety for others by making sure his smoking supplies were in a secure area. His care plan was updated to include the necessity of assuring smoking supplies are stored in a secure area as well as an intervention for nurses to secure smoking supplies in the med cart if resident does not secure these items appropriately. The facility has identified that all residents have the potential to be affected by this practice. On 8/18/26, the Director of Nursing conducted training for nursing staff on fall prevention strategies and the importance of environmental safety. The policies "Accidents and Supervision" and "Smoke Free Facility" policies were reviewed and revised if indicated. Nursing staff were educated on these policies along with education on monitoring residents at risk for fall and the prop storage of smoking supplies. Nurse helper cards were laminated and placed at the nurse's station to provide guidance on proper procedure following a fall. A falls management investigation tool will be started which will be used following a fall to collect information that may help to determine the root cause and therefore incorporate appropriate interventions into a resident's plan of care. The Director of Nursing or designee will conduct audits of fall incidents weekly X 4, monthly X 3, and quarterly X 3 to ensure the post fall tool is being utilized and interventions are being placed into the care plan. Any identified concerns will be immediately corrected, and additional education or corrective action will be provided as appropriate.	08/21/2026

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F0689 SS = G	Continued from page 14 The current care plan stated, ". . . Impaired mobility with potential for falls related to: poor safety awareness . . . Ambulates x2 [times two] assist with FWW [front wheeled walker] as tolerated . . . Bed in low position when occupied . . . Check on resident frequently, encourage assist with all transfers and ambulation . . . Do not leave unattended in . . . dining room [Initiated on 06/30/26 after the resident's fifth fall in the dining room] . . . Transfers x1-2 [times one-two] assist . . . Trial use of leg support on footrests [Initiated on 07/27/26 after 37 falls] . . . Wheelchair per staff assist . . . Requires assistance with daily cares . . . Dependent for toileting hygiene . . ." Resident #5's progress notes identified the following dates and locations of falls: * One fall in the activity room: 07/05/26 * Six falls in the dining room: 09/09/25, 03/28/26, 04/06/26, 04/10/26, 04/19/26, 06/25/26 * Seven falls in the "day, lobby, lounge, tv" area: 10/15/25, 10/22/25, 10/24/25, 11/30/25, 04/13/26, 04/26/26, 05/15/26 * Two falls near the nurses' station: 03/12/26, June 2026 (day of month was not visible on report) * 16 falls in the resident's room: 08/16/25, 10/19/25, 12/01/25, 01/30/26, 02/06/26, 03/11/26, 03/13/26, 03/14/26, 03/30/26, 04/02/26, 04/03/26, 04/13/26, 05/25/26, 06/16/26, 06/30/26, 07/12/26 The progress note, dated 07/12/26 at 1:10 a.m., stated, ". . . the resident was found partially suspended from the head of the bed. Resident's lower extremities remained on the bed, while the resident's head and upper body were hanging over the side, with the head wedged between the closet and wall . . . swelling and a visible red indentation to the left side of resident's head. Redness was also noted to the resident's shoulder. Skin remained intact . . . Resident . . . reported pain. . . . Neurological checks were initiated . . . During the second neurological assessment, the resident appeared increasingly lethargic . . . with delayed response to verbal and tactile stimuli. . . . EMS [Emergency Medical Services] . . . transported the resident to the local hospital for further evaluation. . . ." * Four falls in unknown locations: 01/09/26,	F0689		08/21/2026

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F0689 SS = G	Continued from page 15 02/23/26, 04/12/26, 06/20/26 * 16 falls required neuro-checks (as assessment used to monitor changes or deterioration in neurologic functions): 08/16/25, 10/22/25, 10/24/25, 11/30/25, 12/02/15, 02/06/26, 03/13/26, 03/14/26, 04/03/26, 04/13/26, 04/26/26, 05/15/26, 05/25/26, 06/16/26, 06/20/26, 06/25/26 * Two falls required transfer to the emergency room: 10/22/25, 07/12/26 * One fall required an assessment by the provider: 04/13/26 During an interview on 07/30/26 at 9:10 a.m., an administrative staff member (#1) described Resident #5 as "quick and can walk when he wants." When asked what interventions the facility has tried, the administrative staff member (#1) stated, "He doesn't engage in a lot of activities. We've tried to toilet him more frequently. Staff have been told he can't be left in the dining room unattended." When asked about new interventions and when the interventions are added to the resident's care plan, she responded, "We discuss falls during the morning meetings, to see if there is anything else we can do." When asked if staff rearranged Resident #5's room after the fall on 07/12/26 when his head was wedged between the closet and the wall, the administrative staff member (#1) stated, "I don't know" and "We would probably have to move him to a different room." The staff member agreed Resident #5 could end up in the same position (with his head wedged between the closet and wall) again. Resident #5 experienced approximately 36 falls between 08/16/25 and 07/12/26, which resulted in two transfers to the emergency room, increased lethargy/delayed responses to stimuli, and minor injuries including an abrasion to his lower back, a laceration to his elbow, a large mark on his forehead, redness to his shoulder, hip, and knee, rib pain, scrapes/scratches to his forearms and knee. Staff repeatedly reminded Resident #5 to use the call light for assistance even though the resident had severely impaired cognition. The facility failed to provide the necessary supervision, assistance, and appropriate interventions to prevent future falls. 2. Based on observation, record review, review of facility policy, and staff and resident interviews, the facility failed to ensure the residents' environment	F0689		08/21/2026

