

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

|                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  |                                                                                             |                                                                                                                                                                                                                                                                                                               |                                                        |                            |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355112</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____ |                                                                                                                                                                                                                                                                                                               | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/15/2016</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODSIDE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4000 24TH AVE S<br/>GRAND FORKS, ND 58201</b>   |                                                                                                                                                                                                                                                                                                               |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |  | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                      |                                                        | (X5)<br>COMPLETION<br>DATE |
| K 000                                                       | INITIAL COMMENTS<br><br>This survey used the 2000 edition of NFPA 101, Life Safety Code, Chapter 19 Existing Health Care Occupancies in compliance with 42 CFR 483.70(a). The findings that follow demonstrate noncompliance with these standards.<br><br>The facility was located in a two-story building of Type I (332) construction. Attached to the facility and separated with an occupancy separation having a two-hour fire resistance rating was a one-story ancillary Commons Building, along with an assisted living unit to the north, and an independent living apartment building to the east. The Commons Building (Towne Square) housed service areas for the nursing facility to include dietary, auditorium, chapel, beauty shop, and exercise/game room. The Commons Building was of Type V (000) construction. The nursing facility and the Commons Building were protected with a wet/dry automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. |                                                                            |  | K 000                                                                                       |                                                                                                                                                                                                                                                                                                               |                                                        |                            |
| K 038<br>SS=E                                               | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br>This STANDARD is not met as evidenced by:<br>During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 inches into the required width of an aisle, corridor, passageway, or landing, when fully open. 7.2.1.4.4.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | K 038                                                                                       | The maintenance staff will remove the door closures and add spring loaded hinges to allow the doors to open fully and not project into the corridor beyond seven inches. The Director of Environmental Services is responsible to inspect all corridor doors and make necessary modifications by April 28 and |                                                        | 4/28/16                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/24/2016

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 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

|                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                    |                            |                                                        |
|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355112</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                                                                                        |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/15/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODSIDE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4000 24TH AVE S<br/>GRAND FORKS, ND 58201</b>                                                                                          |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                           | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 038                                                       | <p>Continued From page 1<br/>Observation determined:</p> <p>1) The west door leaf of the double doors to the 2nd floor Oxygen Storage Room opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened.</p> <p>2) The door to the Janitor Mop Room on the Oakcrest Wing, 2nd floor opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened.</p> <p>3) The door to the Electrical Room on the Oakcrest Wing, 2nd floor opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened.</p> <p>4) The door to the Janitor Mop Room on the Heartland Place Wing, 1st floor opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened.</p> <p>5) The door to the Janitor Mop Room on the Hearthstone Wing, 1st floor opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened.</p> <p>6) The double doors to the Clean Linen Room on the Hearthstone Wing, 1st floor opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened.</p> <p>This deficiency affected seven (7) of numerous corridor doors in the means of egress throughout the facility.</p> <p>The facility failed to ensure exit access was readily accessible at all times.</p> | K 038                                                                      | <p>on a quarterly basis thereafter to ensure compliance with life safety code requirements. The results of the inspections will be presented to the facility Safety Committee.</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

|                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                            |                                                        |
|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355112</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/15/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODSIDE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4000 24TH AVE S<br/>GRAND FORKS, ND 58201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 062<br>SS=D                                               | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by:<br/>The facility failed to ensure the automatic fire sprinkler system was continuously maintained in a reliable operating condition as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems.</p> <p>Observation determined four (4) sprinklers in the Kitchen Mop Room and Dish Washing Area were corroded and may not operate at the correct temperature.</p> <p>Failure to inspect, test and maintain the automatic sprinkler system in accordance with NFPA 25 increases the risk of death or injury due to fire.</p> <p>This deficiency affected numerous inspections, tests and components of the automatic fire sprinkler system which serves the entire facility.</p> | K 062                                                                      | <p>The corroded sprinkler heads were replaced on March 24. Maintenance staff will perform an inspection of the remainder of the facility to ensure the all sprinkler heads are free from corrosion. Any other corroded sprinkler heads will be replaced by April 28. Maintenance staff will inspect all sprinkler heads on a semi-annual basis and annually with the outside contracted inspector. The Director of Environmental Services is responsible to report the results of the inspections to the facility Safety Committee.</p> | 4/28/16                    |                                                        |
| K 144<br>SS=F                                               | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>This STANDARD is not met as evidenced by:<br/>The facility failed to ensure the emergency generator was in compliance with NFPA 110, Standard for Emergency and Standby Power</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | K 144                                                                      | <p>The specific gravity of the batteries is checked on a weekly basis and documented. There are no other</p>                                                                                                                                                                                                                                                                                                                                                                                                                            | 4/28/16                    |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

|                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                                  |                            |                                                        |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355112</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                                                                                                                                                                                                      |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/15/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODSIDE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4000 24TH AVE S<br/>GRAND FORKS, ND 58201</b>                                                                                                                                                                                                        |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                         | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 144                                                       | <p>Continued From page 3<br/>Systems. 6-3.6.</p> <p>Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.</p> <p>Record review determined the specific gravity of the emergency generator battery was not checked at seven (7) day intervals during the last three (3) weeks of September 2015 and during the first week of October 2015.</p> <p>Failure to inspect and maintain the emergency generator in accordance with NFPA 110 increases the risk of death or injury due to fire.</p> <p>The deficiency affected one (1) emergency generator which provides all emergency power to the facility.</p> | K 144                                                                      | <p>batteries that would need the specific gravity checked on a weekly basis as specified for the generator. The Director of Environmental Services will audit the emergency generator documentation on a monthly basis and report the results of the audit to the facility Safety Committee.</p> |                            |                                                        |