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 _____	05/19/2016

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 May 16, 2016 and completed on May 19, 2016, the sample included 5 residents for complete review, 15 residents for focused review, and 3 closed records for review. The sample included 6 additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		6/23/16

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

Electronically Signed | 06/09/2016

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 _____	05/19/2016

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 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the RAI (Resident Assessment Instrument) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 6 of 20 sampled residents (Resident #2, #5, #8, #9, #10 and #20). Failure to accurately code Section E (Behaviors) (Resident #8, #9, #10, and #20) and Section M (Skin Conditions) (Resident #2, #5, and #10) does not allow the residents' assessments to reflect their current status/needs, and may affect the development of a comprehensive care plan, and affect the care provided to residents. Findings include: BEHAVIORS The Long-Term Care Facility RAI Manual, revised October 2015, Chapter 3 pages E-4, E-13, and E-17, stated, ". . . E0200: Behavioral Symptom - Presence and Frequency . . . A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing	F 278	**F 278 Accuracy of assessments** Nutrition/Skin: MDS corrections will be submitted for all of the sampled residents affected by the inaccurate coding in M1200 with nutrition and hydration interventions. The most current MDS for all residents will be reviewed for accuracy in those areas. Any corrections needed will be changed and submitted by June 23, 2016. Beginning June 9, 2016, the RN Care Coordinator and the Licensed Registered Dietitian are completing this section together to ensure accuracy. Nurses attended meetings on June 1 and June 3 to review the plan of correction and stress the importance of individualized planning and care for any skin issues. All RN Care Coordinators and Licensed Registered Dietitians will complete MDS Section M training through Health Care Academy by June 23, 2016. A minimum of four MDSs will be audited for accuracy on M1200 by the RN Care Coordinators weekly for the next four weeks and monthly for three months. The Director of Nursing Services will report the results to the Quality Review Team and determine the frequency of continued audits. Behavior Symptoms Affecting Others: Modifications of MDS assessments will be	

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 _____	05/19/2016

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 278	Continued From page 2 or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) . . . E0800: Rejection of Care-Presence & Frequency . . . Did the resident reject evaluation or care (e.g. bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals. . . . E0900: Wandering-Presence & Frequency . . . Has the resident wandered? . . . " - Review of Resident #8's medical record occurred on May 16-19, 2016. A significant change MDS, dated 03/12/16, identified the resident with moderate cognitive impairment, and displayed verbal behavioral symptoms directed toward others four to six days during the 7-day assessment period. A quarterly MDS, dated 01/18/16, identified the resident with intact cognition and displayed wandering behaviors one to three days during the 7-day assessment period. The medical record lacked evidence to support coding of behaviors/wandering on the MDSs. - Review of Resident #9's medical record occurred on May 16-19, 2016. An annual MDS, dated 03/11/16, identified the resident with severe cognitive impairment, and displayed physical behavioral symptoms directed toward others with behaviors occurring one to three days during the 7-day assessment period. A quarterly MDS, dated 12/11/15, identified the resident with	F 278	completed on the most recent assessments for residents in the survey sample affected by inaccurate coding on E0200. Social Service will review section E of the most recent assessments of all current residents and any modifications required will be completed by June 23, 2016. Social Service staff has revised the behavior documentation requirements for nurses and CNAs to include documentation of all physical, verbal, and other behavior and who it is directed at. Social Service staff will meet with CNAs and licensed nurses during neighborhood meetings on June 8, 9, 15, and 16, 2016 to review reporting responsibilities and changes in documentation process. Additionally, a written memo compiled by the Director of Social Services will be reviewed by nursing staff by June 23, 2016. Social Service staff has completed training on Section E of the MDS via Healthcare Academy on June 7, 2016. The Director of Social Services will complete random audits of a minimum of two MDSs per week for one month and then one per week for two months to ensure accuracy and proper documentation for E0200. The Director of Social Services will report the results to the Quality Review Team and determine the frequency of continued audits.	

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 _____	05/19/2016

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 278	Continued From page 3	F 278		

severe cognitive impairment, and displayed other behavior symptoms directed towards others one to three days during the 7-day assessment period. The medical record lacked evidence to support coding of behaviors on the MDSs.

During an interview on 05/19/16 at 8:30 a.m., two administrative staff members (#2 and #4) identified the facility lacked supportive documentation to code Resident #8 and #9's behaviors.