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F0689 SS = G	Continued from page 16 remained as free of accident hazards as possible for 1 of 1 sampled resident (Resident #10) who kept cigarettes and a lighter in their room. Failure to safeguard the accessibility of smoking supplies from other residents, including residents known to wander, may result in injury, burns, fire, or other smoking-related accidents. Findings include: Review of the facility policy titled "Smoke Free Facility" occurred on 07/28/26. This policy, dated April 2025, stated, "Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees. Therefore, this facility is a 'Smoke Free Facility.' Policy Explanation and Compliance Guidelines: 1. This policy applies to all residents, visitors, and employees. . . . 6. Residents who are cognitively intact and are determined to be safe may choose to leave facility grounds to smoke. . . ." Review of Resident #10's medical record occurred on all days of survey. The current care plan stated, "Resident is alert and oriented and is known to independently leave facility grounds without notifying staff to smoke . . . Document any known episodes of unsafe smoking behavior . . . Educate resident regarding facility non-smoking policy and rationale . . . Encourage resident to avoid smoking near schools, churches, behind vehicles, funeral homes, or inappropriate public locations. . . . Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. . . " The care plan failed to identify where the resident's cigarettes and lighter were to be stored to prevent access by other residents. During an interview on 07/28/26 at 9:28 a.m., Resident #10 stated he smoked and had been instructed he could smoke as long as he went off facility grounds, such as across the street. Observation showed a package of cigarettes and a lighter on the resident's bedside table. When asked whether other residents entered his room, Resident #10 stated the resident across the hall had wandered into his room during the night. Observations conducted on 07/28/26 at 8:00 a.m., the morning of 07/29/26, and on 07/30/26 at 8:38 a.m. showed Resident #10's room door open and	F0689		08/21/2026

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F0689 SS = G	Continued from page 17 the cigarettes and a lighter on the resident's beside table in plain view. During an interview on 07/29/26 at 4:32 p.m., an administrative nurse (#8) stated Resident #10 purchased his own smoking supplies and kept the supplies in a bag attached to the back of his wheelchair. During an interview on 07/30/26 at 8:19 a.m., Resident #10 stated he kept his smoking supplies on the table in his room. During an interview on the afternoon of 07/30/26, an administrative nurse (#1) confirmed Resident #10 should not keep cigarettes and lighter on the bedside table because the facility has residents who wander into other residents' rooms.	F0689		08/21/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F0580	Immediate corrective action for resident #5 included a review of recent glucose readings to determine if further adjustments needed to be made on his medication. The facility has determined that all residents with a significant change in condition have the potential to be affected by this practice. An in-service education meeting was conducted on 8/18/26 by the Director of Nursing with licensed staff addressing circumstances requiring the notification of the resident's physician, legal representative or family member and also included review of policies: Notification of Change, Hyperglycemia, and Hypoglycemia. Education was also provided on "Nurse's responsibility to notify doctor of change in condition of nursing home resident" by Safe Nursing Home Advocates. The facility has also incorporated special requirements that are included in glucose checks to alert nursing staff of when to notify the physician. Management nurses will review daily progress notes to identify circumstances that may indicate the need to notify the phyisian or family representative. The Director of Nursing Services, or designee will conduct a random audit of five (5) residents weekly X 4, monthly X 3, and quarterly X3. These residents will be newly assessed to ensure that any declines in condition have been identified, properly evaluated	08/21/2026

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F0580 SS = D	Continued from page 18 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the physician and/or resident representative of a change in condition and falls for 1 of 5 sampled residents (Resident #5) reviewed for symptoms of hypoglycemia and falls. Failure to promptly notify the physician regarding low blood glucose readings and failure to notify the resident representative regarding the falls limited the physician's ability to alter treatment and limited the resident representative's ability to make informed decisions regarding Resident #5's care. Findings include: Review of the facility policy titled "Notification of Change" occurred on 07/30/26. This policy, dated 2017, stated, ". . . An accident involving the resident which results in injury and has the potential for requiring physician intervention. . . . A significant change in the resident's physical, mental, and psychosocial status. These changes may include a deterioration in health, mental, or psychosocial	F0580	Continued from page 18 and communicated to the appropriate people. Monitoring and further interventions will be put into place if evidence that further education or interventions are needed.	08/21/2026

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F0580 SS = D	Continued from page 19 status in either life-threatening conditions or clinical complications. . . .” Review of the facility policy titled “Hypoglycemia” occurred on 07/30/26. This policy, dated, 2017, stated, “. . . Hypoglycemia is defined as a blood glucose less than 70 mg/dl [milligrams per deciliter], with or without symptoms and requires immediate treatment. . . . Notify physician of blood glucose levels below 60 mg/dl . . .” BLOOD GLUCOSE Review of Resident #5’s medical record occurred on all days of survey and identified blood glucose levels less than 60 mg/dL on five occasions. Review of Resident #5’s blood glucose readings from April – May, 2026 showed the following: * 04/03/26, 45 mg/dL and 46 mg/dL * 04/14/26, 54 mg/dL * 04/28/26, 45 mg/dL * 05/01/26, 35 mg/dL * 05/08/26, 58 mg/dL Review of Resident #5’s progress notes identified the following: * 04/03/26 at 6:43 a.m., “. . . Given Breeze, Root Beer, and a cookie at 0615 [6:15 a.m.] for a blood sugar of 45 taken by night nurse at 0515 [5:15 a.m.]. Blood sugar did not increase much at this time, so was given more Breeze and cookie.” * 04/03/26 at 6:57 a.m., “Resident had blood glucose of 45 mg/dL at 0525 [5:25] am and he was asymptomatic. He was given fortified high calorie drink and a few wafers by the AM nurse. Recheck at 0640 [6:40 a.m.] and BGL [blood glucose level] is now 69 mg/dL. Will continue to monitor.” * 04/03/26 at 7:05 a.m., “. . . Administration was: Effective Blood sugar up to 93 at this time.” * 04/14/26 at 4:56 a.m., “. . . attempted to provide Resident with chocolates and orange juice to	F0580		08/21/2026

