STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W , CAVALIER, North Dakota, 58220**

(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 facility reported incidence survey started on 07/07/26 and concluded 07/09/26.	F0000		07/22/2026
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels	F0584	For Resident #11, Resident #12, Resident #14, and common area Hall B fans were cleaned on July 10, 2026. These fans will be kept clean by the Environmental Services Department during a weekly inspection and cleaning to promote a homelike living environment. Any other resident fans or common area fans identified were cleaned and placed on a weekly inspection and cleaning schedule on July 21, 2026. The policy for Fan Cleaning was developed on July 22,2026 to include fan cleaning. This policy will be reviewed with Environmental Services during a scheduled meeting on July 27, 2026, to ensure all fans are monitored and cleaned. Any Environmental Service employees not at the meeting will review the policy at their next scheduled shift. The Maintenance Supervisor /designee will ensure that Resident #11, #12, #14, Hall B and any other fans in use are monitored for cleanliness. The QA monitoring process will begin the week of July 27, 2026. Report of the fan monitoring process will be submitted to the QA Committee during their monthly scheduled meeting. If concerns are identified they will be reported to the Administrator and corrective action will occur immediately. QA monitoring of fan cleanliness will occur weekly x 1-month, monthly x 3 months and quarterly thereafter x 1year.	08/07/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2026

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F0584 SS = E	Continued from page 1 in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to provide housekeeping services to maintain a safe, clean, comfortable and homelike environment for 3 of 3 sampled residents (Residents #11, #12, and #14's) and 1 of 1 commons area (Hall B) with circulating fans. Failure to ensure the residents' environment and equipment (fans) are kept clean and sanitary does not promote a homelike living environment. Findings include: Observations on 07/07/26 showed the following: * At 1:59 p.m., the grates of a black pedestal fan coated with dust and debris next to an oxygen concentrator in Resident #14's room. * At 4:42 p.m., the grates of table fan coated with dust and debris located in the common area of Hall B. Observations on all days of survey showed the following: * Resident #11's fan with visible dust debris. * Resident #12's fan grate coated with dust debris and hanging fuzz. On 07/08/26 at 3:05 p.m., a nurse (#5) placed nebulizer equipment directly in front of the blowing fan to air dry. During an interview on 07/09/26 at 10:30 a.m., a housekeeping staff (#7) stated the certified nurse aides and housekeeping staff were expected to identify dirty fans and inform maintenance staff for cleaning and confirmed the fans in Hall B common area and in residents' rooms needed cleaning.	F0584		08/07/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F0580	For Resident #15 any blood glucose level below or above the ordered parameters, the Physician/FNP/PA will be notified immediately to provide further orders in management of the blood	08/07/2026

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F0580 SS = D	Continued from page 2 §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. (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,	F0580	Continued from page 2 glucose level. The phone call to the provider and any new orders will be completed and documented in Resident #15's EMR. The nurse will carry out these orders to ensure the physician is notified of any change in a timely manner. On July 21, 2026, Resident # 15's Primary Care Physician adjusted/increased insulin orders. All residents who have the potential to be affected by monitoring of their blood glucose levels that may fall outside of their ordered parameters will be reported to the Physician/FNP/PA for further orders. This phone call to the Provider and any new orders received will be documented in the individual's EMR. The nurse will carry out these orders to ensure the Provider is notified of any changes in a timely manner. A new policy for Blood Glucose Monitoring was developed on July 22, 2026, and will be reviewed with nurses on July 27th, 2026, during a scheduled meeting. The importance of notifying Providers of any blood glucose levels outside of individual resident parameters will be reviewed. Any nurses unable to attend the meeting will receive the training at their next scheduled shift. The QA Nurse/designee will monitor Resident # 15 and any other residents that have blood glucose monitoring weekly x 1-month, monthly x 3 months and then quarterly thereafter x 1 year. The QA process will start during the week of July 27th, 2026. The QA Nurse/designee will report any concerns to the DON and immediate corrective action will be implemented. The QA Nurse/Designee will submit a report of the monitoring results to QA Committee at each scheduled monthly meeting.	08/07/2026

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F0580 SS = D	Continued from page 3 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 interviews, the facility failed to notify the resident's medical provider for 1 of 1 sampled resident (Resident #15) with high blood glucose readings. Failure to notify the provider of high blood glucose levels as ordered may result in adverse outcomes for the resident and delay in treatment. Findings include: Review of the facility policy titled “Physician Notification” occurred on 07/09/26. This policy, dated 05/29/24 stated, “. . . The facility must timely notify the attending physician or practitioner on call of change in condition, lab results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per ordering physician’s orders. Examples of timely Notification Orders: Blood glucose levels outside the individual resident parameters. . . Guidelines: . . . Immediate notifications . . . Document notification of result and condition . . .” Review of Resident #15's medical record occurred on all days of survey and included a diagnosis of type 2 diabetes mellitus. A physician's order, dated 01/22/26 stated, “Parameters for blood glucose—Call physician if BS [blood sugar] below 70 mg/dl [milligrams per deciliter] and above 400 mg/dl." Review of Resident #15's "Blood Sugar Summary," dated April 10 - July 9, 2026, showed the following blood glucose readings: * 05/19/26 at 9:42 p.m. - 445.0 mg/dL * 06/12/26 at 4:45 p.m. - 412.0 mg/dL * 06/18/26 at 4:39 p.m.- 453.0 mg/dL The medical record lacked documentation the facility notified Resident #15's provider of the elevated blood glucose levels. During an interview on 07/09/26 at 11:30 a.m., an	F0580		08/07/2026

