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 _____	06/10/2010

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 June 7, 2010 and completed on June 10, 2010, the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review.	F 000	A communication was placed in the neighborhood communication book to always protect resident #5's privacy while toileting. Residents #5 and #12 are now wearing an undershirt beneath their adaptive garments. A communication was placed in the communication book on all neighborhoods to address privacy issues for residents in semi-private rooms and applying undershirts to those residents wearing adaptive garments. The CNA assignment sheet and the adaptive garment assessment form were revised to indicate the need for an undershirt under the adaptive garment.	6-30-10
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	Information on privacy and dignity issues will be communicated in a nursing department newsletter on 6-28-10. Privacy and dignity standards will be reviewed at Licensed Staff meetings on 7-5-10 and 7-7-10; at CNA meetings on 6-30-10; and at CNA inservices on 7-6-10 and 7-12-10. Audits will be completed at random to ensure that all residents have their privacy and dignity protected while cares are being provided for 4 weeks. Results of the audits will be shared at the monthly Quality Review meeting and the need for continuing audits will be addressed by the Director of Nursing Services.	7-15-10

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

Administrator 6/29/2010

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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to provide privacy for 1 of 5 sampled residents (Resident #5) observed while assisted with personal cares in a semi-private room, and for 2 of 2 sampled residents (#3 and #12)observed receiving assistance with toileting and incontinence care while wearing a one piece garment. Failure to preserve residents' privacy during cares infringed on the residents' right to personal privacy. Findings include: - On 06/08/10 at 9:45 a.m., observation showed Resident #5 in her room. A certified nurse assistant (CNA) (#6) transferred Resident #5 from her wheelchair into the bathroom using a standing mechanical lift. The CNA failed to pull the privacy curtain between the resident and roommate's side of the room. The CNA failed to close the sliding door to the bathroom before removing Resident #5's brief and lowering her onto the toilet. Resident #5's roommate sat in a wheelchair on her side of the room in view of the bathroom. Upon leaving the room, the CNA closed the bathroom door. Ten minutes later, observation showed the CNA (#6) entered the bathroom to assist Resident #5 off the toilet. The CNA transferred the resident with the stand lift to an area in front of the sink. With the bathroom door and privacy curtain open, and the roommate in plain sight, the CNA (#6) performed pericares, applied powder to the resident's anterior skin folds, and applied a new brief. On 06/08/10 at 1:56 p.m., observation showed a	F 164		

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F 164	Continued From page 2 CNA (#6) transferred Resident #5 with a standing mechanical lift from her wheelchair into the bathroom. The CNA removed Resident #5's brief and lowered her onto the toilet. The CNA failed to close the privacy curtain to the roommate's side of the room. Observation showed the roommate present. Review of Resident #5's medical record occurred on June 08-09, 2010. Diagnoses included debility. Resident #5's current Minimum Data Set (MDS), dated 05/11/10, identified the resident required extensive assist of one person with toilet use and personal hygiene. During an interview on 06/10/10 at 09:15 a.m., an administrative nursing staff member (#7) agreed the privacy curtain should be pulled between the roommates when transferring a resident to the toilet and doing cares. - Observation of CNAs providing toileting assistance to Resident #3 occurred on 06/08/10 at 8:45 a.m. CNAs (#9 and #10), 1:05 p.m. CNA (#9 and #11), and 3:05 p.m. CNA (#12). Each observation showed Resident #3 dressed in a one piece adaptive garment, zippered in the back, with a safety pin also fastening the garment in the back at the neckline. Once assisted onto the toilet, observation showed Resident #3 totally exposed, except for her bra, from her neck to her knees. During each of the above referenced observations, Resident #3 questioned staff regarding the reason she needed to remove all her clothing to sit on the toilet. Comments made by the resident included, "Do I have to take all that off to go to the bathroom [8:05 a.m.]? Do I	F 164		

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have to take all this off to sit on the toilet [1:05 p.m.]? Why do I have to take this down to sit on the toilet [3:05 p.m.]?"