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F0580 SS = D	Continued from page 20 increase blood glucose levels resident refused. Resident sated [sic] repeatedly 'leave me the [profanity] alone' This writer informed and educated resident that his glucose was out of normal range and that it needed to be addressed immediately to prevent potential injury. Resident stated 'Get the [profanity] out of my room you [profanity].'" * 05/01/26 at 6:04 a.m., ". . . Checked blood glucose at 4:00 AM blood sugar was 37 Gave resident snack as he stated 'I am not drinking no [profanity] orange juice' but agreed to nutri-grain bar Rechecked and it was 35 resident not agreeable to any attempts to raise glucose." * 05/08/26 at 4:21 a.m., ". . . 240 ml of boost offered and resident drink it all." * 05/17/26 at 10:02 a.m., [pharmacist entry] "Resident with recurrent fasting hypoglycemia including BG as low as 35 mg/dL. Recommend reducing insulin glargine dose to decrease severe hypoglycemia risk. . . ." The facility failed to notify the provider about Resident #5's low blood glucose readings and failed to address the resident's low blood glucose level on 04/28/26. FALLS Review of Resident #5's progress notes identified approximately 36 falls between 08/16/25 and 07/12/26. The medical record lacked documentation the facility notified the resident's representative of approximately 10 of the 37 falls. During two interviews on 07/30/26, an administrative staff member (#1) indicated she expected staff to document any physician and/or resident representative contact in the resident's progress notes and confirmed staff failed to notify the physician about Resident #5's low blood glucose readings.	F0580		08/21/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect	F0605	The PRN psychotropic medication used by resident #22 was reviewed by his primary care physician on 8/12/26 and 8/20/26 resulting in continuation of the medication related to comfort care orders. The PCP rationale for continued use of the PRN psychotropic is that resident has a terminal condition and the medication is needed for symptom control when the	08/21/2026

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F0605 SS = D	Continued from page 21 and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from	F0605	Continued from page 21 time arises. This medication will be continued per PCC until 9/8/26 when the PCC completes facility rounds. All residents prescribed PRN psychotropic medications have the potential to be affected. On review of all facility residents, the Resident Care Coordinator found no additional residents ordered for a PRN psychotropic medication. The Resident Care Coordinator or designee will maintain a PRN Psychotropic Medication Log to identify the resident, the prescribed medication as well as the start and end date of the medication. Labels have also been created that will be placed on the PRN medication card indicating the date the medication will be discontinued so it can be removed from the medication cart. The Use of Psychotropic Drugs policy was updated on 8/13/26. Nursing staff were educated on 8/18/26 that PRN psychotropic medications must be discontinued after 14 days unless determined by prescribing practitioner that continued use is appropriate. They were also educated on changes to the updated "Use of Psychotropic Drugs" policy. The Director of Nursing/designee will audit all residents receiving PRN psychotropic medication orders weekly X 4 weeks, monthly X 3, and quarterly X 3 to assure appropriate indication for the use of the PRN psychotropic medication, and end date is indicated on the EMAR and on the medication card and proper documentation is obtained for continued use of the PRN medication.	08/21/2026

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F0605 SS = D	Continued from page 22 unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are	F0605		08/21/2026

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F0605 SS = D	Continued from page 23 limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review and review of facility policy, the facility failed to ensure residents remained free from unnecessary psychotropic medications for 1 of 1 sampled resident (Resident #22) reviewed for as needed (PRN) psychotropic medication. Failure to limit PRN psychotropic medication orders to 14 days or obtain physician documentation supporting clinical rationale for extending the order beyond 14 days placed the resident at risk of receiving unnecessary psychotropic medication and potential adverse effects associated with its use. Findings include: Review of the facility policy "Use of Psychotropic Drugs" occurred on 07/29/26. This policy, dated 2017, stated, "Policy: It is the policy of Golden Acres Manor that each resident's drug regiment is free from unnecessary drugs . . . Policy Explanation and Compliance Guidelines: 1. Resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: . . . b. For excessive duration . . . . 6. PRN orders for psychotropic drugs are limited to 14 days, except as provided if the attending physician or prescribing practitioner believe that it is appropriate for the PRN order to be extended beyond 14 days. He or she should document their rationale in the resident medical record and indicate the duration for the PRN order. . . ." Review of Resident #22's medical record occurred on all days of survey. Physician's orders included lorazepam (an anti-anxiety medication) every four hours as needed for restlessness/anxiety, initiated 06/18/26. Review of Resident #22's electronic medication administration record (EMAR) showed the facility administered PRN lorazepam on July 23, 25, and 26, 2026. These dates were beyond the acceptable duration of 14 days. The medical record failed to show physician documentation supporting the clinical rationale to extend the PRN lorazepam order beyond 14 days.	F0605		08/21/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse,	F0609	Immediate corrective action included providing education on the Golden Acres Manor Abuse and Neglect Policy and Procedure on 7/28/26 to all facility staff. Re-education was provided immediately to involved staff on the reporting requirements for	08/21/2026

