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 _____	C 11/30/2023

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 recertification survey started on 11/27/23 and concluded on 11/30/23.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 26 sampled residents (Resident #103). Failure to accurately code the MDS does not allow each resident's assessment to reflect their status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2023, pages J-34 and J-36 stated, ". . . J1800: Any Falls Since Admission/Entry . . . Code 1, yes, if the resident has fallen since the last admission . . . J1900: Number of Falls Since Admission/Entry . . . Code 1, one, if the resident had one major injurious fall since admission/entry or reentry or prior assessment . . ." - Review of Resident #103's medical record occurred on all days of survey. A progress note,	F 641	F641: Accuracy of Assessments 1. A MDS modification was submitted on November 2, 2023, on the affected resident, #103. 2. All residents who have had a major injury have the potential to be affected. 3. An audit of residents MDS J1800 and J1900 C who have had a major injury since their last CMS Assessment will be completed on or before January 4, 2024. MDS modifications will be submitted on any inaccurate assessments. All Care Coordinators will be assigned education on MDS section J that will be completed on or before January 4, 2024. 4. Care Coordinators, or their designee, will complete four audits of MDS sections J1800 & J1900 C monthly for three months. Based on the results of this audit we will determine the frequency of continued audits for the next nine months. The Director of Nursing Services will	12/20/23

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

Electronically Signed | 12/20/2023

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F 641	Continued From page 1 dated 10/18/2023 at 2:25 p.m., stated, ". . . Aware of activity [fall] that occurred on 10/17/2023. [Resident #103] is independent with transfers and ambulation. [Resident #103] was taking [sic] to [Hospital] via ambulance which x-rays showed closed displaced fracture of right femoral neck. Resident was admitted to [Hospital] . . . ." The discharge/return anticipated MDS, dated 10/17/23, failed to identify a fall at J1800 and a fall with major injury at J1900 C. During an interview on 11/30/23 at 10:00 a.m., a managerial nurse (#6) confirmed staff failed to code a fall with major injury on the MDS.	F 641	report the results of the audits to the QAPI team monthly. 5. January 4, 2024.	
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 the facility's policy, and staff interview, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 1 of 12 sampled residents (Resident #112) observed during stand-lift transfers. Failure to ensure proper use of a mechanical stand-lift resulted in Resident #112 experiencing pain and placed him at risk for possible accidents	F 689	F689: Free of Accident Hazards/Supervision/Devices 1. An OT evaluation was ordered on November 30, 2023, and completed on December 1, 2023, on resident #112. Recommended changes have been implemented.	12/20/23

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F 689	Continued From page 2 with/without injury. Findings include: Review of the facility policy titled ". . . Sit-to-Stand Lift" occurred on 11/30/23. 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. . . ." - Review of Resident #112's medical record occurred on all days of survey. Diagnoses included a history of falls. The current care plan stated, ". . . I transfer with the stand lift with assist of 1 from wheelchair or toilet and assist of one to get out of bed. . . ." Observation showed the following: * 11/27/23 at 3:21 p.m., a certified nurse aide (CNA) (#7) toileted Resident #112. The CNA lifted Resident #112 approximately six inches in a sit-to-stand lift before transferring him into and out of the bathroom. Resident #112 remained in a semi-seated position with the harness straps pulling upward into his armpits, raising his shoulders to ear level, extending his elbows out horizontally. As the CNA (#7) transferred Resident #112 out of the bathroom, one of the resident's elbows hit the doorframe, and he stated, "ow, ow, ow" in a loud voice. The CNA failed to ensure Resident #112 could bear weight while in the stand lift and failed to ensure his arms cleared the doorframe before pushing him out of the bathroom. * 11/28/23 at 9:40 a.m. and at 3:01 p.m., two CNAs (#8 and #10) toileted Resident #112. The CNAs lifted Resident #112 approximately twelve	F 689	2. All residents who use a mechanical stand-lift as their transfer method have the potential to be affected. 3. OT/PT screenings were ordered on each resident who uses a stand lift as their transfer method. Direct care staff will be trained on proper use of mechanical stand-lifts, emphasizing that residents must be able to weight bear through their lower extremities during transfers. Staff will be trained to report to their nurse when a resident does not effectively weight bear or has complaints of pain with transfers. This will be done through an educational module assigned to all direct care staff that will be completed on or before January 4, 2024.. 4. The Staff Development Nurse, or their designee, will audit staff performing resident transfers with mechanical stand-lifts. 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 monthly. 5. January 4, 2024.	

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F 689	Continued From page 3 inches in the sit-to-stand lift before transferring him into and out of the bathroom. Resident #112 remained in a semi-seated position with the harness straps pulling upward into his armpits, raising his shoulders to ear level. The CNA (#8 and #9) failed to ensure Resident #112 could bear weight while in the stand lift. During an interview on 11/30/23 at 10:00 a.m., an managerial nurse (#6) confirmed staff should ensure residents can bear weight while utilizing the stand lift and should report to the charge nurse if they are unable to do so.	F 689		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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:	F 812		12/20/23

