North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8201	A. BUILDING: _____ B. WING _____	C 09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WEST FARGO	645 33RD AVENUE EAST WEST FARGO, ND 58078

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B 000	INITIAL COMMENTS For the unannounced complaint survey completed on 09/16/26, the sample included 3 residents for review. Tier II citations included B925, B1240, and B2403.	B 000	See Attachment.	
B 925	33-03-24.1-09,2,e GOVERNING BODY e. Prohibition of resident abuse, neglect, and misappropriation of resident property, including investigation, reporting, and follow-up action. This State Licensing Rule is not met as evidenced by: Based on record review, review of the resident's rights guide, review of facility policy, and staff interview, the facility failed to ensure resident remained free from abuse for 1 of 1 sampled resident (Resident #2) who experienced physical abuse from another resident. Failure to implement appropriate and immediate interventions resulted in continued physical abuse to Resident #2. Findings include: Review of "A Guide to Your Rights as an Individual Living in a Basic Care Facility In North Dakota" occurred on 09/16/26. This guide, dated August 2025, stated ". . . You should not experience . . . physical . . . abuse. . ." Review of the facility policy titled "Behavioral Expression Management" occurred on 09/16/26.	B 925		

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Crystal Cayla TITLE Executive Director (X6) DATE 10-14-26

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B 925	Continued From page 1 This policy, dated April 2026, stated, ". . . The licensed nurse or designee will . . . document and track interventions and their outcomes with the goal of managing behavioral expression by identifying successful resident-specific interventions and decreasing or eliminating behavioral expressions by identifying and avoiding triggers of the behavioral expressions . . ." Findings include: Review of the incident reports identified Resident #2 was subjected to physical abuse by Resident #3 on two occasions (09/04/26 and 09/12/26). -Review of Resident #2's medical record occurred on 09/16/26. Diagnosis included mild cognitive impairment. -Review of Resident #3's medical record occurred on 09/16/26. Diagnosis included dementia. Review of Resident #3's progress notes showed the following: *09/04/26 at 10:37 a.m., stated ". . . CNA [certified nursing assistant] reported hearing a loud scream and observed resident [Resident #3] standing over his wife [Resident #2] and repeatedly hitting her in the chest. Staff intervened and attempted to redirect and calm the resident; however, resident continued to display aggressive behavior toward staff. Nurse contacted resident's son, who came to the facility and assisted with calming resident. CNA administered PRN [as needed] olanzapine [antipsychotic] 2.5 mg [milligram] as ordered for agitation/aggressive behavior. PRN medication was effective, and resident became calmer	B 925		

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B1240	Continued From page 3	B1240		
B1240	33-03-24.1-12,4 RESIDENT ASSESSMENTS/CARE PLANS 4. The care plan must be updated as needed, but no less than quarterly. This State Licensing Rule is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure care plans reflected the current status for 1 of 3 sampled residents (Resident #3). Failure to review and revise care plans limits staff's ability to meet residents' current care needs. Findings include: Review of the facility policy titled "Assessments and Evaluations" occurred on 09/16/26. This policy, dated April 2026, stated, "The community will conduct assessments, observation, and reassessments . . . to determine the services needed by residents in an effort to support . . . safety. . . Assessments will be thorough and timely to support the identification of resident care needs. . . " Review of Resident #3's medical record occurred on 09/16/26. Diagnoses include severe dementia. The individualized service plan (care plan) failed to include behavioral interventions. Review of Resident #3's progress notes showed the following: *09/04/26 at 10:37 a.m., ". . . CNA [certified nurse aide] reported hearing a loud scream and observed (Resident #3) standing over his wife [Resident #2] and repeatedly hitting her in the chest. Staff intervened and attempted to redirect	B1240		

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B1240	Continued From page 4 and calm the resident; however, resident continued to display aggressive behavior toward staff. . . ." *09/12/26 at 3:58 p.m., "Med Passer called stating that resident [Resident #3] is striking his spouse [Resident #2]. POA [power of attorney] called to come to community to help defuse the situation . . ." *09/14/26 at 3:34 p.m., "Resident [Resident #3] and spouse [Resident #2] were sitting at a table in the dining room when the resident [Resident #3] started hitting his wife [Resident #2]. When staff tried to stop him, he turned on staff. . . ." The facility failed to update Resident #3's current care plan related to behaviors and interventions to address the resident's physical behaviors. During an interview on 09/16/26 at 5:15 p.m., an administrative nurse (#1) confirmed she expected staff to update residents' care plans to reflect their current behavioral status and individualized interventions.	B1240		
B2403	33-03-24.1-24,3 Optional Alzheimer's, Demential, Special Mem The facility or unit licensed to provide specialized care and services to residents under this section shall provide: a. Care of residents with chronic moderate to severe memory loss or an individual who has significant emotional, behavioral, or cognitive impairments and needs services that may include independent living skills, support and training to promote and develop relationships, participate in the social life of the community, and develop behavioral skills	B2403		