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F0609 SS = D	Continued from page 24 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy and staff interview, the facility failed to report incidents of abuse to the State Survey Agency (SSA) within the required time frames for 3 of 16 sampled residents (Resident #47, #56 and #57) reviewed for resident-to-resident abuse. Failure to ensure incidents of potential abuse are reported to the SA immediately, but no later than 2 hours after the allegation is made, may result in continued abuse, fear, anxiety, and psychosocial harm. Findings include: Review of the facility policy titled Resident to Resident Altercation occurred on 07/29/26 and 07/30/26. This revised policy, dated 05/25/26, stated, ... 4. If a Resident-to-Resident Altercation is suspected or alleged, the facility will take the following actions: . . ..e. Notify the administrator or Director of Nursing. f.. . 2.If there is no serious bodily injury, report no later than 24 hours to the State Survey Agency	F0609	Continued from page 24 resident-to-resident altercations to the State Agency. A Facility Reported Incident was submitted on 7/27/26 for residents #56 and #57. Resident #56 was immediately provided with emotional support and offered a room on a different unit. The facility has determined that all residents have the potential to be affected. A Progress Note type “Resident-to-Resident Altercation” was added to Point Click Care to allow management nurses to review daily progress notes specific to resident altercations that may be necessary to report to the State Agency. Education was provided on 8/18/26 to direct care staff on the Golden Acres Abuse and Neglect Policy and Procedure with emphasis on the types of abuse and reporting requirement time frames. Additional education included a video on “Abuse, Neglect, Exploitation, and Misappropriation of Property”. A Health Care Academy course “Abuse, Neglect, Exploitation Mandatory Reporter was assigned to all facility staff with an additional course “Conducting Abuse and Neglect Investigation” to facility nurses. Staffing agencies used within the facility were also asked to provide additional education on Abuse. Helper cards were placed at the nurse’s stations on 8/17/26 with instructions on what to do when a resident-to-resident altercation occurs. The Director of Nursing or designee will review daily progress notes to identify any incidents that may require the need to report to the appropriate state agencies. This will be completed weekly times 4 weeks, monthly X 3, and quarterly X 3 to verify timely reporting. Any non-compliance will result in immediate re-education and corrective action.	08/21/2026

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F0609 SS = D	Continued from page 25 - Review of Resident #56's medical record occurred on all days of survey. Diagnoses included borderline personality disorder, mild intellectual disabilities, Post-Traumatic Stress Disorder, major depressive disorder, and mood disorder. The current care plan stated, "Post Traumatic Stress Disorder. . . Goal: patient will acknowledge and feel that they are safe and cannot be harmed. . .. Interventions: acknowledge the resident's feelings and show understanding, monitor for avoidances of places, people, or situations. . . ." A progress noted, dated 07/25/26 at 5:07 p.m., stated, "Resident [Resident #57] was ambulating near the nurses' station toward her room when she became verbally upset with another resident [Resident #56] after believing the resident [Resident #56] was talking about her. Resident [Resident #57] stated, '[profanity] you,' to the other resident. The other resident [Resident #56] responded with the same statement, after which the resident became increasingly agitated, walked toward the other resident, and stated, 'Do you want to [profanity] fight?' Writer immediately intervened by positioning self between both residents to prevent further escalation. Resident [Resident #57] was given clear verbal redirection, instructed to stop using inappropriate language and making threats, and directed to disengage from the interaction and return to her room. Resident initially complied and began walking away. As the resident [Resident #57] was walking toward her room, the other resident [Resident #56] stated to nursing staff that she believed the resident 'should be at the state hospital.' Upon hearing this comment, the resident turned and yelled, 'If I had a knife, I will cut your [profanity] throat.' Writer immediately redirected the resident again, instructed her to stop making threatening statements, and reinforced expectations for appropriate behavior. Resident [Resident #57] complied with redirection, continued to her room, and no further verbal or physical aggression was observed. Both residents were separated for the remainder of the shift and monitored closely to prevent further interaction. No physical contact or injuries occurred. Resident [Resident #57] remained in her room following the incident, and no additional behaviors were observed during the remainder of the shift. Continued monitoring and behavioral observation will be maintained."	F0609		08/21/2026

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F0609 SS = D	Continued from page 26 During an interview on 07/27/26 at 6:38 p.m., two administrative staff members (#1 and #4) confirmed the facility failed to report the altercation that occurred on 07/25/26 to the SSA until the morning of 07/27/26. - Review of Resident #47 medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, anxiety, dementia with psychotic disturbance, and depression. The current care plan stated, ". . . Alteration in mood and behaviors . . . Tends to wander/follow other residents at times, may attempt to hold their hand at times. Likes to hang around . . . front lounge. Periods of increased restlessness, delusions . . . Redirect as able away from other residents if appears unwanted attention attempted. . . . When resident is anxious, take her for a walk outside . . . or 1:1 . . ." Resident #47's progress note, dated 06/22/26 at 1:58 p.m., stated, ". . . Resident was involved in a physical altercation with another resident. Writer observed both residents striking each other. Staff intervened immediately and separated the residents. Resident was assessed for injuries, no injuries was [sic] noted." During an interview on 07/29/26 at 5:30 p.m., an administrative staff member (#1) confirmed staff failed to report the incident that occurred on 06/22/26 to the SSA.	F0609		08/21/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations	F0610	1. Immediate corrective action for residents involved included separating the individuals immediately, close monitoring of the individuals, providing emotional support, and providing an option to relocate to a different wing. A medication review was also completed on resident #57 by her Mental Health provider. A Facility Reported Incident was completed on 7/27/26 for unreported incident that occurred on 7/25/26. 2. The facility has determined that all residents have the potential to be affected by this practice. 3. The facility had recognized the need for additional staff in the evening hours related to increased behaviors due to sundowning. An additional staff member was assigned starting 5/1/26 to care for residents recognized to have these increased behaviors. Education of the Golden Acres Manor	08/21/2026

