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 _____	06/07/2018

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 000	INITIAL COMMENTS The standard Medicare/Medicaid survey started on 06/04/18 and concluded on 06/07/18.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		7/12/18

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

Electronically Signed | 06/20/2018

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F 656	Continued From page 1 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of facility policy, the facility failed to develop a comprehensive care plan for 2 of 24 sampled residents (Resident #55 and #84). Failure to develop a care plan may negatively impact the resident's quality of life. Findings include: Review of the facility policy titled "Care Plan, Comprehensive Interdisciplinary" occurred on 06/06/18. This policy, dated March 2017, stated, ". . . The comprehensive care plan must describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. . . ." - Review of Resident #84's medical record occurred on all days of survey. Diagnoses included pain in the thoracic spine, weakness, and dementia. A quarterly Minimum Data Set (MDS), dated 05/08/18 identified the resident required extensive assistance with bed mobility, transfers, and locomotion. Observation of Resident #84 on all days of survey identified a pummel cushion in place to	F 656	Care plans of residents affected by the deficient practice were updated to reflect current individual needs. Care plans of all residents with pressure injuries and specialized cushions will be reviewed for accuracy. The Pressure Injury Report Form was updated to ensure that licensed nurses add "actual impairment to skin integrity" to the care plan when a pressure injury is identified. A written memo to licensed nurses will educate and inform them of changes to the Pressure Injury Report Form. Audits that are completed monthly were updated to include auditing the care plan and Kardex for use of special cushions. A written memo to restorative aides will educate and inform them of the changes to this audit. Care Coordinators, or their designee, will complete audits of all residents with pressure injuries for accuracy of the pressure injury on their care plan every week for one month, then audit eight residents per month for eleven months.	

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F 656	Continued From page 2 her wheel chair. An occupation therapy (OT) note dated 08/25/17 stated, ". . . ModA [moderate assist] to maintain upright sitting balance. . . . Seated pt. [patient] in new 18 x 18 high back reclining w/c [wheel chair] with pummel seat for improved posture and positioning of LLE [left lower extremity]. . . ." Resident #84's current care plan stated, ". . . Mobility: I move around the neighborhood by using a w/c [wheel chair], requiring extensive assist of staff. I have anti rollbacks [brakes] on my w/c for safety . . . I have a pressure relieving/reducing cushion in both my wheelchair and recliner to protect the skin while up. . . ." The care plan failed to address Resident #84's pummel cushion used in the wheelchair. During an interview on 06/06/18 at 9:13 a.m., a nurse care coordinator (#1) confirmed the care plan lacked the use of a pummel cushion for Resident #84. - Review of Resident #55's medical record occurred on all days of survey. Diagnoses included left radial palsy. Health Status Note Data, dated 05/27/18 stated,". . . pressure area on left thumb. Area measures 1.2 cm [centimeter] long, and 0.9 cm wide and depth is superficial. . . . Doctor ordered cleanse area with soap and water, apply Vaseline and cover with telfa . . . change daily until resolved . . . soft carpel brace . . . "Health Status Note Data, dated 05/29/18 stated,". . . wear compression glove on in am and off at bedtime. . . ." Observation of Resident #55 on all days of	F 656	Restorative aides will audit the kardex and care plan for accurate documentation of special cushions every week for four weeks then monthly for eleven months. The Director of Nursing Services will report the results to the QAPI Team on a monthly basis.	

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F 656	Continued From page 3 survey identified a compression glove and brace to left hand. Review of a Care Coordination Note, dated 05/20/18 stated,". . . Document/take picture of open area to left thumb. . . every Wednesday day shift for Facility/protocol. Picture of pressure ulcer stage 2 documented on 05/03/18. . . ." Review of a Care Coordination Note, dated 06/04/18 stated,". . . Resident has been ordered to wear a brace on the left wrist/hand by Ortho [Orthopedic physician] and hand therapy following a diagnosis of left radial palsy. This area has no measurable depth during writers assessment and is closed at this time. . . . Resident declines use of alternate, soft-brace . . . is self-removing it and does not retain the ability to recall its improtance due to dementia disease process. . . ." During an interview on 06/06/18 at 11:35 a.m., a nurse care coordinator (#1) stated there was a care plan for potential injury development related to the fracture and confirmed staff should develop a care plan specific to the resident's left thumb pressure ulcer. During an interview on 06/06/18 at 3:55 p.m., an adminitrative nurse (#4) agreed the care plan was not specific to an aquired pressure ulcer.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		7/12/18

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F 689	Continued From page 4 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's policy, and staff interview, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 2 of 8 sampled residents (Resident #12 and #17) observed during stand-lift transfers. Failure to ensure proper use of a mechanical stand-lift resulted in Resident #12 experiencing pain and placed Resident #12 and #17 at risk for possible accidents with/without injury. Findings include: Review of the facility policy titled "Volaro Sit-to-Stand Lift" occurred on 06/06/18. This policy, revised January 2017, stated, ". . . Encourage the resident to use their arms and legs while being lifted. . . . Note: Resident must be able to weight bear during transfer. . . . Unlock the brakes and roll the lift to the second surface. . . ." - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included fatigue, osteoarthritis, and pain. The annual Minimum Data Set (MDS), dated 04/30/18, identified extensive assistance of two or more persons required for transfers. The current care plan stated, ". . . use mechanical stand lift, X2 [times two] CNA [certified nursing assistants] assist to toilet. . . .	F 689	OT/PT evaluations were ordered on the sampled residents affected by the deficient practice. Recommended changes will be implemented and carried out. OT/PT screenings or evaluations were ordered on each resident who uses a mechanical stand lift. Direct care staff will be trained on proper use of mechanical stand-lifts, emphasizing that residents must be able to weight bear during transfers. Staff will be trained to report to their nurse when a resident does not weight bear or has complaints of pain with transfers. The Staff Development Nurse or designee will train staff. The Staff Development Nurse, or their designee, will audit staff performing resident transfers. All residents who use a mechanical stand-lift will be audited every month for twelve months. The Director of Nursing Services will report the results to the QAPI Team on a monthly basis.	

