STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355112	A. BUILDING _____ B. WING	04/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSIDE VILLAGE	4000 24TH 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 For the standard Medicare/Medicaid recertification survey, started on 04/21/14 and completed on 04/23/14, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of daily menus, and staff interview, the facility failed to meet the nutritional needs of residents by serving incorrect portion sizes during 3 of 4 observations of tray line (noon meal in the first floor dining room on 04/22/14 and 4/23/14 and noon meal in the second floor dining room on 4/23/14). Failure to follow recommended portion sizes as outlined on the facility's menus has the potential to result in weight changes and inadequate nutritional intake. Findings include: - Observation of tray line occurred on 04/22/14 during the noon meal in the first floor dining room. Observation showed the following inconsistencies between portion sizes listed on the facility's	F 363	Staff responsible for improper portions will be conferenced and educated on proper scoop sizes. The orientation checklist will be revised to include education on scoop sizes with portion control. The weekly menu showing proper serving sizes will be available in the serving areas. Skills validation on proper serving sizes will be completed with all dining services staff. Meetings will be held with dining service staff to discuss portion control and proper scoop sizes. Random audits of proper portion size will be completed for the next 3 months. The results of the audits will be reported to the Dining Services Manager and shared at the monthly Quality Review meeting. Further audits will be done at the discretion of the Dining Services Manager.	5-28-14 5-28-14 5-28-14 5-28-14

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

Administrator 5/9/14

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.

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F 363	Continued From page 1 menus and the actual amount served to residents: *Ground sausage served with a 2 ounce [oz] scoop (the menu identified 3 oz) *Ground chicken served with a 3 oz scoop (the menu identified 2 oz) - Observation of tray line occurred on 04/23/14 during the noon meal in the first floor dining room. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Ground roast beef served with a 2 oz scoop (the menu identified 3 oz) *Pureed roast beef served with a 2 oz scoop (the menu identified 3 oz) *Pureed beets served with a 2 oz scoop (the menu identified 3 oz) - Observation of tray line occurred on 04/23/14 during the noon meal in the second floor dining room. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Ground roast beef served with a 2 oz scoop (the menu identified 3 oz) *Pureed chicken pot pie served with a 3 oz scoop (the menu identified 4 oz) During interview on the afternoon of 04/23/14, an administrative dietary staff member (#7) confirmed staff should follow the serving sizes listed on the menu.	F 363		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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F 425	Continued From page 2 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, record review and staff interview, the facility failed to administer medication according to professional standards of practice for 1 of 1 supplemental resident (Resident #25) receiving inhalant medication. Failure to administer an inhalant medication utilizing the proper technique of waiting 1 to 2 minutes between puffs may prevent the second puff from fully penetrating the resident's lungs. Also, failure to wait 3 to 5 minutes before administering a second inhalant medication may result in an ineffective response to the medication. Findings include:	F 425	Added to resident #25 MAR to wait 1 minute between puffs of same inhalant and 3-5 minutes between puffs of different inhalant medications. Conferenced and educated CMA #4 on proper administration of inhalant medications. Audited all MAR's to identify residents on inhalant medications and added same instructions to applicable orders. Policy on 'Medication Administration, Inhaler Instructions' revised to add "Wait 3-5 minutes before administering a second inhalant medication". Skills Validation forms for licensed staff and CMA's were revised to include the above instructions. The change in the instruction for use of inhalant medication was reviewed with the licensed nursing staff at the monthly meetings. Information was shared with CMA's individually. All licensed staff and CMA's were skills validated on this procedure. Skills validation of licensed nurses and CMA's will continue on an annual basis, including the revised directions. Random audits will be completed on residents with inhalers over the next 3 months. Results of audits will be reported to the DONS and shared at the monthly Quality Review Meeting. Further audits will be done at the discretion of the DONS.	5-16-14 5-16-14 5-16-14 5-28-14 5-28-14 5-28-14

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F 425	Continued From page 3 Review of the facility policy titled "Medication Administration, Inhaler Instructions" occurred on 04/22/14. This policy, dated July 2001, stated, "PROCEDURE: . . . 5. Instruct resident to: . . . d. Repeat per Doctor orders. Wait for at least one minute between doses if more than 1 puff is ordered." Review of Resident #25's April 2014 medication administration record (MAR) identified Atrovent HFA inhaler 2 puffs every six hours for COPD (chronic obstructive pulmonary disease) and Combivent inhaler one puff four times daily for COPD. Observation on 04/22/14 at 8:40 a.m., showed a medication aide (MA) (#4) administered to Resident #25 two puffs of Atrovent, waiting two to five seconds between puffs, then after ten to fifteen seconds administered one puff of Combivent. The MA failed to wait at least one minute between the Atrovent puffs and five minutes between inhaler medications. During an interview on 04/22/14 at 2:30 p.m., a licensed nurse (#5) and an administrative nurse (#6) confirmed the wait time of one minute between puffs and an expectation of a five minute wait between different inhalers.	F 425		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		

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F 502	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the laboratory (lab) collection tubes (vacutainers) available for use by lab personnel and facility staff in 2 of 4 medications rooms (Prairie View and Oak Crest) had current dating. Use of expired vacutainers when obtaining blood samples from residents may result in inaccurate lab test results. Findings include: Observations in the facility's medication rooms occurred on the morning of 04/23/14 with an administrative nurse (#3) and revealed the following: * At 8:15 a.m. observation revealed the entire supply (14 tubes) of red topped vacutainers in the Prairie View medication room had expired. Two of the tubes expired in March 2014 and 12 in February 2014. * At 8:25 a.m. observation in the Oak Crest medication room showed 1 red topped vacutainer had expired in March 2014. Interviews with licensed nurses (#1 and #2) occurred on 04/23/14 at 8:30 a.m. and 8:37 a.m. respectively. Both nurses stated staff obtain the vacutainers from a local lab and nursing staff are responsible for checking the dates and ordering a new supply when the tubes expire.	F 502	Expired tubes were removed and replacement tubes ordered. Altru lab director was notified of expired vacutainers. The phlebotomy procedure was revised to include checking the date of vacutainers prior to blood draw. Information on the requirement to check vacutainer expiration prior to blood draw and weekly audit of expiration dates on vacutainers was reviewed with the licensed nursing staff at the monthly meetings. Weekly audits of expiration dates on vacutainers will be added to our weekly med room audit. Results will be reported to the DONS and shared at the monthly Quality Review meeting. Audits will continue for no less than 1 year.	5-8-14 5-8-14 5-8-14 5-9-14