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 _____	11/03/2022

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 10/31/22 and concluded on 11/03/22.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 2 sampled residents (Resident #14) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identity and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's	F 637	F637 1. A MDS modification was submitted on November 2, 2022 on the affected resident, #14. 2. All residents have the potential to be affected. 3. On November 30, 2022, Care Coordinator #4 received education on the failure to complete a significant change in status assessment. All Care Coordinators will be assigned education on significant changes that will be completed on or before	12/8/22

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

Electronically Signed | 12/02/2022

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F 637	Continued From page 1 Manual (Version 1.15), dated October 2017, page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . ." Review of Resident #14's medical record occurred on all days of survey. An admission Minimum Data Set (MDS) dated 05/15/22 identified the resident was independent with bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, eating, toilet use, and supervision with hygiene. The medical record identified Resident #14 was hospitalized 07/19/22 - 07/21/22. A quarterly MDS, dated 07/27/22, identified the resident required extensive assistance with bed mobility, transfers, walk in room, locomotion on and off the unit, dressing, eating, toilet use, and hygiene. A resident progress note dated 07/28/22 at 1:49 p.m., stated, "[resident] triggered for significant change in status on MDS, however, it was expected upon return from hospital on 07/21/22, that he would have a change, but would improve . . . Continued improvements expected." A Quarterly MDS dated 10/21/22 identified the resident required extensive assist with bed mobility, transfers, walk in room, locomotion on and off the unit, dressing, eating, toilet use, and	F 637	December 8, 2022. 4. Care Coordinators or their designee will audit for two or more functional improvements or declines in the MDS that would require a significant change assessment by completing random audits of twelve MDS assessments per month for three months. The results of the audits will be submitted to the QAPI team on a monthly basis. Based on the results of this audit we will determine the frequency of continued audits for the next nine months. 5. December 8, 2022.	

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F 637	Continued From page 2 hygiene. The record lacked evidence why staff failed to complete a SCSA following Resident #14's continued decline. During an interview on 11/02/22 at 8:00 a.m., a care coordinator (#4) confirmed staff failed to complete a significant change in status assessment after Resident #14 did not return to status after hospital return 07/21/22 and after further observation from the Quarterly MDS completed 07/27/22.	F 637		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement pressure ulcer prevention measures for 1 of 5 sampled residents (Resident #87) utilizing pressure-relieving devices. Failure to ensure orders for pressure-relieving boots were followed and consistent with the care plan and the treatment administration record (TAR)	F 686	F686 1. Resident #87 physician order was updated on November 4, 2022 to match with the resident's care plan. 2. All residents with an order to wear	12/8/22

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F 686	Continued From page 3 (and updated on the care plan and TAR) may result in the development of new and/or reopening of previously healed pressure ulcers. Findings include: Review of the facility policy titled "Skin Prevention Protocol" occurred on 11/03/22. This policy, revised November 2020, stated, ". . . Purpose: To prevent the breakdown of skin integrity . . . and incorporating interventions to alleviate/minimize pressure . . . ." Review of the facility policy titled "Physician Orders, Transcription of" occurred on 11/03/22. This policy, revised June 2007, stated, " . . . All new orders are to be transcribed to the appropriate location, such as . . . TAR . . ." Review of Resident #87's medical record occurred on all days of survey and showed the following: * Current signed physician's orders included, "Prevalon boot (specialized boot to relieve pressure) to bilateral feet for potential for high risk skin breakdown to be worn at all times . . . A skin assessment dated 09/07/22, showed the resident had a stage 2 pressure ulcer to his left foot first toe acquired in the facility and healed on 09/07/22. A second skin assessment, dated 09/20/22, showed another stage 2 pressure ulcer to his right foot second toe acquired in the facility and healed on 9/20/22. * Current care plan stated, ". . . I have an actual impairment to skin integrity on my left great toe and right second toe . . . Please follow prescribed	F 686	pressure relieving boots have the potential to be affected. 3. All licenses nurses will be assigned an educational model in regards to the 2022 survey findings that will be completed on or before December 8, 2022. 4. All residents who wear pressure relieving boots will be audited by the Care Coordinator or their designee to ensure that the care plan, treatment administration record and physician orders match. These audits will be done weekly for four weeks then monthly for eleven months. The results of the audits will be submitted to the QAPI team on a monthly basis. 5. December 8, 2022.	