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F0610 SS = D	Continued from page 27 to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the facility reported incident (FRI) investigation, review of facility policy, and staff interviews, the facility failed to investigate incidents of verbal and physical abuse for 3 of 16 sampled residents (Resident #47, #56 and #57) reviewed for resident-to-resident abuse. Failure to investigate alleged violations of resident-to-resident abuse, ensure residents were protected during investigation, implement corrective actions, and evaluate the effectiveness of the actions, placed Resident #47, #56, and #57, and all residents at risk for possible mental/emotional distress and injury. Findings include: Review of the facility policy Abuse and Neglect Policy and Procedure occurred on 07/29/26 and 07/30/26. This undated policy stated, ", . . Investigation must include: Date, time and place of incident, adverse reactions, results of interviews, and actions taken. . . ." - Review of Resident #56's medical record occurred on all days of survey. Diagnoses included borderline personality disorder, mild intellectual disabilities, Post-Traumatic Stress Disorder, major depressive disorder, and mood disorder. The current care plan stated, “Post Traumatic Stress Disorder. . . Goal: patient will acknowledge and feel that they are safe and cannot be harmed . . . Interventions: acknowledge the resident's feelings and show understanding, monitor for avoidances of places, people, or situations. . . .” A progress noted, dated 07/25/26 at 5:07 p.m., stated, "extra space Resident [Resident #57] was ambulating near the nurses' station toward her room when she became verbally upset with another resident [Resident #56] after believing the resident [Resident #56] was talking about her. Resident [Resident #57] stated, '[profanity] you,' to the other resident. The other resident [Resident #56] responded with the same statement, after which the	F0610	Continued from page 27 Abuse and Neglect Policy was provided to facility and agency staff on 7/28/26 emphasizing types of abuse and reporting requirements. The policy was reviewed and updated on 8/17/26. A structured progress note type was added to PCC labeled "Resident-to-Resident altercation" to more readily identify resident-to-resident altercations in which a timelier review of the incident can occur. An online course on "Abuse, Neglect, and Exploitation: Mandatory Reporter" was assigned to all facility staff to be completed by 8/19/26. An additional course "Conducting Abuse and Neglect Investigation" was assigned to the facility nurses. Education was provided to direct care staff on 8/18/26 on the revised Abuse and Neglect Policy and the new structure progress note type. 4. The Director of Nursing or designee will monitor progress notes daily X 4 weeks, weekly X 4, monthly X 4, and quarterly X 2 to review documentation of investigations and follow-up. If non-compliance is found immediate re-education and further interventions will be implemented.	08/21/2026

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(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
F0610 SS = D	Continued from page 28 resident became increasingly agitated, walked toward the other resident, and stated, 'Do you want to [profanity] fight?' Writer immediately intervened by positioning self between both residents to prevent further escalation. Resident [Resident #57] was given clear verbal redirection, instructed to stop using inappropriate language and making threats, and directed to disengage from the interaction and return to her room. Resident initially complied and began walking away. As the resident [Resident #57] was walking toward her room, the other resident [Resident #56] stated to nursing staff that she believed the resident 'should be at the state hospital.' Upon hearing this comment, the resident turned and yelled, 'If I had a knife, I will cut your [profanity] throat.' Writer immediately redirected the resident again, instructed her to stop making threatening statements, and reinforced expectations for appropriate behavior. Resident [Resident #57] complied with redirection, continued to her room, and no further verbal or physical aggression was observed. Both residents were separated for the remainder of the shift and monitored closely to prevent further interaction. No physical contact or injuries occurred. Resident [Resident #57] remained in her room following the incident, and no additional behaviors were observed during the remainder of the shift. Continued monitoring and behavioral observation will be maintained." During an interview on 07/27/26 at 6:38 p.m., two administrative staff members (#1 and #4) verified the resident-to-resident altercation occurred on 07/25/26 and the facility had not started an investigation. - Review of Resident #47 medical record occurred on all days of survey. Diagnoses included Alzheimer’s disease, anxiety, dementia with psychotic disturbance, and depression. The current care plan stated, “. . . Alteration in mood and behaviors . . . Tends to wander/follow other residents at times, may attempt to hold their hand at times. Likes to hang around . . . front lounge. Periods of increased restlessness, delusions . . . Redirect as able away from other residents if appears unwanted attention attempted. . . . When resident is anxious, take her for a walk outside . . . or 1:1 . . .”	F0610		08/21/2026