- Review of Resident #10's medical record occurred on May 16-19, 2016. A significant change MDS, dated 04/28/16, and an annual MDS, dated 05/15/16 identified the resident with short and long term memory problems and severely impaired for making daily decisions. The significant change MDS identified Resident #10 displayed physical/verbal behavioral symptoms, rejected care, and wandering behaviors four to six days during the 7-day assessment period. The annual MDS identified Resident #10 displayed physical behavioral symptoms, and rejection of care one to three days, and verbal behavioral symptoms four to six days during the 7-day assessment period. The medical record lacked evidence to support coding of behaviors on the MDSs.

- Review of Resident #20's medical record occurred on May 18-19, 2016. A quarterly MDS, dated 04/13/16 identified the resident displayed physical behaviors four to six times during the 7-day assessment period. An annual MDS, dated 01/20/16 identified the resident displayed verbal/wandering behaviors and rejection of care one to three times during the 7-day assessment

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 _____	05/19/2016

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 278	Continued From page 4	F 278		

period. The medical record lacked evidence to support coding of behaviors on the MDSs.

During an interview on 05/19/16 at 8:15 a.m., two administrative staff members (#1 and #3) identified the facility lacked supportive documentation to code Resident #10 and #20's behaviors.

SKIN AND ULCER TREATMENTS

The Long-Term Care Facility RAI User's Manual, revised October 2015, pages M-38 and M-39 stated, ". . . M1200D Nutrition or Hydration Intervention to Manage Skin Problems: The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,' . . ."

- Review of Resident #10's medical record occurred on May 16-19, 2016. A significant change MDS, dated 04/28/16, identified the resident received nutrition or hydration

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 _____	05/19/2016

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 278	Continued From page 5 interventions for skin and ulcer treatments. The medical record lacked an individualized nutritional assessment during the MDS reference period to indicate Resident #10 required nutrition or hydration interventions to support healthy skin. During an interview on 05/18/16 at 1:15 p.m., an administrative nurse (#1) identified she coded the MDS at M1200D because the resident is receiving supplements. Receiving nutritional supplements alone is not enough to code Section M1200D. - Review of Resident #2's medical record occurred on all days of survey. The annual MDS, dated 05/27/15, and the significant change MDS, dated 10/20/15, both identified nutrition/hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment during the MDS reference period to determine whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Review of Resident #5's medical record occurred on all days of survey. The significant change MDS, dated 04/19/16, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment during the MDS reference period to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.	F 278		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		6/23/16

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 _____	05/19/2016

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 323	Continued From page 6 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: ASSISTIVE DEVICES 1.) Based on observation, record review, and staff interview, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 6 of 17 sampled residents and 4 supplemental residents. Failure to use foot pedals while transporting a resident in a wheelchair (Resident #5, #6, #8, #15, #18, #20, #26, #27, #28 and #29) and to supervise a resident while in the bathroom (Resident #8) placed these residents at risk for sustaining a fall or injury. Findings include: - Review of Resident #8's medical record occurred on May 16-19, 2016. A significant change Minimum Data Set (MDS), dated, 03/12/16, identified the resident with moderate cognitive impairment, requiring extensive assist of two staff members for transfer, set up with one person assist for locomotion on the unit, and extensive assist of one person for locomotion off the unit. The current care plan, stated, "Focus: I need help with my ADL's [activities of daily living]	F 323	F 323 □ Accident and Incident Prevention Wheelchair Transport: Residents in the sample affected by failure to use foot rests on their wheelchair while being transported will be assessed for need and use of foot rests on their wheelchair by June 10. All residents will be reviewed for their need for foot rests both on and off the neighborhood by June 23. Residents needing foot rests will have them available in kangaroo bags on the back of the wheelchair. This information will be included in the care plan and on CNA assignment sheets. Facility staff education through a written memo will be reviewed by nursing staff by June 23, 2016. Proper wheelchair transportation was discussed at licensed staff meetings on June 1 and June 3. The Staff Development Coordinator will audit the use of foot rests used when pushing wheelchairs will be done daily for	