Resident #3 resides in the facility's secure memory care unit. Review of the resident's medical record occurred June 8-9, 2010, and showed the facility admitted the resident 03/16/10, with diagnoses including, Alzheimer's disease and anxiety.

The record included the resident's initial MDS completed 04/08/10. The MDS identified Resident #3 as experiencing long and short term memory problems and exhibiting severely impaired cognitive skills.

The record and plan of care for Resident #3 showed justification for the use of the adaptive garment in response to the resident's behavioral problems/concerns. However, the above described observations and the verbal reactions of the resident showed toileting in a manner inconsistent with the resident's customary routine, and disregard for the privacy of the resident's body.

During an interview on the morning of 06/10/10, an administrative nurse staff member (#13) stated, "She [Resident #3] should be wearing a t-shirt under the one-piece garment."

- Observation of a licensed nurse (#17) and a CNA (#20) providing incontinence cares to Resident #12 occurred on 06/08/10 at 3:30 p.m. Observation showed Resident #12 dressed in a one piece adaptive garment, zippered in the back. The staff members unzipped the garment and pulled it down to the resident's ankles.

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F 164	Continued From page 4 Observation showed Resident #12 completely exposed from her neck to her ankles, including her breasts, throughout pericares. Review of Resident #12's medical record occurred June 8-9, 2010. The resident's diagnoses included Downs Syndrome, mental retardation, depression, Alzheimers disease, and end stage dementia. The Minimum Data Set (MDS) indicated short and long term memory problems, severe decision making impairment, and rare to no ability to understand others and make self understood. Activities of daily living (ADLs) showed total dependance upon staff for all personal and incontinence cares. The record and plan of care for Resident #12 showed justification for the use of the adaptive clothing in response to the resident's behavioral problems/concerns. However, the above observation showed disregard for the privacy and dignity of the resident's body. An interview with an administrative nursing staff member (#3) occurred the afternoon of 06/09/10. The staff member agreed Resident #12 should wear a tank top or t-shirt beneath her one piece garment to preserve her privacy and dignity during incontinence cares.	F 164		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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.	F 323		

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and policy review, the facility failed to ensure the safe transfer of 2 of 9 residents (Resident #6 and #17) using a stand-up mechanical lift. Failure to use the mechanical lift according to facility policy placed the residents at risk for falls and injury. Findings include: Review of facility policy titled "Pro-Assist Lift (PAL)" occurred on 06/10/10. This policy, dated 10/01/98, stated, "PURPOSE: To provide instruction for safe use of the PAL (Pro-Assist Lift). The PAL is a Stand-up Lift. This lift can be used for residents with very little leg and arm strength, some torso strength, and the ability to sit in an upright position. This lift is used for the resident who needs assistance from bed to chair or chair to toilet. . . . CAUTIONS FOR USE OF PAL: . . . 7. Once the resident starts lifting snug up the safety restraint strap. When the torso straightens, the strap will loosen. . . . PROCEDURE: . . . B. APPLYING THE BUTTERFLY SLING: . . . Fasten the safety support strap and pull out the excess slack. Don't hold on to the buckle and pull or sometimes it binds and feels snug when it is not. With a person in the sitting position, the torso is compressed together. Once the person starts lifting the torso will straighten out and restraint strap will loosen. When this point is reached, retighten the strap to ensure the comfort and safety of the person being transferred. . . ." - Review of Resident #6's medical record occurred on June 08-10, 2010. Diagnoses	F 323	Residents #6 and #17 will be evaluated to determine the appropriateness of transfers using the sit-to-stand lift. Their care plans and CNA assignment sheets will be reviewed and revised based on the results. The RN Care Coordinators will review their resident care plans and assess the appropriateness of other residents care planned for the use of the sit-to-stand lift. All CNAs will continue to be skills validated upon hire and annually for proper use of the sit-to-stand lift, ensuring that the safety belt is tightened properly. Information on proper use of the lift will be communicated in a nursing department newsletter on 6-28-10. Proper use of the lift and skills validations will be reviewed beginning 6-29-10 and at Licensed Staff meetings on 7-5-10 and 7-7-10; at CNA meeting on 6-30-10; and at CNA inservices on 7-6-10 and 7-12-10. Audits of proper lift use will be completed randomly for 4 weeks to ensure that staff continue to use the lifts properly. Results of the audits will be shared at the monthly Quality Review meeting and the need for continuing audits will be addressed by the Director of Nursing Services.	6-30-10 7-15-10