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F 686	Continued From page 4 treatments and/or interventions as ordered. . . . I wear prevalon boots and heel protectors on when in bed. . . ." The October and November 2022 TAR included the following, "Prevalon boot to bilateral feet for potential for high risk skin breakdown to be worn at all times . . ." The facility failed to ensure the care plan matched the current orders and TAR. Random observations on all days of survey showed Resident #87 in his wheelchair or recliner without Prevalon boots. During an interview on 11/02/22 at 11:34 a.m., a nurse (#1) verified Resident #87's record contained no order for the change of Prevalon boots at all times to only when in bed. The facility failed to ensure the medical record correctly and consistently reflected the use of pressure-relieving boots to prevent new pressure ulcers and/or the reoccurrence of healed pressure ulcers.	F 686		
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 §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	F 689	F689	12/8/22

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F 689	Continued From page 5 facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 2 of 8 sampled residents (Resident #12 and #41) observed during a transfer. Failure to use a gait belt and or use it correctly when transferring a resident placed the residents at risk for falls and injury. Findings include: Review of the facility policy titled "Gait Belt" occurred on 11/03/22. This policy, revised 2017, stated, "1. Policy: Valley Senior Living will utilize gait belts to aid in the transfer of residents from a sitting to standing position for residents who are partially dependent, have some weight-bearing capacity, and are cooperative. . . ." - Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, "TRANSFER . . . I transfer with assist of one with a gait belt . . ." Observation on 11/02/22 at 1:50 p.m. showed a certified nursing assistant (CNA) (#2) assisted Resident #12 off the toilet with a gait belt placed around the resident's waist. The CNA instructed the resident to stand as she lifted under the resident's arms. The CNA failed to use the gait belt to transfer the resident from the toilet to the wheelchair. - Review of Resident #41's medical record occurred on all days of survey. The current care plan stated, "TRANSFER . . . I transfer with assist of one and a gait belt . . ."	F 689	1. Staff #2 and #3 received education on proper gait belt use on November 29, 2022. 2. Any resident who transfers using a gait belt has the potential to be affected. 3. All direct care staff will be assigned an educational module in regards to the 2022 survey findings that will be completed on or before December 8, 2022. 4. The Staff Development RN or designee will be responsible to complete a minimum of eight audits per neighborhood of transfers using gait belts for twelve weeks, followed by eight audits per neighborhood monthly for nine months. The results of these audits will be reported by the Staff Development RN to the QAPI team on a monthly basis. 5. December 8, 2022.	

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F 689	Continued From page 6 Observation on 11/01/22 at 9:42 a.m. showed a CNA (#3) transferred Resident #41 from the wheelchair to the bed. The CNA pulled on the back of the resident's pants during the transfer. The CNA failed to use a gait belt during the transfer. During an interview on the morning of 11/03/22, an administrative nurse (#1) confirmed she expected staff to follow the care plan and utilize a gait belt to transfer Resident #12 and #41.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692		12/8/22

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F 692	Continued From page 7 Based on observation, record review, and staff interview, the facility failed to provide/offer fluids to 1 of 6 sampled residents (Resident #8) observed during cares and required staff assistance for fluid intake. Failure to offer/encourage fluid intake may result in dehydration, constipation, and urinary tract infections. Findings include: Review of Resident #8's medical record occurred on all days of survey. Diagnoses included cerebral vascular disease, and dementia. The care plan stated, ". . . I have an ADL [Activity of Daily Living] self-care performance deficit r/t [related to] Dementia and right-sided weakness . . . I require total assistance by staff to eat . . . Provide and serve a pureed diet and honey/moderately thick liquids . . . Encourage good nutrition and hydration in order to promote healthier skin. . ." Observation on 11/01/22 at 10:45 a.m. showed a certified nursing assistant (CNA) (#9) and an unidentified CNA assisted Resident #8 with cares and transferred the resident to the wheelchair. The resident had a disposable cup full of thickened liquid and a nosey cup (cup with opening for the nose) on the bedside table. The CNAs failed to offer the resident thickened liquids with cares. Observation on 11/02/22 at 10:40 a.m. two CNAs (#9 and #10) assisted the resident into bed and failed to offer fluids to the resident. Observation on 11/02/22 at 4:15 p.m. showed	F 692	F692 1. Resident #8 was assessed for dehydration risk by the licensed registered dietitian on November 30, 2022. The care plan will be reviewed and updated as needed. 2. All residents who require total assistance to drink fluids have the potential to be affected. 3. All direct care staff will be assigned an educational module in regards to the 2022 survey findings that will be completed on or before December 8, 2022. 4. The Staff Development RN or designee will be responsible to complete audits of two dependent residents per neighborhood weekly for twelve weeks, then monthly for nine months. The results of this audit will be reported by the Staff Development RN to the QAPI team on a monthly basis. 5. December 8, 2022.	