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F0610 SS = D	Continued from page 29 Resident #47's progress note, dated 06/22/26 at 1:58 p.m., stated, ". . . Resident was involved in a physical altercation with another resident. Writer observed both residents striking each other. Staff intervened immediately and separated the residents. Resident was assessed for injuries, no injuries was [sic] noted." During an interview on 07/29/26 at 5:30 p.m., an administrative staff member (#1) confirmed the facility failed to thoroughly investigate the incident that occurred on 06/22/26.	F0610		08/21/2026
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #5) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: Review of the facility policy titled "Resident	F0644	The facility immediately reviewed the PASARR and documentation of PASARR screening for resident #5. A new PASARR was completed for resident#5 and a care plan was implemented. All residents with serious mental disorders, intellectual disabilities or related conditions have the potential to be affected by this practice. The Social Service designee conducted an audit on 8/17/26 of residents with serious mental disorders and intellectual disability or related conditions. Audits performed were evaluated for completion of a PASARR screening and an evaluation if a Level II PASARR was indicated. Care plans were reviewed by the MDS nurses to ensure that residents had an appropriate care plan indicating PASARR recommendations. The Social Worker designee was reeducated on 8/17/26 on the Resident Assessment-Coordination with PASARR Program policy and the requirements for screening residents with serious mental disorders, intellectual disabilities and related conditions as well as those that may have a change in status. The MDS nurse and/or Resident Care Coordinator will review practitioner dictations to determine if a new diagnosis is present indicating a significant change and notify Social Service designee if indicated. The Director of Nursing or designee will conduct weekly audits X 4 weeks, monthly X 3, and quarterly X 3 on 10% of the census to verify that PASARR screening/evaluation is completed with new diagnoses when required and recommendations are incorporated into a resident's plan of care.	08/21/2026

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F0644 SS = D	Continued from page 30 Assessment - Coordination with PASARR Program" occurred on 07/30/26. This undated policy stated, ". . . Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. . . ." The North Dakota PASARR Provider Manual, revised 07/19/22, page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Maximus to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #5's medical record occurred on all days of survey. The record showed an initial PASARR completed 02/28/24, and included diagnoses of depression, persistent mood disorder and major neurocognitive disorder due to Parkinson's disease with behavioral disturbances. The medical record showed a new diagnosis of psychosis on 09/24/24. The record lacked evidence the facility notified Maximus when Resident #5 received the diagnosis of psychosis. During an interview on 07/30/26 at 3:29 p.m., an administrative staff member (#4) confirmed the facility failed to contact Maximus with the diagnosis of psychosis.	F0644		08/21/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of professional	F0698	Corrective action for resident #10 occurred immediately on 7/29/26. Orders for the proper care of the Arterio-Venous Fistula were obtained from Sanford. A Dialysis care plan was developed to provide a clear, personalized guide outlining resident's individualized health need. A Dialysis Communication Form was implemented on 7/29/26 to aid in communicating resident#10's condition prior to and following dialysis treatment. The facility has determined that all residents requiring dialysis have the potential to be affected by this practice.	08/21/2026

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F0698 SS = D	Continued from page 31 reference, and resident and staff interviews, the facility failed to ensure provision of care and services consistent with accepted professional standards of practice for 1 of 1 sampled resident (Resident #10) on hemodialysis. Failure to routinely assess and monitor the resident's hemodialysis vascular access site (fistula) may delay the identification of complications, including infection, clotting, bleeding, or loss of vascular access. Findings include: Review of the "Core Curriculum for the Dialysis Technician - A Compressive Review of Dialysis," Fifth Edition, page 121 and 127 states, ". . . Vascular access makes chronic hemodialysis (HD) possible . . . An access is an HD patient's lifeline. . . . Access problems can cause hospital stays, surgery illness, limb loss, and death. . . . Examine the fistula [vascular access] . . . listen for Bruit - the sound and pitch of "whooshing") . . . Feel for: skin temperature - more warmth (could be infection) or cold (could mean less blood flow). Thrill - should be present and constant, . . A fistula should have a strong flow of blood. . . . Teach . . . patients to feel their thrill at least once a day . . . a change in the thrill (or the volume of the bruit) can mean blood flow through the access is slowing down. . . . Types of Accesses. The three main types of access are 1. Fistula. 2. Grafts 3. Central venous catheters. . . ." - During an interview on 07/27/26 at 9:23 a.m., Resident #10 stated he had a fistula in his left arm for hemodialysis. When asked whether staff checked the fistula site, the resident stated, "nobody looks at my arm." Review of Resident #10's medical record occurred on all days of survey. The current care plan stated, "Alteration in health maintenance related to: . . . end stage renal disease . . . Receives Dialysis outside of facility." The care plan failed to identify the resident's vascular access type (left arm fistula), interventions for routine fistula assessment, address potential fistula complications, or provide instructions for ongoing monitoring and care. Review of Resident #10's nurses' progress notes and nursing assessments from admission on 02/03/26 through 07/29/26, failed to show documentation regarding assessment of the residents left arm fistula, including the presence or absence of a bruit or thrill, condition of the access site, or any other vascular access assessment.	F0698	Continued from page 31 Systemic changes made to ensure this practice will not recur, include assuring that residents who receive dialysis have an appropriate care plan for dialysis to help coordinate care among the interdisciplinary team. A Dialysis Communication Form will be implemented for individuals receiving dialysis to assess residents prior to dialysis and following dialysis. Education was provided on Tuesday, August 18 to nursing staff on the Dialysis care plan, care required for individuals on dialysis, and how to complete the Dialysis Communication Form. The Director of Nursing or designee will monitor the completion of the Dialysis Communication Form three days a week when dialysis is performed X 4 weeks, monthly X 3, and quarterly X 3. Progress notes will be reviewed daily to ensure nursing staff are monitoring dialysis site for complications. This will be done weekly X 4, quarterly X 3 and monthly X 3. Monitoring and further interventions will be put into place if it is evident that further education or interventions are needed. Immediate correction completed on 7/29/26. Staff education completed by 8/18/2026. System changed implemented 7/29/26. QA monitoring begins 8/17/26.	08/21/2026