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 _____	05/19/2016

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 323	Continued From page 7 due to my Dementia, Impaired Mobility, Impaired balance, Parkinson's Disease, Fx. [fracture] left arm. I am on comfort care as of 05/10/16 . . . Interventions: . . . ASSISTIVE DEVICES: I use my w/c [wheelchair] for my mobility and I am able to propel myself around the neighborhood and off. I do need staff assistance when I am tired. . . ." Observation on 05/17/16 at 9:11 a.m., showed two CNAs (certified nursing assistants) (#7 and #9) going to Resident #8's room to provide cares. Resident #8 sat in his wheelchair, in the doorway, facing into his room. One CNA attempted to push the resident in his wheelchair, this caused Resident #8's knees to bend and his feet went under the wheelchair, got tangled with the wheels, and blocked the forward momentum of the wheelchair. The CNA attempting to push the resident, turned the chair enough to pull the wheelchair into the room, and pulled the resident backwards causing his heels to bounce along the floor. At the end of cares, the CNAs (#7 and #9) assisted the resident to bed. Observation on 05/17/15 at 4:20 p.m., showed a staff member (#10) transporting Resident #8 in his wheelchair from the auditorium to his room. As the staff member (#10) propelled the resident, he would sometimes "walk" with his feet, let his feet bounce along the floor, at times catching enough on the floor that the staff member (#10) slowed down and the resident would hold up his feet for three to four seconds. At the elevator, a CNA (#8) told the staff member (#10) to tell the resident to lift his feet or get foot pedals if he would not lift his feet. When Resident #8 arrived to his room, a CNA (#11) assisted him with cares.	F 323	one week, weekly for three weeks and monthly for three months. The Director of Nursing Services will report the results to the Quality Review Team and determine the frequency of continued audits. Supervision in the Bathroom: The resident identified in the sample was reassessed and continues to need supervision while in the bathroom. All residents who need supervision while in the bathroom were identified. Staff education and identification of residents care planned for assistance will be completed during shift report three times per week for two weeks and monthly for three months. The charge nurse will audit knowledge of staff regarding which residents in the neighborhood need supervision and the proper procedure for that supervision. The Director of Nursing Services will report the results to the Quality Review Team and determine the frequency of continued audits. Unsecured Chemicals: All chemicals have been secured behind locked doors and cabinets. The housekeeping closet door on Heartland was adjusted by maintenance to close and lock properly on May 18. The policy □Security Procedures for Access to Supplies□ was updated to state that Housekeepers will ensure that his/her housekeeping cart is secured and the housekeeping room is locked when not in visual sight and all chemicals must be kept in visual sight of the	

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 _____	05/19/2016

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 323	Continued From page 8 After completing cares, the CNA (#11) propelled Resident #8 to the Great Room by the nurses station, the resident alternated holding his feet up and having them bounce across the floor. As Resident #8 sat in the Great Room, a CNA (#8), brought a set of wheelchair foot pedals and placed them on the resident's wheelchair. This set did not work properly and the staff member (#8) then obtained a set of wheelchair pedals from Resident #8's room, which she put on the resident's wheelchair. During an interview on 05/19/16 at 8:30 a.m., an administrative nurse (#2) agreed staff should use Resident #8's wheelchair foot pedals for his safety when transporting the resident. - Review of Resident #18's medical record occurred on May 18-19, 2016. Medical diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure, heart failure, and polyosteoarthritis. Resident #18's quarterly MDS, dated 03/21/16, identified extensive assist of one for locomotion on and off the unit. Resident #18's care plan identified the following: "Focus: . . . ADL self-care performance deficit r/t [related to] CHF [chronic heart failure] acute respiratory failure episodes, COPD, general debility, need for asst [assist] with mobility, chronic O2 use, . . . leg edema, intermittent confusion. . . . Interventions: . . . LOCOMOTION: I have a new manual WC [wheelchair] - I want to use my feet to help propel the WC so no legrests [SIC] except for outside appointments. O2 tank to back of my WC. I can propel the WC but just for short distance. I get short of breath so will need asst for longer distances and downstairs."	F 323	housekeeper/custodian unless in locked storage area. All staff in Environmental Services were educated on the policy changes and expectations by reviewing and signing a Conference Sheet by June 2. Audits to ensure cabinets and doors storing chemicals are locked will be done by the Assistant Director of Environmental Services three times a week for three weeks and monthly for three months. The Director of Nursing Services will report the results to the Quality Review Team and determine the frequency of continued audits.	