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F 812	Continued From page 4 Based on observation and staff interview, the facility failed to maintain the food preparation and service area in a sanitary manner for 1 of 3 kitchenettes (Prairieview) observed. Failure to serve food in a sanitary environment has the potential to result in contamination of food and could result in a foodborne illness. Findings Include: Observation of the Prairieview kitchenette occurred on 11/29/23 at 11:00 a.m. with an administrative dietary staff member (#9). Observation showed a tower fan with accumulated dust clumps blowing toward the food service area where staff prepared food for residents. During an interview on 11/30/23 at 8:33 a.m., an administrative dietary staff member (#9) confirmed the facility does not have a process or schedule for cleaning fans and expected them to be dust free.	F 812	F812: Food Procurement, Store/Prepare/Serve-Sanitary 1. The fan with accumulated dust clumps was removed from the kitchenette on 11/29/2023. 2. All residents whose food is served from an area where there is a fan present have the potential to be affected by the deficient practice. 3. Fans in serving areas were put on a weekly cleaning schedule. Dining services staff will be trained to identify the accumulation of dust on fans and the importance of keeping fans clean in food preparation areas to prevent the accumulation of dust, on or bfore January 4, 2024. 4. The Dining Services Director, or their designee, will audit all fans for cleanliness in areas where food is served, weekly for three months, and monthly for the following nine months, in ensure all fans are clean and free of dust clumps. The Director of Dining Services will report the results to the QAPI Team monthly. 5. January 4, 2024.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		12/20/23

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F 880	Continued From page 5 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 6 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 1 of 4 neighborhoods (Oakcrest) observed with Covid-19 outbreak, and 1 of 1 sampled residents (#60) observed with a catheter. Failure to practice infection control standards related to use of personal protective equipment (PPE), and proper care of a catheter has the potential to spread infection throughout the facility. Findings Include:	F 880	F880: Infection Prevention & Control PERSONAL PROTECTIVE EQUIPMENT 1. On November 28, 2023, on duty staff were educated on the requirement to remove their PPE when exiting an area with known COVID positive residents. This education was done through individual training in real time as staff exited the neighborhood, via email and written communication reviewed at report. 2. All neighborhoods with COVID	

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F 880	Continued From page 7 PERSONAL PROTECTIVE EQUIPMENT Review of the facility policy titled "Transmission-Based Precautions" occurred on 11/30/23. This policy, revised July 2023, stated ". . . Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection . . . are additional measures that protect staff, visitors, and other residents from becoming infected . . . Droplet precautions may be implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets . . . Masks and eye protection will be worn when entering the room . . . " During an interview on 11/27/23 at 1:30 p.m., an administrative staff member (#1) identified Covid positive residents on the Oakcrest neighborhood and stated staff were to wear N95 respirators and eye protection while on the neighborhood. Observation showed the following: * 11/27/23 at 6:00 p.m., an administrative nurse (#2) left the Oakcrest neighborhood without removing her N95 facemask and goggles and went to the administrative wing to make copies. * 11/28/23 at 7:57 a.m., an unidentified staff member exited the closed double doors of the Oakcrest neighborhood wearing an N95 facemask and goggles. The staff member stood by the elevator, looked at her phone, then re-entered the neighborhood. The staff members failed to remove their PPE before exiting the Covid area. URINARY CATHETER CARE	F 880	positive residents have the potential to be affected when there is an active COVID outbreak that requires the use of PPE. 3. All staff will be trained on the requirement to remove their PPE when exiting a neighborhood with known COVID positive residents. This will be done through an educational module assigned to all staff regarding the 2023 survey findings on or before January 4, 2024. 4. In the event of a COVID outbreak: The Infection Preventionist, or their designee, will complete a minimum of eight audits per COVID positive neighborhood. During periods without a COVID outbreak: The Infection Preventionist will provide education in the format of competency quizzes. The quizzes will include immediate correction and feedback from the Infection Preventionist on the appropriate removal of PPE when there is a COVID outbreak on their neighborhood. This education will be provided monthly for twelve months. The Infection Preventionist will report the results to the QAPI Team monthly. 5. January 4, 2024. URINARY CATHETER CARE 1. A dignity cover was placed on resident #60□s urine collection bag and it was secured to the resident□s leg to prevent the tip from touching the ground	

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F 880	Continued From page 8 Review of the facility policy titled "Guidelines for Preventing Urinary Tract Infections Catheter-Associated" occurred on 11/30/23. This policy revised June 2019 stated, ". . . always practice hygiene and standard precautions when handling catheter systems . . . do not place the drainage bag on the floor . . ." Review of resident #60's medical record occurred on all days of survey. A physician's order, dated 03/02/23, identified an indwelling Foley catheter. The current care plan, dated 3/01/23 stated ". . . I have an indwelling Foley catheter related to urinary retention . . . history of urinary tract infections (UTI's) . . . I have a dignity bag for my catheter . . . ensure catheter bag cover is on (Dignity Bag)" Observation on 11/28/23 at 9:05 a.m. showed a urine collection bag attached to Resident #60's lower leg. As the resident propelled in a wheelchair, the drainage tip of the collection bag dragged on the carpeted floor. Facility staff failed to secure the urine collection bag to the resident's leg to prevent the tip from touching the floor and failed to place the collection bag in dignity bag for privacy and protection. During an interview on 11/30/23 at 10:43 a.m., an administrative nurse (#1) stated she expects staff to position urine bags to keep them from dragging on the floor and to place them in a dignity bag.	F 880	on November 28, 2023. 2. All residents with urine collection bags have the potential to be affected by the deficient practice. 3. All residents with urine collection bags were audited to ensure their collection bags were covered and not contacting the floor on November 29, 2023.Direct care staff will be trained on the proper covering of urine collection bags and that they are not to touch the floor. This will be done through an educational module assigned to all direct care staff regarding the 2023 survey findings on or before January 4, 2024. 4. The Staff Development Nurse, or their designee, will audit residents with urine collection bags to ensure a dignity cover is in use and no part of the collection bag touches the floor. All residents who use a urine collection bag will be audited every week for four weeks. Depending on the results of the audit, they will then be audited monthly for eleven months. The Director of Nursing Services will report the results to the QAPI Team monthly. 5. January 4, 2024.	