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 _____	C 06/19/2025

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

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey and complaint survey started on 06/16/25 and concluded 06/19/25.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the	F 641	1. The MDS from January 6, 2025 was	7/11/25

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

Electronically Signed | 07/01/2025

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F 641	Continued From page 1 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 35 sampled residents (Resident #36). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2024, page A-32, stated, ". . . Coding Instructions. Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . . ." Review of Resident #36's medical record occurred on all days of survey. The record included diagnoses of bipolar disorder, Tourette's disorder, and autistic disorder. A comprehensive MDS, dated 01/06/25, showed the facility failed to code Section A1500 for a serious mental illness. During an interview on 06/19/25 at 10:12 a.m., an administrative nurse (#1) confirmed staff failed to accurately code section A on Resident #36's MDS.	F 641	corrected and submitted for Resident #36 on June 19, 2025. 2. All residents with an identified serious mental illness, intellectual disability, or a related condition have the potential to be affected by this practice. 3. The most recent comprehensive MDS for all residents who have a serious mental illness, intellectual disability, or a related condition will be reviewed for accuracy by July 11, 2025. 4. The Director of Nursing Services or their designee will audit 10 comprehensive MDSs per month for the next 12 months to ensure accurate coding for serious mental illness. The results of those audits will be reported to the Quality Review Team on a monthly basis for the next year.	
F 689 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	F 689		

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F 689	Continued From page 2 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility reported incident (FRI) investigation, and review of facility policy, the facility failed to properly utilize assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #150) who fell during a staff assisted transfer. Failure to utilize the gait belt resulted in Resident #150's fall/fracture and placed all residents transferred with a gait belt at risk for injury. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include: The surveyor determined a deficient practice existed on 02/26/25. The facility implemented corrective action immediately, completed corrective action on 03/03/25, and continues with staff education and monitoring. Review of the facility policy titled "Gait Belt Use" occurred on 06/19/25. This policy, revised August 2023, stated, ". . . Use an underhand grasp to hold on to the gait belt . . ." Review of Resident #150's medical record occurred on all days of survey. Diagnoses included right femur fracture. The care plan stated, ". . . TRANSFER: assist by 1 staff with gait belt . . . I am at risk for falls r/t [relate to] cognitive impairments, gait/balance problems, deconditioning . . . I have parkinsonism affecting	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 3 my balance and mobility. . . ." A FRI investigation, dated 03/03/25, stated, ". . . [Resident #150] was being assisted by [CNA [#3] in her room. [The] Resident is care planned as assist of one with [a] gait belt for transfers and ambulation. [CNA #3] had the gait belt in place and had assisted [the] resident from the bathroom to the sink in her room. LBSW [Licensed Baccalaureate Social Worker #4] came into the room and was talking to resident [#150]. At that time, [CNA #3] let go of the gait belt to throw trash in the bathroom. LBSW [#4] noted [the] resident starting to tip backward and yelled to notify [CNA [#3]. [The] Resident then fell backwards, hitting her head on the sink and fell to the ground. Resident [#150] complained of pain, was transferred to the ER [emergency room], and subsequently diagnosed with a displaced, right femur fracture. She required surgical repair. . . ." The facility failed to ensure staff utilized the gait belt while assisting Resident #150. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the following corrective actions to ensure all residents affected by the deficient practice were transferred in an appropriate manner: * Completed an investigation into Resident #150's fall/right femur fracture. * Suspended CNA (#3) following the incident and terminated him/her after completing the investigation. * Provided staff education regarding	F 689		

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F 689	Continued From page 4 staff-assisted transfers/gait belt use via electronic messages and/or posted memos. * Completed competency testing to ensure staff met the requirements for staff-assisted transfers/gait belt use. * Updated resident care plans as necessary. * Updated policies and procedures addressing staff-assisted transfer/gait belt use. * Initiated a four-stage (plan-do-study-act) quality improvement plan.	F 689		
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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		7/18/25