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 _____	05/19/2016

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 323	Continued From page 9 Observations showed the following: * On 05/17/16 at 8:55 a.m., an unidentified staff member transported Resident #18 from the dining room to his neighborhood in his wheelchair. Resident #18's feet/shoes were audible on the carpet as the staff member transported him. The staff member failed to cue Resident #18 to lift his feet. * On 05/17/16 at 11:00 a.m., an unidentified staff member transported Resident #18 from the Beauty Shop to his neighborhood in his wheelchair. Resident #18's feet/shoes caught and bounced on the carpet as the staff member transported him. The staff member failed to cue Resident #18 to lift his feet. * On 05/17/16 at 11:50 a.m., a staff member (#6) assisted Resident #18 in his wheelchair down the full length of a hall from the nurse's station/lounge area to an area by the oxygen storage room to work on the resident's oxygen tank. The staff member then assisted the resident to the dining room. Observation showed the resident's feet skimmed the surface of the carpeted floor during transport. The staff member (#6) failed to cue Resident #18 to lift his feet. - Review of Resident #20's medical record occurred on May 18-19, 2016. A significant change MDS, dated 04/28/16, identified the resident with short and long term memory problems, severely impaired for making daily decisions, totally dependent on two staff members for transfers, and required extensive assistance of one staff member for locomotion on the unit. The current care plan, stated, "Focus: I have an ADL self-care performance deficit r/t Dementia, Confusion, Alzheimer's . . .	F 323		

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 _____	05/19/2016

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 323	Continued From page 10 Interventions: . . . Assistive Device: I use a w/c for my locomotion and I need staff to assist me to get to locations on and off the neighborhood. I also will use the hand rails to pull myself down the hall. . . ." Observation on 05/17/16 at 9:39 a.m. showed an unidentified staff member transported Resident #20 down the corridor. Resident #20's feet/shoes skimmed the surface of the carpeted floor during transport. The staff member failed to cue Resident #20 to lift his feet and/or apply foot pedals during transport. An observation on 05/18/16 at 5:20 p.m. showed two CNAs (#17 and #18) assisted Resident #20 out of bed and into his wheelchair for the evening meal. As the CNA (#17) transported the resident down the hall, his gripper socks would catch on the carpet and pull Resident #20's feet under the chair and then his feet would snap forward again as the CNA (#17) continued down the hall. Resident #20's feet bounced this way from his room to the dining area. During an interview on 05/19/16 at 9:00 a.m., an administrative nurse (#1) identified Resident #20 does not propel himself anymore and agreed wheelchair foot pedals would be an appropriate safety intervention for Resident #20. - Review of Resident #29's medical record occurred on May 18-19, 2016. Medical diagnoses included dementia, osteoarthritis, and fatigue. Resident #29's care plan identified the following: "Focus: . . . "ADL self-care performance deficit r/t dementia, communication deficit, . . . activity intolerance, arthritis, chronic knee pain. . . .	F 323		

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 _____	05/19/2016

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 323	Continued From page 11	F 323		

Interventions: . . . LOCOMOTION: I use a WC to get around. I am able to propel some for short distances but I get tired easily and frustrated. I will need x1 asst [assist] prn [as needed] and for longer distance. No footrests as I propel some with my feet. Legrests for outside appointments. . . ."

Observation on 05/18/16 at 4:40 p.m. showed a staff member (#16) assisted Resident #29 down the full length of the hall from the nurse's station/lounge area to the resident's room without foot pedals on the wheelchair. Observation showed Resident #29's feet skimmed the surface of the carpeted floor during transport. The staff member failed to cue the resident to lift her feet.

During an interview on the morning of 05/19/16, an administrative nursing staff member (#5) confirmed staff should cue residents to lift their feet or use foot pedals for longer distances.

- Review of Resident #26's medical record occurred on 05/19/16. Medical diagnoses included Parkinson's disease, cerebral infarction (stroke), dementia, and osteoarthritis. The annual MDS, dated 04/11/16, identified moderately impaired cognition and extensive assistance of one person required for transfers and locomotion on the unit.

The current care plan identified, ". . . I mainly get around in a WC [wheel chair]. I need extensive asst [assist] to propel the WC. . . . Ask me to hold my feet up if I decline the legrests. . . ."

Observations showed the following:
* On 05/17/16 at 12:00 p.m. showed an

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 _____	05/19/2016

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 323	Continued From page 12	F 323		

unidentified staff member transported Resident #26 down the hallway in her wheelchair. Resident #26's feet/shoes were audible on the carpet as the staff member transported her. The staff member failed to cue Resident #26 to lift her feet.
* On 05/17/16 at 1:55 p.m., an unidentified activity staff member transported Resident #26 from the lounge to her room. Resident #26's feet/shoes skimmed the surface of the carpeted floor during transport. The staff member failed to cue Resident #26 to lift her feet.

