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 _____	06/10/2021

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 The Standard Medicare/Medicaid recertification survey started on 06/07/21 and concluded on 06/10/21.	F 000		
F 689 SS=E	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 §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, review of facility policy, and resident and staff interview, the facility failed to ensure an environment free from accident hazards on 4 of 4 resident neighborhoods (Heartland, Hearthstone, Oakcrest, and Prairieview). Failure to ensure safe water temperatures and secure chemical storage may result in injuries to residents. Findings include: HOT WATER TEMPERATURES Review of the facility policy titled "Hot Water Temperature Procedure" occurred on 06/10/21. This policy, revised October 2017, stated, ". . . Hot water shall be provided for essential functions of the skilled nursing centers, assisted living, and independent living areas. Water shall be maintained at 115 [degrees] Fahrenheit. . . ."	F 689	F689 HOT WATER TEMPERATURES 1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected. 3. The water temperature at the water heaters was lowered to 125 degrees Fahrenheit on 6/10/2021 and then to 120 degrees Fahrenheit on 6/30/2021 to ensure that water, once it reached the distance of the resident rooms, will not reach temperature higher than 115 degrees Fahrenheit . New mixing valves were ordered on 7/01/2021 to replace the current equipment. Replacement will be scheduled immediately upon receipt of the new valves.	7/9/21

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

Electronically Signed | 07/01/2021

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F 689	Continued From page 1 During an interview on 06/08/21 at 5:33 p.m., Resident #90 stated, "It [the water] gets a little hot, but I like it. You could get scalded if [you] stay in it too long." Water temperature measurements obtained in each of the four resident neighborhoods on the morning and afternoon of 06/08/21 and the morning of 06/09/21 showed the following: *Room 110: 126.1 degrees Fahrenheit (F) *Room 111: 125.3 F *Room 114: 126.6 F *Room 117: 125.8 F *Room 123: 120.6 F *Room 138: 122.1 F *Room 142: 125.5 F *Room 145: 124.1 F *Room 150: 122.8 F *Room 151: 120.4 F *Room 154: 120.5 F *Room 164: 120.3 F *Room 211: 127.3 F *Room 214: 124.7 F *Room 240: 122.4 F *Room 246: 127.3 F *Room 247: 125.7 F *Room 245: 125.4 F During an interview on the morning of 06/10/21, administrative staff members (#1 and #2) agreed the water was too hot for residents. CHEMICAL STORAGE Review of the facility policy titled "Security Procedures for Access to Supplies" occurred on 06/10/21. This policy, revised May 2016, stated, ". . . All chemicals must be kept in visual sight of	F 689	4. Environmental Services will be responsible for bi-weekly audits of water temperatures in resident rooms until replacement of the mixing valve has been completed to ensure water temperatures remain stable. Once replacement of the mixing valve is complete, audits will continue on a weekly basis for one month and decrease to monthly for a year to ensure water temps remain at a level per the Hot Water Temperature Procedure policy. The Director of Environmental Services, or their designee, will report the audit results to the QAPI Team on a monthly basis for the next twelve months. CHEMICAL STORAGE 1. No residents were affected by the deficient practice. Housekeeper (#4) was re-educated on securing of chemicals when unattended on 6/10/2021. All housekeeping carts were audited to ensure that chemicals were secured. 2. All residents have the potential to be affected. 3. Security Procedures for Access to Supplies policy was reviewed and remains in place. All housekeepers and custodians were re-educated to the policy on 6/10/2021 with an emphasis on ensuring that chemicals are secured within cleaning carts when carts are unattended. All housekeeping and custodial staff will complete a review of	

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F 689	Continued From page 2 the housekeeper/custodian unless in locked storage area. . . ." Observations on 06/07/21 at 1:01 p.m., 06/09/21 at 10:54 a.m., and 06/10/21 at 10:00 a.m. on Prairieview neighborhood, showed cleaning chemicals (Symmetry foaming hand sanitizer, Easy Task Wipes and Generations Bowl Cleaner) unsecured on a cleaning cart and unattended by a housekeeper (#4). During an interview on 06/10/21 at 11:20 a.m., a housekeeping director (#5), confirmed staff should lock all chemicals inside the housekeeping cart."	F 689	the policy and will relay verbal understanding of the policy by 7/09/2021. 4. The Assistant Director of Environmental Services, or designee, will audit 6 housekeeping carts per week for the first month and 6 housekeeping carts per month for the following eleven months to ensure chemicals are secured at all times while unattended. The Assistant Director of Environmental Services, or designee, will report the audit results to the QAPI Team on a monthly basis for the next year.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policy, and staff interview, the facility failed to ensure proper respiratory care for 1 of 1 sampled resident (Resident #50) with orders for oxygen (O2) therapy. Failure to provide oxygen as ordered may complicate the resident's respiratory status. Findings included	F 695	F695 1. Resident #50's care plan was reviewed and the oxygen flow concentration was corrected on 6/10/2021. Appropriate interventions remain in place. 2. All residents with orders for oxygen therapy have the potential to be affected.	7/15/21