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F0698 SS = D	Continued from page 32 During an interview on 07/29/26 at 2:30 p.m., an administrative staff member (#1) stated the facility does not have a policy or process regarding the care and monitoring of residents receiving hemodialysis.	F0698		08/21/2026
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 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, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of medications in 1 of 3 units (100-unit) observed. Failure to secure medications may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Medication Administration" occurred on 07/29/26. This policy, revised 04/28/26, stated, ". . . Lock cart when not attended to. . . ." Observation on 07/28/26 at 7:40 a.m. showed an unlocked medication cart in the 100-unit hallway	F0761	The medication cart was immediately secured and locked upon discovery. The responsible licensed nurse was educated regarding the requirement to keep the medication cart locked whenever it is not under the nurse's direct supervision. All residents have the potential to be affected by this practice. New medication carts have been ordered which have an auto locking feature. The facility policy "Medication Administration" was reviewed and updated on 8/14/26. Licensed nursing staff were educated on 8/18/26 on the updated medication Administration Policy and the requirements on medication security. The Director of Nursing/designee will perform 10 observations of medication carts weekly for 4 weeks, monthly for 3 months, and quarterly for 3 months to verify that carts are locked and privacy screens are placed when cart is left unattended. Any identified variance will be corrected immediately, and additional staff education will be provided as indicated.	08/21/2026

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F0761 SS = D	Continued from page 33 with a medication cup containing two pills on the top of the cart, and the computer screen open and displaying resident information. Observation showed facility staff left the medication cart unattended for over 3 minutes with residents present in the hallway. During an interview on 07/29/26 at 3:38 p.m., an administrative nurse (#1) confirmed she expected staff to lock the medication cart, not leave medications unattended, and close out of the computer screen when the medication cart is left unattended.	F0761		08/21/2026
F0804 SS = D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policies, and staff interviews, the facility failed to serve beverages at palatable temperature in 1 of 2 dining rooms (Dining Room 300) observed. Failure to serve breverages at palatable temperatures to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled "Policy for Temperature Control of Foods" occurred on 07/29/26. This undated policy stated, "Goal: To provide food that is palatable, attractive, and at the proper temperature . . . Cold foods will be refrigerated until the appropriate time to be served. . . . . Food temperatures will be periodically monitored. If temperature control standards are not consistently met. Procedures will be reviewed, with recommendations made for change." Review of the facility policy titled "Policy on Food Handling" occurred on 07/29/26. This undated policy stated, ". . . Appropriate food temperatures are maintained during food preparation and serving	F0804	Corrective action was taken at the time of the incident. Dietary Cook probed the milk, determined that it was of incorrect temperature, disposed of it, and poured fresh glasses. the dietary manager immediately placed a memo on the communication whiteboard in the kitchen providing education on proper pouring times for milk as it is a temperature control safety issue. All residents who consume milk have the potential to be affected by this practice. All dietary staff will be required to read and sign/date the facility's policy regarding food temperature safety by 8/21/26. An in-service will be conducted by the dietitian and dietary manager on 8/25/26 with all dietary staff to review the policy on safe food temperatures and re-educate on the importance of this matter. The dietary manager will perform random inspections on milk temperatures, and monitor times that dietary aids are pouring beverages. This will be done weekly X 4, monthly X 3, and quarterly X 3. Monitoring and further interventions will be put into place if evidence that further education or interventions are needed.	08/21/2026

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F0804 SS = D	Continued from page 34 to protect against food borne illness: . . Observation in the 300-dining room occurred on 07/27/26 at 11:45 a.m. and showed an unidentified dietary staff member filled milk glasses and placed on the dining room tables. At 12:40 p.m. (55 minutes later), Resident #16 and Resident #22 arrived at their dining tables. Resident #16 took a sip of the milk and stated it was warm. A dietary staff member (#5) measured the temperature of Resident #16's milk, and the reading showed 64.9 degrees Fahrenheit. The dietary staff member confirmed the temperature of the milk should be 40 degrees or lower, removed Resident #16 and Resident #22's milk and replaced it with freshly poured milk. The dietary staff member (#5) did not check the temperature of Resident #22's milk, stating "I am sure it is the same temperature".	F0804		08/21/2026
F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F0867	On 8/19/26 the Quality Assurance (QA) committee conducted review of the QAPI program and identified areas requiring urgent attention. The QA Coordinator facilitated this review ensure that relevant staff were involved. The facility has determined that all residents may be affected by this practice. On 8/18/26, the Staff Development Coordinator conducted training for nursing staff on the QAPI process, focusing on identifying and addressing resident behaviors and implementing interventions that are effective. Nurses have been educated on using appropriate progress note types to ensure documentation of residents with frequent behaviors include documentation of activity prior to and following a behavior as well as potential triggers for their behaviors. Staff were educated on the importance of documenting triggers and interventions effectively to prevent future incidents. The Quality Assurance Committee continues to meet weekly to identify problems, find solutions, measure results, and continuously improve the care and services we provide. The QA committee will implement the QAPI process to help identify and act on problem areas. The QA Coordinator will conduct audits of the QAPI program and progress notes weekly X 4, monthly x 3, and quarterly X 3 focusing on the identification of resident behaviors and the effectiveness of interventions. Findings will be reviewed at the Quality Assurance meetings and thereafter per the facility's QAPI review schedule.	08/21/2026

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F0867 SS = D	Continued from page 35 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F0867		08/21/2026