- Review of Resident #27's medical record occurred on 05/19/16. Medical diagnoses included dementia. The quarterly MDS, dated 02/26/16, identified severely impaired cognition and extensive assistance of one person required for transfers and locomotion on the unit.

The current care plan identified, ". . . I use a w/c for all mobility, and can propel myself, but I do need more assist at times because I get tired. . . ."

Observation on 05/17/16 at 2:33 p.m. showed an unidentified staff member transported Resident #27 to an activity in her wheelchair. Resident #27's feet/shoes skimmed the surface of the carpeted floor during transport. The staff member failed to cue Resident #26 to lift her feet and/or apply foot pedals during transport.

- Review of Resident #28's medical record occurred on 05/19/16. Medical diagnoses included cerebral infarction, dementia, weakness, and history of traumatic fracture. The quarterly MDS, dated 02/26/16, identified severely

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 _____	05/19/2016

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 323	Continued From page 13	F 323		

impaired cognition and extensive assistance of one person required for transfers and locomotion on the unit.

The current care plan identified, ". . . I use a w/c for all mobility, often propelled by staff . . . I need footrests on the w/c. . . ."

Observation on 05/17/16 at 4:27 p.m. showed an unidentified staff member transported Resident #27 to her room in her wheelchair. Resident #27's right foot/shoe had slipped off the footrest and skimmed the surface of the carpeted floor during transport. The staff member failed to cue and/or assist Resident #25 to lift her right foot.

During an interview on the morning of 05/19/16, an administrative nursing staff member (#19) confirmed staff should cue resident's to lift their feet or use foot pedals for longer distances.

- Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included dementia. The annual MDS, dated 03/09/16, identified severely impaired cognition and extensive assistance of one person required for locomotion on and off the unit.

The current care plan identified, ". . . I use a w/c for locomotion on the neighborhood. Assist me in getting to locations on and off of the neighborhood as needed . . . Safety interventions . . . Leg rest with transport . . ."

Observation on 05/17/16 at 9:40 a.m. showed a CNA (#20) transported Resident #6 from the activity room to her room. Resident #6's feet/shoes skimmed the surface of the carpeted

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 _____	05/19/2016

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 323	Continued From page 14	F 323		

floor during transport. The staff member failed to cue Resident #6 to lift her feet and/or apply foot pedals during transport.

Observation on 05/17/16 at 2:40 p.m. showed a CNA (#21) transported Resident #6 from her room to the activity room. Resident #6's feet/shoes skimmed the surface of the carpeted floor during transport. The staff member failed to cue Resident #6 to lift her feet and/or apply foot pedals during transport.

- Review of Resident #15's medical record occurred on 05/19/16. Medical diagnoses included dementia. The quarterly MDS, dated 04/23/16, identified severely impaired cognition and extensive assistance of one person required for locomotion on the unit.

The current care plan identified, ". . . I use my w/c for my locomotion. I am able to propel myself short distances but will need staff assistance for longer distances and off neighborhood and to appts [appointments]. I use leg rests with transports . . ."

Observation on 05/17/16 at 8:23 a.m. showed an unidentified staff member transported Resident #15 from the dining room to his room and back to the dining room for breakfast. The staff member applied a foot pedal to the right side of the wheelchair. Resident #15's left foot skimmed the surface of the carpeted floor during transport. The staff member failed to cue Resident #15 to lift his foot and/or apply a foot pedal to the left side of the wheelchair during transport.

Observation on 05/17/16 at 12:02 p.m. showed a

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 _____	05/19/2016

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 323	Continued From page 15	F 323		

nurse (#22) transported Resident #15 down the corridor to the activity room. Resident #15's feet skimmed the surface of the carpeted floor during transport. The staff member failed to cue Resident #15 to lift his feet and/or apply foot pedals during transport.

During an interview on 05/19/16 at 9:30 a.m., an administrative nurse (#14) stated she expected staff to cue residents to lift their feet during wheelchair transports without foot pedals and expected staff to utilize foot pedals when transporting residents off their neighborhood.