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included debility, depression, and other persistent mental disorder. Resident #6's current Minimum Data Set (MDS), dated 05/26/10, identified she required extensive assistance of two staff for transfers and toilet use. The careplan, dated 06/09/09, stated, ". . . I have advanced dementia and I am not able to make my needs and wants known to staff. . . . INTERVENTIONS: . . . I need assist of 2 and the stand up lift for all of my transfers. . . ."

On 06/08/10 beginning at 1:23 p.m., two certified nurse assistants (CNAs) (#15 and #16) placed the sling of the PAL lift behind Resident #6's back, guided her to hold the handles, placed her feet on the lift's platform, clamped the safety strap around her waist, stood her up with the lift, removed her soiled brief, and transferred her to the toilet. After several minutes, the CNAs raised Resident #6 up from the toilet with the stand lift. The safety strap slid up above the resident's breasts and pulled her shirt up, partially exposing her breasts. Resident #6's elbows raised up to shoulder level. The resident started to void, so the CNAs lowered her back onto the toilet. The safety strap slid down below the resident's breasts. At 1:33 p.m., one CNA (#16) lifted Resident #6 up from the toilet with the PAL lift and another CNA (#15) performed pericares. The safety strap moved up above the resident's breasts and her elbows elevated at or slightly above the level of her shoulders. The resident made sounds with occasional single words and frowned throughout this. By 1:39 p.m., as the CNA finished pericares and applied barrier cream, Resident #6 stated, "I can't do it." One CNA (#16) lowered the resident back on the toilet, while the other CNA (#15) left the room to talk to the nurse. At 1:41 p.m., the CNA (#15) returned

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to the room. The CNA (#16) raised Resident #6 from the toilet and the safety strap slid up above the resident's breasts. The CNAs placed a new brief on the resident, pulled up her pants, and transferred her into the wheelchair. The CNAs failed to tighten the safety strap as required with standing the resident up with the lift, causing a potential for injury to the resident and causing her distress.

- Review of Resident #17's medical record occurred on June 09-10, 2010. Diagnoses included Alzheimer's disease, postural kyphosis (hunchback), arthritis, prior fall, and prior hip fracture. The current MDS, dated 04/29/10, identified Resident #17 rarely/never made self understood or understood others, and required extensive assistance of one staff for transfers and toilet use. The careplan, dated 07/31/09, stated, "Because of my advanced dementia, arthritis and decreased mobility I am unable to care for myself anymore. . . . INTERVENTIONS: . . . I need assist of 1 and the stand up lift for all of my transfers. . . ."

On 06/09/10 beginning at 1:39 p.m., a CNA (#15) placed Resident #17's feet on the platform of the PAL lift, fastened a safety strap around her calves, placed the sling behind her back, connected the sling to the lift, and applied the safety strap around the resident's waist. The CNA placed Resident #17's right hand on the lift's handle. Observation showed a splint on Resident #17's left hand. The CNA (#15) reminded the resident to hold on as she raised the resident to a standing position. Observation showed Resident #15's right elbow just slightly lower than her shoulder level and her left arm hanging at her side. The CNA failed to tighten the safety strap as