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F 692	Continued From page 8 two CNAs (#11 and #12) assisted Resident #8 into the wheelchair and transported the resident to the TV area. The CNAs failed to offer fluids to the resident. A large nosey cup full of an orange thickened liquid and a disposable cup of thickened water sat on the resident's bedside table, untouched. During an interview on 11/03/22 at 10:30 a.m., an administrative nurse (#8) stated she expected staff to offer Resident #8 fluids with every interaction.	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		12/8/22

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F 758	Continued From page 9 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days for 1 of 1 sampled resident (Resident #105) receiving a PRN antianxiety medication. Failure to ensure the physician renewed the PRN order after 14 days may result in the resident receiving an unnecessary medication. Findings include: Review of the facility's policy titled "Psychotropic	F 758	F758 1. Resident #105 physician order was changed on November 14, 2022 to reevaluate Lorazepam order every fourteen days. 2. Any resident with a prn psychotropic medication order has the potential to be affected. 3. All licensed nurses will be assigned an educational module in regards to the	

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F 758	Continued From page 10 Drugs" occurred on 11/03/22. This policy, revised April 2017, stated, ". . . PRN orders for psychotropic drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration [sic] the PRN order. . . ." Review of Resident #105's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, depression, and anxiety. The current physician's orders identified "Lorazepam [antianxiety medication] Tablet 0.5 MG [milligrams]. Give 0.5 mg by mouth every 4 hours as needed for anxiety . . . re-eval [re-evaluate] with hospice nurse every 30 days and document visit." Resident #105's medical record identified the resident discharged from hospice care on 09/23/22. The medical record identified the physician last evaluated the PRN Lorazepam on 10/04/22. The record lacked evidence the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication every 14 days after discharged from hospice. During an interview on 11/02/22 at 10:38 a.m., a care coordinator (#4) confirmed the provider failed to review the PRN medication every 14 days.	F 758	2022 survey findings that will be completed on or before December 8, 2022. Hospice agency staff were educated on November 29, 2022 in regards to the review of PRN per the regulation in a skilled nursing setting. 4. Care Coordinators or their designee will be responsible to audit that the evaluation of PRN psychotropic medication orders is completed per the requirements of the PRN psychotropic medications regulation. This will be audited for all residents on a PRN psychotropic medication weekly for four weeks then monthly for eleven months. The results of the audits will be submitted to the QAPI team on a monthly basis. The need for further audits will be determined at the discretion of the QAPI team. 5. December 8, 2022.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		12/8/22

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F 812	Continued From page 11 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store food and beverages in a sanitary manner for 3 of 4 dining/kitchenette areas (Heartland, Prairieview, and Oakcrest). Failure to discard milk-based nutritional beverages by the throw by date, maintain clean refrigerators for storage of food and beverages, and label food prior to placing in the refrigerator or freezer has the potential to result in the spread of foodborne illness to residents, staff, and visitors. Findings include: Review of the facility policy titled "Food Storage"	F 812	F812 1. All kitchenette and parlor refrigerators were inspected on November 2, 2022 and all expired/outdated or unlabeled food was discarded. The Oakcrest refrigerator was cleaned on November 2, 2022. 2. All residents have the potential for harm if expired food is served. 3. All kitchenette and parlor refrigerators will be audited for expired/outdated or	

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 _____	11/03/2022

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 812	Continued From page 12 occurred on 11/02/22. This policy, revised 2017, stated the following: ". . . N. All refrigerator units are kept clean . . . O. Refrigeration: . . . All foods should be covered, labeled and dated. . . . P. Frozen Foods: . . . Foods should be covered, labeled and dated. . . ." Observation of the posting on the main kitchen's freezer door on 11/02/22 at 2:13 p.m. stated, "Starting Monday August 9th Mighty Shakes [a milk-based nutritional supplement] will be labeled with a throw by date instead of the date they were pulled from the freezer. . . ." Observation during the dietary tour on 11/02/22 at 12:28 p.m. with the food service supervisor (#5) showed the following: * Heartland: - One unlabeled/undated container of food in a hallway refrigerator. * Prairieview: - Three unlabeled/undated food containers in a kitchenette freezer. - Four containers of chocolate Mighty Shakes with throw by dates of 10/31/22 in a kitchenette refrigerator. * Oakcrest: - Four containers of vanilla Mighty Shakes with throw by dates of 10/31/22 in a kitchenette refrigerator. - A small overflow resident refrigerator contained an unlabeled/undated bag of corn on the cob and plastic food container, and an orange substance covered the bottom of the refrigerator. During an interview on 11/02/22 at 2:13 p.m., the food service supervisor (#5) stated she expected staff to dispose of unlabeled/undated food found	F 812	unlabeled items and cleanliness of refrigerators by Dining Services staff on a weekly basis. All Dining Services staff will be assigned to watch an educational video and complete a post-test on ServSafe Food Storage on or before December 8, 2022. 4. The Dining Services Director or designee will be responsible to audit all kitchenette and parlor fridges weekly for two months, then twice per month for the following ten months. The audits will check for expired/outdated or unlabeled food and cleanliness of refrigerators. The Director of Dining Services will report the results to the QAPI Team on a monthly basis. 5. December 8, 2022.	

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 _____	11/03/2022

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F 812	Continued From page 13 in the refrigerators/freezers and dispose of Mighty Shakes based on the throw by date.	F 812		