STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 01/27/20 and concluded 01/30/20.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		3/5/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/21/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care in a manner that enhanced or maintained residents' dignity for 2 of 36 sampled residents (Resident #111 and #130). Failure to ensure residents' privacy while providing personal cares does not enhance their quality of life and is a violation of residents' rights. Findings include: Review of the facility's standards of care policy occurred on 01/30/20 and identified skills/tasks to be completed by the certified nursing assistants (CNAs). The document stated, "Privacy/Dignity . . . Knock & count to 5 or await response before entering room . . ." - Observation on 01/27/20 at 2:58 p.m. showed a staff member (#1) assisted Resident #111 to the bathroom. While the resident was in the bathroom and seated on the toilet, another unidentified staff member knocked on the door to the resident's room. The staff member (#1) stated, "Just a minute;" however, the unidentified staff member entered the room to bring fresh water. While Resident #111 was standing and the staff member (#1) provided perineal care, a	F 550	The staff who care for Residents #111 and #130 were reeducated to the appropriate protocol for entering a resident's room through a memo, an on-line learning module, and a post-test by 3/5/2020. All residents have the potential to be affected by the practice of not of staff not waiting five seconds prior to entering their rooms. It is the standard of Valley Senior Living to have all staff knock and wait five seconds prior to entering a resident room unless told to enter sooner. CNAs will be educated by 3/5/2020 on the standard of waiting five seconds after knocking including times when another staff member is already in the room. To ensure that CNAs and Nurses are preserving resident dignity, the Staff Development Nurse or designee will be responsible to conduct a minimum of ten random resident care audits per week and share the results at the monthly Quality Review Team meetings. Upon completion of three months of audits, a determination will be made for the continued audit frequency. Audits will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 550	Continued From page 2 different unidentified staff member knocked on the door. The staff member (#1) again stated, "Just a minute;" however, the unidentified staff member entered the room to bring fresh water. The staff member noticed Resident #111 already had water, looked into the bathroom, and stated, "Oh, you already have some [water]," and then left the room. - Observation on 01/28/20 at 4:49 p.m. showed a CNA (#3) assisted Resident #130 with catheter care in the resident's room. An unidentified staff member knocked on the door and immediately entered the room. The staff member stated, "Oh," and then left the room. During an interview on the morning of 01/30/20, a supervisory staff member (#2) stated staff are expected to knock on doors and wait for a response.	F 550	continue for the remainder of the year but may decrease based on the results.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 623	Continued From page 3	F 623		

paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 623	Continued From page 4	F 623		

hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 623	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and review of the facility policy, the facility failed to provide residents, and/or the resident's legal representative, and/or the Office of the State Long Term Care (LTC) Ombudsman a written notice of transfer for 3 of 6 sampled residents (Residents #29, #49, and #114) transferred to the hospital. Failure to provide a notice of transfer and/or a written copy of the transfer form and inform the Ombudsman of all transfers does not allow residents and/or their representative to make informed decisions. Findings include: Review of the facility policy titled "Transfer and Discharge of Residents" occurred on 01/30/20. This policy, revised on September 2019, stated, ". . . Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing in a language and manner that they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman and will document such in the medical record. . . . Contents of notice will be specified in writing and a copy provided to the resident and the resident's legal representative. . . . " - Review of Resident #29's medical record occurred on all days of survey and identified the facility transferred Resident #29 to the hospital on 10/24/19 and 10/28/19. The record lacked evidence the facility provided the resident's representative and the State LTC Ombudsman a written copy of the notice of transfer for both	F 623	Even though all instances of the notices are beyond the 30 day window, the transfer forms for Residents #29, #49, #106, and #114 will be sent to the Office of the State Ombudsman. The notices were provided in writing to the residents and resident's representatives at a date that was near the transfer. All residents who transfer between care settings have the potential to be affected by not completing the transfer/discharge paperwork appropriately. The Director of Social Services or designees are responsible for the following process changes to ensure the ombudsman has the required notices. First, the facility will send the ombudsman a monthly list of residents starting in March for the February transfers that are exceptions to the 30-day requirement of prior notification. February's transfer list will be submitted prior to March 5, 2020. Second, prior to giving the resident and resident's representative a written copy of the transfer notice, social services staff will ensure that each notice has been completed correctly. The Director of Social Services or designee will audit every transfer notice on a monthly basis for three months and report the results of the audits at the monthly Quality Review Team meetings. The first audit will be completed by 3/5/2020. Upon completion of three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 623	Continued From page 6 hospitalizations. - Review of Resident #49's medical record occurred on all days of survey and identified the facility transferred Resident #49 to the hospital on 02/15/19. The record lacked evidence the facility provided the State LTC Ombudsman a written copy of the notice of transfer. - Review of Resident #114's medical record occurred on all days of survey and identified the facility transferred Resident #114 to the hospital on 12/19/19. The record lacked evidence the facility provided the resident's representative and the State LTC Ombudsman a written copy of the notice of transfer for the hospitalization.	F 623	months of audits, a determination will be made for the continued audit frequency. Audits will continue for the remainder of the year but may change based on the results of the audits.	
F 644 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.	F 644		3/5/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 644	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASRR), the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #50) 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: The North Dakota PASRR Provider Manual states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend 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 a 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 #50's medical record occurred on all days of survey. The record showed an initial PASRR completed on 08/08/18 and identified a diagnosis of dementia and no mental illness. A psychiatric progress note, dated 09/05/19, identified a diagnosis of unspecified psychotic disorder. The record lacked evidence	F 644	A new Level 1 screening was completed for Resident 50 on 1/30/2020. Any resident who has a newly diagnosed mental illness or significant change in status could be affected by not completing an updated Level 1 screening. The Director of Social Services and designees will conduct an audit of all current residents' status compared to the prior Level 1 screening by 3/5/2020. If a change in status is found, a new Level 1 screening will be completed. It is the responsibility of the Director of Social Services and designees to repeat this audit for all residents during their quarterly assessment and report the findings to the Quality Review Team on a monthly basis. The first audit will be completed by 3/5/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 644	Continued From page 8 of an updated Level I screening/change in status assessment since this diagnosis.	F 644		
F 880 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: §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 §483.70(e) 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	F 880		3/5/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 880	Continued From page 9 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. §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, and staff interview, the facility failed to follow infection control practices for 1 of 3 meals observed. Failure to follow infection control	F 880	CNA #4 will receive one-on-one hand hygiene education and complete a hand hygiene module in Healthcare Academy by 3/5/2020. All residents who require	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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
F 880	Continued From page 10 practices during meals has the potential to transmit infections to other residents and staff. Findings include: Review of the facility policy titled "Standard Precautions" occurred on 01/30/20. This policy, revised on July 2019, stated, ". . . Standard precautions will be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, . . . may contain transmissible infectious agents. . . . Gloves (clean, sterile) are worn when you anticipate direct contact with blood, body fluids . . . Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. After gloves are removed, perform hand hygiene immediately to avoid transfer of microorganisms to other residents or environments. . . " Observation on 01/27/20 at 6:26 p.m. showed a certified nurse assistant (CNA) (#4) seated at the dining room table feeding two different residents their evening meal. The CNA (#4), with gloved hands, wiped one of the resident's nose secretions with a paper napkin a total of four times throughout the meal, and continued to feed both residents wearing these same gloves. The CNA (#4) failed to remove the contaminated gloves and complete hand hygiene. During an interview on 01/30/20 at 11:23 a.m., administrative staff (#5 and #6) agreed the CNA (#4) failed to follow appropriate infection control practice when feeding residents during the	F 880	assistance with the consumption of meals have the potential to be affected by this practice. CNAs and Nurses will complete the hand hygiene module in Healthcare Academy by 3/5/2020. To ensure the use of standard precautions while assisting a resident to dine, The Infection Preventionist or designee is responsible to complete ten random mealtime audits per week and report the results of the audits at the monthly Quality Review Team meetings. Upon completion of three months of audits, a determination will be made for the continued audit frequency. Audits will continue for the remainder of the year but the frequency may change based on the results of the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	**2900 14TH AVE S GRAND FORKS, ND 58201**

(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
F 880	Continued From page 11 01/27/20 evening meal.	F 880		