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F 323	Continued From page 8 the resident stood. The waist safety strap slid upward with standing and pushed the resident's shirt up to the level of her breasts. The CNA pulled the shirt down, removed the resident's brief, and assisted her onto the toilet. At 1:50 p.m., the CNA (#15) assisted Resident #17 up from the toilet with the stand lift. The CNA failed to tighten the waist safety strap as required. The safety strap slid above the level of the resident's breasts and she let go of the lift with her right hand. The CNA assisted the resident to take hold of the handle, and performed pericares and applied a new brief. Observation showed the resident's hips flexed at approximately a 120 degree angle, and in more of a sitting position than a standing position. The CNA assisted the resident to hold the right handle again, and stated, "Don't let go of it." The CNA pulled the resident's pants up, transferred her out of the bathroom into her room, and assisted the resident to hold the right handle again. The CNA then transferred the resident to her bed.	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		

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F 441	Continued From page 9 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, review of facility policy, and review of professional reference, the facility failed to implement infection control practices that were consistent with the facility's policy/procedure and with professional standards of practice for 6 of 15 residents observed during incontinence cares (Resident #4, #5, #6, #10, #13 and #17) and for 2 of 2 residents observed during dressing changes (Resident #10 and #11). Failure to implement infection control practices has the potential to place residents, visitors, and staff members at risk of developing infections.	F 441	CNAs and licensed nurses providing care for residents #4, #5, #6, #10, #11, #13, and #17 were all retrained on proper hand washing and peri-care as appropriate. The measures we will put into place to prevent improper hand washing and peri-care include department - wide education on CMS standards and facility policy on the use of hand sanitizer versus soap and water hand washing and proper peri-care. A communication will be placed in the communication book on all neighborhoods regarding hand washing, for both staff and residents, and peri-care. Information on hand hygiene and peri-care will be communicated in a nursing department newsletter on 6-28-10. Hand washing standards and proper peri-care will be reviewed at Licensed Staff meetings on 7-5-10 and 7-7-10; at CNA meeting on 6-30-10; and at CNA inservices on 7-6-10 and 7-12-10. Audits of proper hand washing will be completed for 4 weeks to ensure that proper soap and water hand washing is completed per CMS standards and facility policy. Results of the audits will be shared at the monthly Quality Review meeting and the need for continuing audits will be addressed by the Director of Nursing Services.	7-15-10 7-15-10

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F 441	Continued From page 10 Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding infection control which states hand washing with soap and water is required under certain conditions, including before and after assisting a resident with toileting. Review of the facility policy titled "Handwashing" occurred on 06/09/10. This policy, dated 4/21/00, stated, ". . . 1. All personnel shall follow our established handwashing procedures to prevent the spread of infection and disease to other personnel, residents, and visitors. 2. Appropriate fifteen (15) second handwashing must be performed under the following conditions: . . . e. Before handling clean or soiled dressings, gauze pads, etc.; f. After handling used dressings, contaminated equipment, etc.; g. Before and after assisting a resident with toileting (cleaning/wiping perineal area or providing incontinent cares); . . . j. After handling items potentially contaminated with blood, body fluids, excretions, or secretions; . . . m. After removing gloves; . . . 4. The use of gloves does not replace handwashing. . . ." Review of the facility policy titled "Colostomy/Ileostomy Care" occurred on 06/10/10. This policy, dated 04/21/2000, stated, "Exposure to . . . body fluids may occur when performing this procedure. Protective Barriers 1. Handwashing 2. Gloves . . . Purpose: To provide guidelines that will aid in preventing exposure to fecal matter. . . . Miscellaneous . . . 3. If hands or skin are exposed to feces, the area must be washed as soon as practical. . . ." - On 06/08/10 at 8:40 a.m., observation showed a	F 441		