SUPERVISION

- Review of Resident #8's medical record occurred on May 16-19, 2016. A significant change MDS, dated, 03/12/16, identified the resident with moderate cognitive impairment, requiring extensive assist of two staff members for transfers and toileting. The current care plan, stated, "Focus: I need help with my ADL's due to my Dementia, Impaired Mobility, Impaired balance, Parkinson's Disease, Fx. [fracture] left arm. I am on comfort care as of 05/10/16 . . . Interventions: . . . TOILET USE: I need extensive assist of two with toileting . . . . I need supervision in the bathroom as I am at risk for falls. . . ."

Observation on 05/17/16 at 9:11 a.m., showed two CNAs (certified nursing assistants) (#7 and #9) assisted Resident #8 with toileting cares. After the CNAs (#7 and #9) assisted Resident #8 onto the toilet they asked if he would like to sit awhile, he said "yes," they gave the resident the call light, told him to turn it on when he finished, and left the resident's room. The CNAs (#7 and

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 _____	05/19/2016

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 323	Continued From page 16 #9) just entered the hallway when Resident #8 turned on the call light. The CNAs (#7 and #9) enter the room/bathroom and asked the resident if he was finished. Resident #8 replied "no." The CNAs (#7 and #9) again asked if he wished to sit awhile, he said "yes," they gave him the call light, told him to turn it on when he was ready, and left the resident's room. Again, the CNAs (#7 and #9) just entered the hallway when Resident #8 turned on the call light. At this time, they completed the cares for Resident #8. The CNAs (#7 and #9) failed to provide supervision for Resident #8 while in the bathroom as care planned due to his fall risk. Observation on 05/17/16 at 1:35 p.m., showed two CNAs (#8 and #9) assisting Resident #8 to toilet. The CNAs (#8 and #9) assisted the resident to the toilet, asked him if he wanted to sit, he said "yes," they gave the resident the call light, told him to turn it on when he finished, and left the resident's room. Resident #8 turned on the call light and two CNAs (#7 and #9) responded. The CNAs (#7 and #9) entered the bathroom and completed care for Resident #8. The CNAs (#7 and #9) failed to provide supervision for Resident #8 while in the bathroom as care planned. HAZARDOUS CHEMICALS 2. Based on observation, review of facility policy, and staff interview, the facility failed to maintain an environment free of accident hazards in 2 or 4 nursing units (Prairieview and Heartland). Failure to secure hazardous chemicals placed cognitively impaired and wandering residents at risk for accidents/injury.	F 323		

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 _____	05/19/2016

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 323	Continued From page 17 Findings include: Review of the facility policy titled "Security Procedures for Access to Supplies" occurred on 05/19/16. This policy, dated 1999, stated, "Policy: It is the policy of the Housekeeping Department of Valley Memorial Homes to allow access to the cleaning supplies to only those personnel working in the housekeeping department. . . ." Observations showed the following: * On 05/17/16 at 11:00 a.m. - a locked and unattended housekeeping cart on Prairieview. Chemicals on top of the cart included Pledge furniture polish and a spray bottle of 9% HCL (hydrochloric acid) Porcelain (May be harmful if swallowed or inhaled and may cause severe skin burns and eye damage). Observation showed a housekeeping staff member (#15) cleaned/vacuumed in resident rooms and obtained clean towels from another area of the unit. * On 05/17/16 at 11:15 a.m. - an unlocked cupboard in the tub room on Prairieview. The cupboard contained Turbo Clean (acute exposure may cause mild irritation of sensitive skin and mucus membranes), and Apollo Cid-A-L II (toxic if swallowed and may cause severe skin burns and eye damage). * On 05/17/16 at 11:20 a.m. - An unlocked housekeeping closet on Heartland. The closet contained Bio-enzymatic spot cleaner, Sealed Air spot cleaner (irritating to eyes, respiratory system, and skin), Sani Shield (may cause eye irritation), and Lysol disinfectant (keep out of reach of children).	F 323		

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 _____	05/19/2016

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 323	Continued From page 18 The environmental tour of the facility occurred on 05/17/16 at 4:00 p.m. with three administrative staff members (#12, #13, and #14). Observation showed the housekeeping closet remained unlocked and the cupboard in the tub room on Prairieview unlocked with the key left inserted in the lock. During an interview on 05/19/16 at 10:15 a.m., an administrative staff member (#13) stated she expected staff to lock chemicals in the housekeeping cart.	F 323		