

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355067		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/26/2025	
NAME OF PROVIDER OR SUPPLIER VALLEY SENIOR LIVING ON COLUMBIA				STREET ADDRESS, CITY, STATE, ZIP CODE 2900 14TH AVE S , GRAND FORKS, North Dakota, 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	
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on November 26, 2025. During the report investigation the facility was found noncompliant with regulatory requirements.		F0000				
F0600 SS = D	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 -review of a facility reported incident (FRI), record review, review of facility policy, and resident and staff interviews, the facility failed to ensure residents remained free from abuse for 1 of 1 sampled resident (Resident #2) who experienced unwanted sexual contact from another resident (Resident #1). Failure to protect residents from sexual abuse places all residents at risk for psychosocial harm and mental and emotional distress. Findings include: The surveyors determined a deficient practice existed on 08/19/25. the facility implemented and completed corrective action on 08/19/25.		F0600	"Past Noncompliance - no plan of correction required"			

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: 355067		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/26/2025	
NAME OF PROVIDER OR SUPPLIER VALLEY SENIOR LIVING ON COLUMBIA				STREET ADDRESS, CITY, STATE, ZIP CODE 2900 14TH AVE S , GRAND FORKS, North Dakota, 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	
F0600 SS = D	Continued from page 1 Review of the facility policy titled "Valley Senior Living Personnel Policy and Procedure 207.7" occurred on 11/26/25. This policy, dated October 2024, stated, "... Every resident has the right to be free from abuse ..." Review of the FRI identified on 08/19/25 at 8:30 a.m., "... Residents [#1 and #2] were self mobilizing their wheelchairs after breakfast down the hallway. [Resident #1] wheeled next to [Resident #2], reached out and cupped her breast, then blew kisses at her. ..." - Review of Resident #1's medical record occurred on 11/26/25 and identified a diagnosis of dementia with other behavioral disturbance. The quarterly Minimum Data Set (MDS), dated 08/08/25, identified severe cognitive impairment and physical behaviors towards others. The care plan stated, "... I have sexually inappropriate behaviors such as sexually explicit comments and inappropriate touching due to dementia ... Be observant of my interactions with other residents, such as in communal room. ... Explain/reinforce why my behavior is inappropriate and/or unacceptable. ... Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. ..." - Review of Resident #2's medical record occurred on 11/26/25. The quarterly MDS, dated 10/14/25, identified intact cognition. A progress note dated 08/19/25 at 11:14 a.m. stated, "... SW (social worker) interviewed [Resident #2], charge nurse ... present. She has some expressive aphasia so was prompted on what occurred. [Resident #2] stated that [Resident #1] touched her and when asked where, stated 'breast.' When asked if he said anything, she nodded yes but could not verbalize what was said. When asked if she was afraid, she said 'no'. When asked if she felt safe, she said 'yes' ..." During an interview on 11/26/25 at 2:40 p.m., Resident #2 stated she could not recall the incident very clearly. When asked if she was afraid of [Resident #2] she nodded no. When asked if she was afraid of anyone else, she said, "No." Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented the corrective action for the deficient practice by: *Completing an investigation with interviews of		F0600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355067		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/26/2025	
NAME OF PROVIDER OR SUPPLIER VALLEY SENIOR LIVING ON COLUMBIA				STREET ADDRESS, CITY, STATE, ZIP CODE 2900 14TH AVE S , GRAND FORKS, North Dakota, 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
F0600 SS = D	Continued from page 2 residents and staff. *Placed Resident #1 on 72-hour monitoring *Completed an interdisciplinary team meeting immediately after the incident. *Referred Resident #1 to their primary care provider regarding his behavior and reviewing/adjusting medications. *Updated Resident #1's plan of care to include 1:1 supervision when out of his room. *Provided education to all nursing staff on supervision requirements, behavior interventions, and reporting on 08/19/25.			F0600			