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F 695	Continued From page 3 Review of the facility policy titled "Oxygen Therapy" occurred on 06/10/21. This policy, dated October 2018, stated. ". . . Assessment . . . Review resident's medical record for medical order for oxygen, note delivery method, flow rate . . . Documentation . . . Record the respiratory assessment findings, method of oxygen delivery, oxygen flow rate . . . in electronic medical record. . . ." Review of Resident #50's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD). A physician's order, dated 04/04/17, showed, "O2 continuously at 3 Liters per nasal cannula (NC) every shift . . ." The current care plan stated, ". . . I have Emphysema/COPD . . . OXYGEN SETTINGS: O2 @ 3L [liters] per nasal cannula continuously. . ." Observations on 06/08/21 at 10:21 a.m., 06/09/21 at 8:19 a.m., and 06/10/21 at 11:19 a.m. showed Resident #50 lying in her bed with a nasal cannula in place and the oxygen concentrator flow rate set at 4 liters. During an interview on 06/10/21 at 11:37 a.m., an administrative staff member (#3) confirmed Resident #50's oxygen flow rate is ordered at 3L and staff should set the concentrator at 3L, not 4 liters.	F 695	3. All Licensed Nurses will be educated on accuracy of oxygen concentrator flow. The Director of Nursing, or designee, will provide education through a Licensed Staff Meeting on 7/07/2021 and/or a memo to be reviewed and acknowledged by all licensed nurses by 7/15/2021. 4. The Staff Development Nurse, or designee, will audit provider's orders for oxygen therapy versus actual oxygen concentrator flow rates for accuracy each week for four weeks, then monthly for eleven months. The Staff Development Nurse, or their designee, will report the audit results to the QAPI Team on a monthly basis for the next twelve months.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of	F 697		7/15/21

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F 697	Continued From page 4 practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to provide treatment and services in a manner to maintain the highest practicable physical well-being for 1 of 5 sampled residents on hospice(Resident #97). Failure of staff to adequately control the resident's pain resulted in Resident #97 experiencing pain/discomfort. Findings include: Review of the facility policy titled "Pain Management" occurred on 06/10/21. This policy, dated December 2001, stated, ". . . Pain in residents will be assessed and treated properly and consistently to ensure the highest level of pain relief possible. . . ." Review of Resident #97's medical record occurred on all days of survey. Diagnoses included failure to thrive, left femur fracture and polyosteoarthritis. The current physician's orders showed, ". . . Morphine Sulfate (Concentrate) Solution 20 MG[milligrams]/ML[milliliter]. Give 2 milligram by mouth every 1 hours as needed for SOB [shortness of breath] / Pain give 0.1mL . . . APAP Tablet 325 MG (Acetaminophen) Give 650 mg by mouth two times a day for pain . . . [Document] Pain medication offered and declined . . ." Resident #97's medical record identified admission to Hospice on 05/25/21 and an	F 697	F697 1. The pain management regimen of Resident #97 was reviewed by the RN Care Coordinator along with a review of their current pain care plan to ensure that it is effective and individualized. The resident's provider ordered a scheduled pain medication in addition to the current prn order. Monitoring and assessment of the resident's pain is ongoing. 2. All residents experiencing pain have the potential to be affected. 3. All Licensed Nurses will be educated on pain management. The Staff Development Nurse, or designee, will assign online education to licensed nurses to be completed by 7/15/2021. 4. RN Care Coordinators, or their designee, will complete weekly audits of all residents' pain levels and their care plans with respect to pain for four weeks. Upon completion and review of those four weeks, audits will continue monthly for eleven months. Any residents with newly identified or unmanaged pain will be managed per our revised Pain Management Policy. The RN Care Coordinator, or their designee, will report the audit results to the QAPI Team on a	

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F 697	Continued From page 5 unstageable pressure injury to her coccyx with a treatment ordered every other day or as needed. A significant change minimum data set (MDS), completed on 04/27/21, indicated the resident rated her pain 7 of 10 (signifying intense pain per the numeric pain scale) and experienced frequent pain in the last 5 days causing her to limit her day-to-day activities. The MDS also showed a BIMS (Brief Interview for Mental Status) of 13, identifying the resident as cognitively intact. Observation on 06/08/21 at 10:01 a.m., showed a staff nurse (#6) perform a dressing change to Resident #97's coccyx. The resident verbalized pain multiple times during the procedure. The nurse stated she premedicated the resident prior to the dressing change. Review of the resident's electronic medication administration record (eMAR) identified the as needed Morphine Sulfate administered at 9:59 a.m., 2 minutes prior to the dressing change. Random observations showed Resident #97 calling out for help from her room: * On 06/08/21, shortly after the coccyx dressing change completed, "Please help me. I hurt." * On 06/08/21 at 10:40 a.m., "Please help me. I hurt." "Please help the pain go away." "Please come and help." * On 06/09/21 at 2:33 p.m., "Please help me. Please. Please help me." Observations showed facility staff failed to enter Resident #97's room to assess her needs. Review of Resident #97's eMAR, May 25, 2021 through June 9, 2021, identified the resident took	F 697	monthly basis for the next twelve months.	

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F 697	Continued From page 6 all doses of her scheduled Tylenol, did not refuse/decline any offers for pain medications, and received the as needed Morphine Sulfate only once a day on 9 of the 16 days, when the resident could have received the Morphine every hour. The medical record lacked evidence of routine pain assessment and monitoring. During an interview on 06/09/21 at 2:33 p.m., Resident #97 stated she did not feel her pain was controlled, reached out and stated, "I want my bottom to feel better." "Please help me." During an interview on 06/10/21 at 10:28 a.m., and administrative staff member (#3) agreed the facility did not effectively control resident #97's pain.	F 697		