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F 689	Continued From page 5 Medium sling. . . ." Observation showed the following: * On 06/04/18 at 1:20 p.m., two CNAs (#7 and #8) toileted Resident #12. After a CNA (#8) raised Resident #12 approximately 20 degrees off of the toilet utilizing a sit-to-stand lift, another CNA (#7) completed peri-cares. Resident #12 remained in a semi-seated position, with the harness straps pulling upward into her armpits, raising her shoulders to ear level. Resident #12 groaned when the CNA (#8) raised the lift a few extra inches prior to transporting her back to her wheelchair. Following the transfer, Resident #12 stated, "I have a shoulder that hurts." The CNA (#8) told her she would pass the information on to her nurse. The CNAs (#7 and #8) failed to ensure Resident #12 could bear weight while in the stand lift. * On 06/05/18 at 10:27 a.m., two CNAs (#7 and #9) toileted Resident #12. After a CNA (#9) raised Resident #12 approximately 20 degrees off of the toilet utilizing a sit-to-stand lift, another CNA (#7) completed her peri-cares. Resident #12 remained in a semi-seated position, with the harness straps pulling upward into her armpits, raising her shoulders to ear level. Resident #12 remained in this position as the CNAs (#7 and #9) then transported her back to her wheelchair. The CNAs (#7 and #8) failed to ensure Resident #12 could bear weight while in the stand lift. - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included osteoarthritis, polyneuropathy, and pain. The admission MDS, dated 03/21/18, identified extensive assistance of two or more persons required for transfers.	F 689		

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F 689	Continued From page 6 The current care plan stated, ". . . I require X2 staff and stand lift for toileting and toilet transfers. . . . Medium sling. . . ." Observation on 06/04/18 at 1:31 p.m. showed two CNAs (#7 and #8) toileted Resident #17. One CNA (#7) lifted Resident #12 approximately 20 degrees out of her wheelchair utilizing a sit-to-stand lift. She continued to raise the resident in the sling an additional 20 degrees as she pushed the lift towards the bathroom. Resident #17 remained in a semi-seated position with the harness straps pulling upward into her armpits, raising her shoulders to ear level and extending her elbows out horizontally. The CNA (#7) then lowered her onto the toilet. The CNAs (#7 and #8) failed to ensure Resident #17 could bear weight while in the stand lift. During an interview on 06/07/18 at 8:51 a.m., an administrative nurse (#4) confirmed staff should ensure residents are able to bear some of their own weight while utilizing a stand lift.	F 689		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803		7/12/18

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F 803	Continued From page 7 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of a facility small portion tray card, and staff interview, the facility failed to ensure staff provided the appropriate serving sizes indicated by the tray card during observation of meals and tray line in 2 of 3 resident dining rooms (First Floor and Second Floor). Failure to ensure staff provided the appropriate serving size placed residents at risk for decreased intake and may result in unplanned weight loss. Findings include: - Observation of tray line for First Floor occurred on 06/05/18 beginning at 12:10 p.m. To serve small portions of the mashed potatoes and vegetables, the dietary staff member (#2) partially filled the regular portion scoops. - Observation of tray line for Second Floor occurred on 06/06/18 at 12:05 p.m. To serve	F 803	In-services on portion control were held on 6/20/18 with dining services staff to ensure foods are being served using the proper serving and scoop sizes for the accurate delivery of portion sizes. All residents receiving small portions have the potential to be affected. In-services on portion control were held on 6/20/18 with dining services staff. Competency testing on portion control will be completed on dining services staff following this education. A chart that outlines regular and small portion sizes and scoops was placed in the main kitchen and kitchenettes for dining services staff. The Director of Dining Services, or their designee, will complete weekly audits in	

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F 803	Continued From page 8 small portions, the dietary staff member (#3) partially filled the regular portion scoops for potatoes and vegetables. When asked, the dietary staff member (#3) explained she dishes small portions by not giving a full scoop, estimating 3/4 to 1/2 a scoop. Review of the facility menu for the noon meal on 06/05/18 and 06/06/18 occurred on 06/06/18 and identified the serving size for the regular menu portion of potatoes and vegetables as 1/2 cup. Review of the small portion tray card showed the portion size as 1/4 cup for the vegetable and potato. During an interview on 06/06/18 at 1:50 p.m., dietary administrative staff members (#5 and #6) identified a small portion is half of the regular portion and designated on the resident's tray card. The staff members (#5 and #6) identified the correct scoop sizes, regular and small, are available and staff should us them for serving.	F 803	each kitchenette to assess for correct scoop use for small portions for one month, then two audits per month in each kitchenette for eleven months. The Director of Dining Services will report the results to the QAPI Team on a monthly basis.	