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F0580 SS = D	Continued from page 4 administrative nurse (#2) confirmed staff failed to notify the physician of Resident #15's high blood sugar levels on the above dates. During an interview on 07/09/26 at 11:46 a.m., an administrative nurse (#1) stated she expected staff to follow orders and notify the physician of Resident #15's high blood sugar levels.	F0580		08/07/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F0656	Resident #8 care plan was updated to include a pain management care plan which addresses opioid use on July 17, 2026. Any resident who is receiving an opioid or on a pain management program that has the potential to be affected will be reviewed by the DON or Nurse Designee to ensure they have a pain management care plan by July 29, 2026. The Care Plan Policy will be reviewed specifically addressing pain management by the nurses during the July 27, 2026, scheduled meeting. Any nurses not at the meeting will receive the training by their next scheduled shift. The DON/Designee will monitor that Resident #8 and any other residents taking opioids have a comprehensive care plan that includes a pain management program. QA monitoring will be completed weekly x 1-month, monthly x 3 months, and quarterly thereafter x 1 year. Any concerns identified will be reported to the Administrator and immediate corrective action will be taken. QA monitoring will begin the week of July 27, 2026. The DON/ Nurse Designee will submit a report of their monitoring results to the QA Committee at their scheduled monthly QA Meeting.	08/07/2026

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F0656 SS = D	Continued from page 5 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 14 sampled residents (Resident #8). Failure to develop a comprehensive care plan that includes opioid medication use and pain may negatively impact the resident's quality of care. Findings include: Review of Resident #8's medical record occurred on all days of survey. Medications included hydrocodone-acetaminophen (an opioid) 5-325 milligrams (mg) every four hours as needed for pain and hydrocodone-acetaminophen 7.50-325 mg three times a day for pain. The admission Minimum Data Set (MDS) dated 06/18/26, identified Resident #8 received opioid medication, non-medication intervention for pain, and experienced pain almost constant during the assessment period. Resident #8's care plan lacked goals and interventions related to opioid use and pain. During an interview on 07/09/26 at 11:50 a.m., an administrative staff nurse (#1) confirmed staff failed to include opioid medication risks/side effects and interventions for pain management in Resident #8's care plan.	F0656		08/07/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F0689	For Resident #6 staff will be educated to use the gait belt during any transfer. Resident #6 will be monitored by the QA Nurse/Designee to ensure staff are transferring with a gait belt to promote an environment free of accidents and hazards. Any resident that may have the potential to be affected by not using appropriate supervision or assistive device with transferring will be monitored to ensure appropriate assistive devices are being utilized during transfers.	08/07/2026

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F0689 SS = D	Continued from page 6 supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to utilize the assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #6) observed during a transfer. Failure to use a gait belt during transfers placed residents at risk for injuries and falls. Findings include: Review of the facility policy titled “Use of Gait Belt” occurred on 07/09/26. This policy, dated 03/16/23, stated, “. . . Use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. . .” Review of Resident #6's medical record occurred on all days of survey. The care plan, stated, “Assist of 1 with transfers with gait belt, toileting, dressing, bathing, and personal hygiene. . . .” Observation on 07/08/26 at 9:35 a.m. showed a certified nurse aide (CNA) (#4) assisted Resident #6 to the bathroom without using a gait belt. During an interview on 07/08/26 at 10:11 a.m., Resident #6 stated, “Therapy uses the gait belt when they are working with me, but the CNA’s typically do not.” During an interview on 07/09/26 at 11:47 a.m., an administrative nurse (#1) stated she expected staff to use a gait belt during transfers.	F0689	Continued from page 6 The policy titled Use of Gait belts will be reviewed by nursing and CNA's on July 27th, 2026. Anyone unable to attend the meeting will receive the training by their next scheduled shift. The QA Nurse/designee will monitor that for Resident #6 and a random resident population of 20% of our resident's census to ensure appropriate supervision and assistance devices are used. Any concerns identified will be reported to the DON and immediate corrective action will occur. QA monitoring will begin the week of July 27, 2026. QA monitoring will occur weekly x 1-month, monthly x 3 months and quarterly thereafter x 1 month. The QA Nurse/Designee will submit a report of the monitoring results to the QA Committee at each scheduled monthly meeting.	08/07/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by:	F0695	For Resident #11 to ensure oxygen is administered as ordered by the physician: Resident #11's oxygen was adjusted to the correct 3 L/m per nasal cannula on July 9th, 2026. Resident #11 will be monitored by the QA Nurse/Designee to ensure that oxygen is administered as ordered by the MD. Resident #11 will have their oxygen orders verified by the day and night nurse on duty each shift to ensure the oxygen is at the ordered rate of administration. To ensure any resident receiving oxygen who has the potential to be affected, they will also be placed on QA monitoring program to ensure they are receiving the oxygen as ordered. Anyone receiving oxygen will have their oxygen orders verified by the day and night nurse on duty to ensure the oxygen is	08/07/2026