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F 441	Continued From page 11 certified nurse assistant (CNA) (#15) performed pericares on Resident #4 after removing his wet brief. The CNA cleansed her hands with a hand sanitizer and left the room to retrieve the nurse to change a dressing on the resident's coccyx. The CNA failed to wash her hands with soap and water after completing pericares. - On 06/08/10 at 1:23 p.m., observation showed two CNAs (#15 and #16) removed a brief soiled with urine and stool from Resident #6 before transferring her onto the toilet. A CNA (#15) performed pericares on Resident #6 after the resident voided on the toilet. The CNA (#15) removed her gloves, cleansed hands with a hand sanitizer, and left the room without washing her hands with soap and water. - On 06/08/10 at 3:55 p.m., observation showed a CNA (#8) performed pericares on Resident #5 following toileting, then gathered the garbage while another CNA (#14) transferred the resident to her wheelchair. The CNA (#8) cleansed her hands with a hand sanitizer and left the room carrying the garbage bag. The CNA (#8) failed to wash her hands with soap and water after completing pericares. - On 06/09/10 at 1:45 p.m., observation showed a CNA (#15) transferred Resident #17 onto the toilet with a mechanical lift. The CNA removed the resident's wet brief. After five minutes, the CNA (#15) cleansed her hands with hand sanitizer and gloved, assisted Resident #17 off the toilet, and performed pericares. The CNA cleansed stool from the resident's buttocks. The CNA changed her gloves and placed a new brief on the resident. The CNA removed the gloves, cleansed her hands with hand sanitizer, and transferred	F 441		

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 _____	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSIDE VILLAGE	4000 24TH AVE S GRAND FORKS, ND 58201

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F 441	Continued From page 12	F 441		

Resident #17 to her bed. The CNA (#15) used hand sanitizer again, gathered the garbage and the mechanical lift, and left the room. The CNA failed to wash her hands with soap and water after completing pericares.

- During an observation at 4:10 p.m. on 06/08/10, a CNA (#5) donned gloves and emptied Resident #13's colostomy bag of loose, liquid stool into a graduate cylinder. The CNA (#5) brought the cylinder into the bathroom, emptied it into the toilet, and rinsed it with water from the spray wand in back of the toilet. The CNA (#5) removed her gloves, and failed to wash her hands before leaving the room.

During an interview on 06/10/10 at 9:15 a.m., an administrative nursing staff member (#7) agreed staff should wash their hands with soap and water after performing pericares or emptying a colostomy.

- Observation on 06/08/10 at 1:00 p.m. showed a restorative therapy aide (RTA) (#18) performed pericares for Resident #10 following toileting. The RTA wiped the resident's perineal area from the rectal area to frontal area three times with a peri-wipe. The standard of practice when wiping a resident's perineal area is to wipe from front to back.

Observation on 06/08/10 at 3:35 p.m. showed a CNA (#19) assisted Resident #10 with toileting. The resident touched the inside of her visibly urine soaked brief. The CNA stated, "Don't touch that. It's dirty." The CNA failed to ask the resident to wash her hands following toileting.

Observation on 06/09/10 at 8:40 a.m. showed a

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F 441	Continued From page 13 nursing staff member (#21) provided a dressing change to Resident #10's coccyx ulcer. The resident's medical record, reviewed on June 8-10, 2010, showed a positive vancomycin resistant enterococcus (VRE) culture in the wound with contact precautions placed. The nurse (#21) gloved, removed the visibly soiled dressing, and changed gloves. The nurse applied a clean dressing to the wound and sanitized her hands. The nurse (#21) failed to wash her hands between glove usage and before exiting Resident #10's room and entering Resident #11's room. Observation on 06/09/10 at 8:55 a.m. showed a nursing staff member (#21) provided Resident #11's dressing change. The staff member (#21) sanitized her hands following the procedure but failed to wash her hands before exiting the resident's room. An interview with an administrative nurse (#2) occurred on 06/10/10 at 10:30 a.m. The staff member verified staff members should wash their hands during dressing changes, following dressing changes, residents should be prompted to wash hands after toileting, and staff should provide pericares by wiping from front to back only.	F 441		