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 _____	05/06/2015

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 05/04/15 and completed on 05/06/15, the sample included five (5) residents for complete review, 16 residents for focused review, and three (3) closed records for review.	F 000		
F 240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure an environment promoting or enhancing the quality of life for 1 of 1 sampled resident (Resident #17) with limited English proficiency. Failure to provide communication aids to the resident does not allow the resident to function at their highest level of over-all well-being. Findings include: Review of the facility policy titled "Procedure for Communication with Persons of Limited English Proficiency" occurred on 05/06/15. This policy, dated 03/13/02, stated: "I. It is the policy of VMH [Valley Memorial Homes] to provide communication aids (at no cost to the person being served) to Limited	F 240	Telephonic translation and interpreter services will be arranged for use with Resident #17 in an attempt to better communicate with the resident. An audit to assess if any other current residents speak a primary language other than English was completed. No other residents have a language other than English as their primary language. The policy on Communication with Persons of Limited English Proficiency was revised. Upon admission any residents whose primary language is not English will be identified. If we are unable to communicate in English with a resident, communication interventions which may include use of the language	6/10/15

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

Electronically Signed | 05/22/2015

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F 240	Continued From page 1 English Proficient (LEP) persons . . . to ensure them a meaningful opportunity to apply for, receive or participate in, or benefit from the services offered . . . The procedures . . . will reasonably ensure necessary steps that persons with Limited English Proficiency or impaired speaking skills receive effective notice-written material or other communication-concerning benefits or services . . . they will provide for an effective exchange of information between staff/employees and patient/clients and/or families while services are being provided . . . 2. The Social worker will: . . . maintain, and routinely update a list of all bilingual persons, organizations . . . who are available to provide bilingual services . . . develop written instructions on how to gain access to these services, i.e., contact persons, telephone numbers, addresses, language available, hours available, fees and conditions under which the person(s) are available. 3. . . . the resident will be informed that the services of a qualified interpreter are available to him/her at no additional charge . . . AT&T language line will be available . . ." Review of Resident #17's medical record occurred on 05/06/15. The current significant change Minimum Data Set (MDS), dated 11/13/14, and the quarterly MDS, dated 03/24/15, identified the resident sometimes understands others and sometimes is able to make himself understood. A functional assessment staging, dated 04/02/15, identified the resident as "Ability to speak limited to about a half-dozen words in an average day . . . No . . ." Care conference notes, dated 01/09/15 and 12/01/14, identified the resident's need for a Spanish interpreter for	F 240	line will be added to the resident's plan of care. Information regarding policy revisions will be reviewed with nursing staff at their monthly meeting. The Director of Social Services will report on the effectiveness of the communication interventions monthly at Quality Review meetings for the next year.	

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F 240	Continued From page 2 communication and staff interaction. Review of Resident #17's care plan, revised on 03/27/15, stated, ". . . Focus . . . I have potential for psychosocial well-being changes due to my . . . language barrier as I only speak Spanish . . . Goal . . . I will participate in my plan of care by making choices about my likes and dislikes . . . Interventions . . . Ask me to express my usual routines and preferences regarding my daily schedule . . . I only speak Spanish . . . There are translating apps [applications] on the facility's iPad's [sic] to help communicate with me . . . Some staff speak fluent Spanish and can help translate for me . . . My speech has been more difficult to understand . . ." Review of Resident #17's care plan, revised on 04/02/15, stated, "Focus . . . I have impaired cognitive and communication functions . . . r/t [related to] Dementia and language barrier . . . Interventions . . . Communicate with me and my family regarding my capabilities and needs . . . I understand consistent, simple, direct sentences but only in Spanish . . . There is also an app [application] on the I-pad that may help to translate . . ." On 05/06/15, observation showed an unidentified CNA (certified nurse assistant) delivered water to Resident #17's room. The CNA repeated the word "aqua" several times to the resident, who was seated in his wheelchair outside his room. Resident #17 responded in non English language and demonstrated frustration by hand movements. The CNA responded to the resident "adios" and walked away from the resident.	F 240		

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F 240	Continued From page 3 On 05/06/15 at 2:15 p.m., an administrative nurse member (#3) identified there are two staff members who are able to speak Spanish; stated Spanish speaking staff are not available 24 hours a day seven days a week; and an Ipod application is available for staff to use for translation, but there is difficulty using this application due to Resident #17's broken Spanish accent. An application on the resident's own electronic device is limited to 10 questions a day and the staff member stated the resident's family does not want to pay for the availability of the application to exceed 10 questions a day. The facility failed to ensure an effective method to provide a readily available translation service for Resident #17. This resulted in the inability for the resident and staff to communicate wants and needs.	F 240		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of care regarding administration of medications for 1 of 1 resident (Resident #17) provided crushed medications in food. Failure to follow the facility's policy while administering medications may result in Resident #17 not receiving the ordered dose. Findings include:	F 281	Resident #17 was assessed and family consulted to determine the need to continue to conceal medication in food. This resident was determined to have continued need to have medications concealed in food. Review of all facility residents' care plans that have an order to conceal medications were reviewed for appropriateness. The	6/10/15