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F 880	Continued From page 5 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. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 6 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 12 sampled residents (Resident #30, #153, and #275) observed during cares/wound care. Failure to practice infection control standards related to enhanced barrier precautions (EBP), perineal care, catheter cares, dressing changes, and hand hygiene, has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Dressings: Dry and Moist-to-Dry" occurred on 06/18/25. This policy, dated April 2022, stated, ". . . Apply antiseptic ointment (if ordered) with sterile cotton-tipped swab or gauze . . . Dispose of gloves and perform hand hygiene. . . ." Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 06/19/25. This policy, dated April 2025, stated, ". . . EBPs apply when: A resident . . . has a wound. . . Indwelling medical devices include . . . urinary catheters . . . EBPs employ targeted gown and glove use in addition to standard precautions during high-contact resident care activities . . . Examples of high-contact resident care activities . . . providing hygiene or grooming; changing briefs or assisting with toileting; transferring; bed mobility; wound care . . ."	F 880	1. CNA #6 will be reeducated to follow appropriate infection control standards for doffing Personal Protective Equipment (PPE), hand hygiene, and draining a urinary catheter bag by July 3, 2025. Nurse #2 will be reeducated on changing gloves after applying an ointment, and Nurses #2 and #5 will be reeducated on the use of a barrier when placing items on the floor by July 3, 2025. 2. All residents have the potential to be affected by lapses in infection control during dressing changes, hand hygiene, improper use of PPE, and improperly emptying a urinary drainage bag. 3. All CNAs and Nurses will receive education about infection control during dressing changes, hand hygiene, emptying urinary drainage bags, and enhanced barrier precautions by July 18, 2025. 4. The Staff Development RN or designee will ensure Resident Care Audits are completed for all CNAs within 30, 60, 90 days of hire and annually. Hand hygiene and proper use of PPE is observed on all of those audits. The Infection Preventionist or designee will complete an audit for proper hand hygiene and use of PPE for 15 nursing staff weekly for 3 months and 40 staff monthly for the next 9 months. The Infection Preventionist or designee will complete 5 weekly Dressing Change Audits for 3 months and 10 per	

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F 880	Continued From page 7 Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 06/19/25. This policy, dated October 2024, stated, ". . . Hand hygiene is indicated: after contact with . . . body fluids or contaminated surfaces; after touching a resident; after touching the resident's environment . . ." - Review of Resident #30 medical record occurred on all days of survey. Diagnoses included us of a urinary device. The quarterly Minumum Data Set (MDS), dated 05/14/25, identified an indwelling catheter. The care plan stated, ". . . I require the use of Enhanced Barrier Precautions d/t [due to] indwelling medical device. . . ." Observation on 06/16/25 at 2:28 p.m. showed two certified nurse aides (CNAs) (#6 and #7) applied a gown and gloves before entering Resident #30's room. One of the CNAs (#6) repositioned the resident's wheelchair, touched the resident's personal items, and without removing her gown and gloves exited the room to obtain an incontinence pad. The CNA (#6) returned to the room, transferred Resident #30 into bed, obtained a graduate, placed the resident's urinary catheter leg bag into the graduate, allowing the bag and the tip to touch the sides of the graduate, and drained the urine. Without removing the soiled gloves the CNA (#6) removed the resident's pants, ace wraps, and compression stockings. The CNA (#6) then removed the soiled gloves, applied new gloves, transferred the resident to a shower chair, exited the room, and transported Resident #30 to the shower room. The CNA failed to follow proper infection control standards for draining a urinary	F 880	month for the next 9 months. The Staff Development RN or designee will audit 10 nursing staff weekly on emptying urinary drainage bags for 3 months and 10 staff monthly for the next 9 months. The results of these audits will be reported to the Quality Review Team monthly for the next twelve months.	

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F 880	Continued From page 8	F 880		

catheter bag, failed to remove her gown/gloves, and failed to complete hand hygiene.

- Review of Resident #275's medical record occurred on all days of survey. Diagnoses included a left heel ulcer with a physician's order for Silvadene cream (topical ointment), xeroform (mesh gauze), absorbent dressing, and gauze.

Observation on 06/17/25 at 8:13 a.m. showed the nurse (#2) applied gloves and applied Silvadene ointment to the Resident's 275's wound with a gloved finger, covered the wound with xeroform, and an absorbent dressing, and wrapped the area with gauze. The nurse (#2) failed to change gloves after applying ointment with gloved finger.

- Review of Resident #153 medical record occurred on all days of survey. Diagnosis included a pressure injury to the left heel with a physician's order for xeroform, absorbent dressing, and wrap every day and evening shift.

Observation on 06/17/25 at 10:25 a.m. showed two nurses (#2 and #5) performed Resident #153's dressing change. During the dressing change the nurses placed the bottle of wound cleanser and hand sanitizer directly on the floor and returned the items to the basin of supplies a few minutes later. The nurses failed to set the items on a clean barrier.

During an interview on the afternoon of 06/18/25 an administrative nurse (#1) confirmed she expected staff to utilize a barrier for clean supplies and follow infection control policies.