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F0867 SS = D	Continued from page 36 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, record review, review of facility policy, survey findings, and staff interview, the facility failed to maintain a Quality Assurance (QA) process, which identified and implemented preventative actions and mechanisms to decrease or prevent adverse events. Findings include: Review of the facility policy Quality Assurance and Performance Improvement (QAPI) occurred on 07/30/26. This policy, revised 04/30/26, stated, ". . . It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. 2. The QAA [Quality Assessment and Assurance] Committee shall be interdisciplinary and	F0867		08/21/2026

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F0867 SS = D	Continued from page 37 shall: . . . c. Develop and implement appropriate plans of action to correct identified quality deficiencies. d. Regularly review, and . . . act on available date to make improvements. . . . The QAPI plan will address the following elements . . . Developing and implementing corrective action or performance improvement activities. v1. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. . . ." Review of the North Dakota Department of Health, Division of Health Facilities Provider files identified the facility failed to maintain compliance in the following area previously cited on 04/30/26: *F600-Free from Abuse and Neglect Review of medical records showed the facility failed to protect Resident #47, #56 and #57 and all other residents from verbal/physical abuse. Review of the Behavior Documentation Tool used by the facility failed to identify potential triggers causing resident behaviors or suggest any new interventions after behaviors occurred. The facility failed to utilize the QAPI process for resident-to-resident altercations and behaviors which resulted in resident abuse and continued noncompliance at F600.	F0867		08/21/2026
F0880 SS = D	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:	F0880	Immediate corrective action was re-education provided to staff member involved in medication administration and dressing change. All residents have the potential to be affected by this practice. The Medication Administration Policy was reviewed and updated. A policy on Clean Dressing Change was implemented. An in-service was conducted on 8/18/26 to direct care staff regarding safe practice on medication administration and how to maintain infection control when providing wound care. Return demonstration was completed by the nurses on maintaining infection control while performing a dressing change.	08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	**1 E MAIN ST , CARRINGTON, North Dakota, 58421**

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F0880 SS = D	Continued from page 38 §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; (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.	F0880	Continued from page 38 The Director of Nursing or designee will complete 3 observations of dressing changes performed weekly X 4, monthly X 4, and quarterly X 3 to ensure infection control is maintained during dressing change. The Director of Nursing or designee will complete 10 observations weekly X 4, monthly X 4, and quarterly X 3 to ensure infection control is maintained during medication administration.	08/21/2026

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F0880 SS = D	Continued from page 39 §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, review of facility policy, review of professional reference, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 3 sampled residents (Resident #1, #24, and #15) observed during wound care and medication administration. Failure to practice infection control standards related to medication administration (Resident #15) and dressing changes (Resident #1 and #24) has the potential to spread infection throughout the facility. Findings Include: DRESSING CHANGES Review of Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, Chapter 28 stated, . . . Skills 28.1 . . ."Standard Precautions. . . . 1. Perform proper hand hygiene after contact with . . . contaminated objects . . . a. Perform proper hand hygiene immediately after removing gloves. . . . 2. Wear clean gloves when touching . . . contaminated items. . . . Gloves. . . . The hands are cleansed each time gloves are removed for two primary reasons: (1) The gloves may have imperfections or be damaged during wearing so that they could allow microorganism entry and (2) the hands may become contaminated during glove removal. . . ." -Observation on 07/28/26 at 10:30 a.m. showed a nurse (#6) donned gloves and placed wound care supplies, including tape, a bottle of wound cleanser, packaged gauze, and packaged dressing directly on top of Resident #24's bedspread. The nurse cleansed the wound with a gauze soaked with wound cleaner and then dried the area. Without changing gloves, the nurse opened the dressing package and applied the dressing to the wound. The nurse failed to place wound supplies on a clean surface and failed to change gloves and perform hand hygiene before applying the new dressing.	F0880		08/21/2026

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F0880 SS = D	Continued from page 40 -Observation on 07/28/26 at 10:49 a.m. showed a nurse (#6) donned a gown and gloves and placed wound care supplies, including tape, a bottle of wound cleanser, unpackaged gauze, and a packaged dressing, directly on top of Resident #1's bedspread. The nurse applied wound cleanser to the gauze and cleansed the resident's wound. The nurse reached into the pocket of a jacket worn beneath the gown, removed a pair of scissors, cut the Xeroform dressing, applied it to the wound, and attempted to cut the tape. The nurse failed to cut the tape, so he/she removed the dressing from the wound, removed the gloves, cut the tap, reached into the jacket pocket to answer a portable radio, and applied tape to the gauze. The nurse reached into the jacket pocket again to answer the portable radio. Without performing hand hygiene, the nurse donned new gloves and applied the dressing. After removing the gloves, the nurse returned the scissors to the jacket pocket and used hand sanitizer before leaving the room. The nurse (#6) failed to place wound care supplies on a clean surface; perform hand hygiene and change gloves after cleansing the wound and before applying the new dressing; disinfect the scissors before cutting the Xeroform and tape; and change gloves and perform hand hygiene after handling the portable radio. MEDICATION ADMINISTRATION Review of the facility policy titled "Medication Administration" occurred on 07/29/26. This policy, revised 04/28/26, stated, ". . . Wash/Sanitize hands prior to administering medication. . . ." -Observation on 07/27/26 at 11:30 a.m. showed a nurse (#7) prepared medications for Resident #15. The nurse opened the medication cart with a key, retrieved the medication card, and removed two pills from the medication card. One of the pills fell on top of the medication cart and the nurse picked it up with bare hands and placed it in the medication cup. During an interview on 07/29/26 at 3:38 p.m., an administrative nurse (#1) stated she expected nursing staff to discard any medication that fall on the top of the medication cart.	F0880		08/21/2026