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F 281	Continued From page 4 Review of the facility policy titled "Nursing Policies and Procedures" occurred on 05/06/15. This policy, revised May 2011, stated, ". . . Procedure . . . Medication Administration . . . 4. Explain procedure to resident 5. Only the nurse that prepares a medication shall administer it. 6. Administer medication and remain with resident until medication is swallowed . . ." Review of Resident #17's medical record occurred on 05/06/15. Resident #17's diagnoses included dementia, heart failure, atrial fibrillation, and hypertension. A significant change Minimum Data Set (MDS), dated 11/03/14, identified the resident's BIMS (brief interview for mental status) at six, moderately impaired decision making. A determination of ability to self-administer medications, dated 09/04/14, identified the resident not able to self administer medications. Review of Resident #17's medical record occurred on all days of the survey. Medications included acetaminophen (generalized pain) 500 mg (milligrams) daily, aspirin (cerebrovascular disease) 81 mg daily, Senna (constipation) 8.6 - 50 mg daily, and metoprolol (hypertension) 50 mg daily. Observation on 05/05/15 at 7:40 a.m., showed a staff nurse (#4) crush Resident #17's medications and mix them in a bowl of oatmeal. The nurse (#4) took the bowl of oatmeal and placed it next to the resident's breakfast plate. The nurse left the resident with the oatmeal, returned to the medication cart and failed to ensure the resident consumed the food containing the crushed medications.	F 281	nurse administering the medication was conferenced and education was provided. The policy Medication Administration was updated to include "If medication is concealed in food or drink, remain with the resident until that food or drink is consumed". Information regarding policy revisions will be reviewed with nurses and CMAs at their June meeting. The Staff Development Nurse will complete weekly audits for four weeks, report results to the Quality Review Team, and evaluate need for continued audits. A comprehensive pain assessment was completed on Resident #13. All residents who receive medication have the potential to be affected by a medication variance. A medication variance report form was completed by the administering nurse. The nurse administering the medication was conferenced and education was provided. The policy Medication Error Report was reviewed without changes. The policy will be reviewed with nurses and CMAs at their June 3rd and 5th meetings. The Staff Development Nurse will complete weekly audits for eight weeks, report results to the Quality Review Team, and evaluate need for continued audits.	

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F 281	Continued From page 5 During an interview on 05/06/15 at 2:15 p.m., an administrative staff nurse (#3) identified Resident #17's family requested all medications be crushed and concealed in food due to the resident refusing to take medications and a physician's order is in place to conceal the resident's medications in food. The staff member (#3) stated a nurse should remain with the resident to ensure the resident consumed all of the food containing the crushed medications. 2. Based on record review, review of facility policy, and staff interview, the facility failed to ensure services provided to residents met professional standards of quality regarding reporting of a medication error for 1 of 4 sampled residents (Resident #13) on a Fentanyl patch (narcotic) for pain control. Failure to report the medication error prevented the facility from investigating the error to determine why or how it may have occurred, and implementing corrective action. Findings include: Review of the facility policy titled "Medication Variance Report" occurred on 05/06/15. This policy, revised in 2007, stated: "I. Policy: It is the policy of Valley Memorial Homes to report any medication variances by completing a written medication variance report. This report is used to: A. Primary Purpose: Record information needed by Valley Memorial Homes for legal reference. B. Observe trends in medication variances and provide information for the Safety Committee, Quality Improvement Committee . . .	F 281		

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F 281	Continued From page 6 II. Definition: A medication variance is defined as any irregularity in the prescribed medication regime of the resident. . . ." Review of Resident #13's medical record occurred on all days of survey. Medications included a Fentanyl patch 100 micrograms (mcg) and another Fentanyl patch 25 mcg to be applied transdermally every 72 hours for pain. Resident #13's progress note, dated 01/12/15 at 12:47 a.m., stated, "Duragesic [Fentanyl] Patch 125 mcg was changed this evening when it was changed this morning also. Was changed in error tonight." Resident #13's "INDIVIDUAL NARCOTIC RECORD" showed a licensed nurse removed a 100 mcg and 25 mcg Fentanyl patch from the locked narcotic box on 01/11/15 at 1:00 p.m. This record showed seven hours later, at 8:00 p.m., another licensed nurse removed a 100 mcg and 25 mcg Fentanyl patch from the narcotic box for the same resident. During an interview on 05/06/15 at 9:30 a.m., two administrative nurses (#1 and #2) stated the nurse who administered the Fentanyl patch in error should have completed a variance report.	F 281		