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F0695 SS = D	Continued from page 7 Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #11) receiving oxygen. Failure to administer oxygen according to the physician's order may result in complications and compromise the resident's respiratory status. Findings include: Review of the facility policy titled "Oxygen Administration" occurred on 07/09/26. This policy, dated March 2023, stated, ". . . Oxygen is administered under orders of a physician . . . Equipment setting for the prescribed flow rates. . . ." Review of Resident #11's medical record occurred on all days of survey. Diagnoses included acute and chronic respiratory failure with hypoxia (inadequate oxygen reaching the body's tissues) and chronic obstructive pulmonary disease with acute exacerbation. A physician's order, dated 05/18/26, stated, "Continuous oxygen via NC [nasal cannula] set at 3 LPM [liters per minute] in use." The current care plan stated, ". . . observe for s/s [signs and symptoms] of sob [shortness of breath]. . . . Oxygen at 3L/min via Nasal Cannula . . ." Review of the nurse's progress notes from February 1 through July 7, 2026, identified 30 times Resident #11 complained of shortness of breath. Observations on all days of survey showed Resident #11's room oxygen concentrator setting at 2 LPM. During an interview on 07/09/26 at 8:35 a.m., Resident #11 stated the oxygen concentrator should be set at 3 LPM. During an interview on 07/09/26 at 8:47 a.m., a nurse (#5) confirmed the physician's order stated oxygen at 3 LPM. During an interview on 07/09/26 at 8:55 a.m., an administrative nurse (#1) stated she expected staff to administer oxygen at the rate ordered by the physician.	F0695	Continued from page 7 at the ordered rate of administration for that individual. The policy for Oxygen Administration was revised on July 22, 2026, to include that the nurse will verify the appropriate flow rate of oxygen is administered by nursing staff each shift. The revised policy on Oxygen Administration will be reviewed during the scheduled meeting on July 27, 2026. Anyone unable to attend the meeting will receive the training by their next scheduled shift. The QA Nurse/Designee will be responsible to monitor Resident #11 and any resident using oxygen to ensure the oxygen is administered at the ordered flow rate for each individual resident. QA monitoring will begin the week of July 27, 2026. Any concerns identified will be reported to the DON and immediate corrective action will occur. QA monitoring will occur weekly x 1-month, monthly x 3 months and quarterly thereafter x 1 year. Results of the QA monitoring will be reported to the QA Committee during the scheduled monthly meeting.	08/07/2026
F0908 SS = D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.	F0908	Resident #12 was given a new nebulizer machine on July 9, 2026, to ensure patient care equipment is in safe operating condition. The old machine was removed from service. Any resident receiving nebulizer treatments their	08/07/2026

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F0908 SS = D	Continued from page 8 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure the safety of equipment for 1 of 2 sampled resident (Resident #12) observed with a nebulizer machine. Failure to maintain equipment in safe operating conditions may result in equipment short circuiting, fires, and injuries to the residents or staff. Findings include: The facility was unable to provide a policy on equipment maintenance. Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, ". . . I self-administer my nebulizer after set up by nurse . . ." Observation on all days of survey showed the power cord to Resident #12's nebulizer machine damaged and the insulated conductor wires exposed. During an interview on 07/09/2026 at 11:16 a.m., an administrative nurse (#1) stated she expected all equipment to be in proper working order and immediately removed the nebulizer machine from Resident #12's room.	F0908	Continued from page 8 nebulizer machines were inspected to ensure their nebulizer machine is in safe operating condition. The policy for Nebulizer Therapy was developed on July 22, 2026, and will be reviewed with staff during the scheduled meeting on July 27, 2026. This policy will include to monitor that nebulizer machines are in safe operating condition. Any staff not in attendance at the meeting will review this policy by their next scheduled shift. Resident #12 and any other resident receiving a nebulizer will be monitored to ensure their nebulizer is in safe operating condition. The QA monitoring will be completed by the QA Nurse/Designee weekly x 1-month, monthly x 3 months and quarterly thereafter x 1 year to ensure machines are maintained in safe, operating condition. Any nebulizer machine that is not in good repair will be removed from service immediately. QA monitoring will begin the week of July 27, 2026. Any concerns identified will be reported to the DON and immediate corrective action will occur. Monitoring results will be reported to QA Committee during their scheduled monthly meeting.	08/07/2026