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B2403	Continued From page 5 as determined necessary based on assessment and care plan; b. Protective oversight and supervision in a structured environment that is staffed with sufficient personal care and intermittent licensed nursing staff to monitor, evaluate, and accommodate an individual's changing needs; c. Service in which assistance with activities of daily living and independent activities of daily living, therapeutic, social, and recreational programming is provided; and d. Care furnished in a way that fosters the maintenance or improvement, as appropriate, to promote independence of the resident. This State Licensing Rule is not met as evidenced by: Based on record review and review of facility policy, the facility failed to ensure specialized care and services including protective oversight and supervision for 2 of 3 sampled residents (Resident #2 and #3) in the memory care unit. Failure to provide care and services for residents with dementia in a manner that meets their individual needs and promotes their safety, dignity, and comfort resulted in physical abuse and unmanaged behaviors. Findings include: Review of the facility policy titled "Behavioral Expression Management" occurred on 09/16/26. This policy, dated April 2026, stated, " . . . document and track interventions and their outcomes with the goal of managing behavioral expression by identifying successful resident-specific interventions and decreasing or	B2403		

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B2403	Continued From page 6 eliminating behavioral expressions by identifying and avoiding triggers of the behavioral expressions . . ." -Review of Resident #2's individualized service plan occurred on 09/16/26. The service plan states, ". . . resident's husband will be in memory care with resident. . . ." The service plan lacked interventions for the mental and safety needs related to the physical abuse from Resident #3. -Review of Resident #3's individualized service plan occurred on 09/16/26. The service plan lacked a plan or interventions regarding the resident's behavior/abuse towards Resident #2 and the resident's emotional needs. The facility failed to provide appropriate protective oversight, and supervision in a memory care setting for Resident #2 and #3 which resulted in continued abuse and unmanaged behaviors. Refer to B925	B2403		

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B2403	Continued From page 6 eliminating behavioral expressions by identifying and avoiding triggers of the behavioral expressions . . ." -Review of Resident #2's individualized service plan occurred on 09/16/26. The service plan states, ". . . resident's husband will be in memory care with resident. . . ." The service plan lacked interventions for the mental and safety needs related to the physical abuse from Resident #3. -Review of Resident #3's individualized service plan occurred on 09/16/26. The service plan lacked a plan or interventions regarding the resident's behavior/abuse towards Resident #2 and the resident's emotional needs. The facility failed to provide appropriate protective oversight, and supervision in a memory care setting for Resident #2 and #3 which resulted in continued abuse and unmanaged behaviors. Refer to B925	B2403		

B925

The Health & Wellness Director (HWD) immediately separated Resident #2 and Resident #3, established 1-on-1 caregiver support for Resident #3, completed a comprehensive behavioral assessment, and updated both residents' service plans with specific risk-minimization measures. The Regional Director of Clinical Services reviewed the records of 5 residents with cognitive impairment and a history of behavioral expressions over the past 30 days to verify that behavioral assessments and individualized risk-minimization plans are in place, correcting any identified gaps. The HWD implemented a standardized clinical review protocol in the electronic health record requiring an immediate vulnerable adult assessment, primary care provider consultation, and legal representative notification within 24 hours of any resident-to-resident physical altercation. The Regional Director of Clinical Services educated the HWD and Executive Director (ED) on resident-to-resident abuse prevention; the HWD then educated all Caregivers, Caregiver Med Passers, and licensed nurses on identifying behavioral triggers, immediate separation interventions, and mandatory reporting timelines. The HWD will review 3 resident behavioral logs and incident reports weekly for 12 weeks to monitor intervention effectiveness; the Regional Director of Clinical Services will audit these reviews monthly for 90 days and present findings to the Quality Assurance (QA) process. Resident #3 has been out of the Community since September 17, 2026. Resident #2 & Resident #3 Power of Attorney has provided written 30-days' notice to end their Residency on November 8, 2026.

Compliance Date: October 14th, 2026. Scheduled audits continue to ensure on-going compliance is maintained

B1240

The Health & Wellness Director (HWD) updated Resident #3's service plan to include specific behavioral interventions and redirection strategies to address physical aggression. The HWD audited service plans for residents with documented behavioral incidents in the past 30 days to verify that appropriate behavioral interventions were incorporated, correcting any gaps found. The HWD implemented a daily clinical review of progress notes to identify behavioral changes, triggering an immediate service plan update and care conference when new behaviors occur. The Regional Director of Clinical Services re-educated the HWD on service plan updates following behavioral changes; the HWD re-educated all RNs and LPNs on the same, validated by a written post-test. The HWD will audit 5 behavioral incident records weekly for 12 weeks to verify service plans are updated; the Regional Director of Clinical Services will audit 20% of these audits monthly and review findings in the Quality Assurance (QA) process.

Compliance Date: October 21st, 2026. Scheduled audits continue to ensure on-going compliance is maintained

B2403

The Health & Wellness Director (HWD) immediately updated the individualized service plans for Resident #2 and Resident #3 to include specific behavioral interventions, safety measures, and triggers, and initiated the Behavioral Expressions Monitoring Log for Resident #3. The Regional Director of Clinical Services conducted a comprehensive audit of memory care resident service plans and behavioral logs over the past 30 days to identify any unmanaged behavioral expressions, updating plans and implementing monitoring logs for any variances found. The HWD integrated a daily week-day review of the 24-Hour Shift Log and Crossover Report into the morning leadership meeting to identify new behavioral expressions and immediately initiate the Behavioral Expressions Monitoring Log and clinical assessment. The Regional Director of Clinical Services re-educated the HWD on behavioral expression management and coordination of care; the HWD then re-educated all Caregivers and Caregiver Med Passers on identifying triggers and documenting interventions. The HWD will audit 5 behavioral logs and observe resident interactions weekly for 4 weeks, then monthly for 3 months; the Regional Director of Clinical Services will review these audits monthly and report findings to the Quality Assurance (QA) process.

Compliance Date: October 23rd. Scheduled audits continue to ensure on-going compliance is maintained