| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355067 | A. Building<br>B. Wing | 05/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Valley Senior Living on Columbia | 2900 14th Ave S<br>Grand Forks, ND 58201 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46963<br><br>Based on observation, record review, review of the facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 2 of 5 sampled residents on oxygen (Resident #32 and #47). Failure to develop a comprehensive care plan limited staffs' ability to communicate needs and ensure the continuity of care.<br><br>Findings include:<br><br>Review of the facility policy titled Care Plan, Comprehensive Interdisciplinary occurred on 05/16/24. This policy, dated 03/2017, stated, . The comprehensive care plan must describe the following: 1. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.<br><br>- Review of Resident #32's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease, heart disease, and palliative care. Physician's orders stated the following: . O2 [oxygen] PRN [as needed] 1.5 Liters per nasal cannula for comfort as needed and every day shift daily. O2 sat [saturation] when PRN O2 orders are in place . O2 tubing to be changed every night shift . Change nasal cannula every night shift every 14 day(s) . and as needed .<br><br>Observations on all days of survey showed Resident #32 with oxygen on per nasal cannula at all times.<br><br>Resident #32's current plan of care failed to identify oxygen use related to respiratory/cardiac diagnoses and palliative care.<br><br>- Review of Resident #47's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease. Physician's orders stated the following: . Check O2 sats every shift for prn oxygen use . 1 L/min [liter per minute] oxygen via nasal cannula continuously as needed for For [sic] O2 less than 90 or SOB [shortness of breath] .<br><br>Observations on 05/13/24 at 1:33 p.m. and 05/14/24 at 10:16 a.m. showed Resident #47 with oxygen.<br><br>Review of Resident #47's annual Minimum Data Set (MDS), dated [DATE], identified oxygen use. The resident's current plan of care failed to identify O2 use.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 05/16/24 at 11:00 a.m., an administrative nurse (#1) confirmed staff are expected to include residents' use of oxygen on the plan of care.<br><br>19410 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>46963<br><br>Based on observation, record review, and review of facility policy, the facility failed to provide care and services to prevent the development of pressure ulcers for 1 of 8 sampled residents (Resident #165) with prevalon boots (used for pressure relief) as ordered by the provider. Failure to apply the pressure relief boots as ordered may result in the development/worsening of pressure ulcers.<br><br>Findings include:<br><br>Review of the facility policy titled Standards of Care occurred on 05/16/24. This policy, dated 05/01/24, stated, . Additional pressure relief measures will be maintained for residents who are considered at risk for pressure injury.<br><br>Review of Resident #165's medical record occurred on all days of survey. Diagnoses included a stage three pressure ulcer on the right ankle. The current care plan stated, I have a potential impairment to skin integrity r/t [related to] Impaired [sic] mobility . I need assistance to apply bilateral prevalon boots, on while in bed. A provider's order, dated 11/13/23, stated, Prevalon boot to BLE [bilateral lower extremities] for potential for high risk skin breakdown r/t immobility to be worn when in bed.<br><br>Observations on 05/14/24 at 10:55 a.m. and 05/15/24 at 12:00 p.m. showed Resident #165 in bed without prevalon boots in place.<br><br>The facility failed to implement pressure relief interventions for Resident #165 as ordered. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19410<br><br>1. Based on record review and review of facility reported incident documents, the facility failed to provide adequate supervision and assistance devices to prevent accidents for 1 of 1 closed record (Resident #285) reviewed for a fall. Failure to use a gait belt and to provide adequate supervision resulted Resident #285 sustaining a fracture.<br><br>Findings include:<br><br>Review of Resident #285's medical record occured on 05/16/24. The care plan identified the following: . Focus: I have an ADL [activities of daily living] self-care performance deficit r/t [related to] Activity intolerance following a hospital stay for weekend, near syncope . and chronic back pain r/t degenerative disc disease (Initiated on 07/12/23). Interventions: AMBULATION: I am able to ambulate with assist of 1 staff with gait belt and FWW [front wheeled walker] . PERSONAL HYGIENE: I require assistance by 1 staff with person hygiene, perineal and oral care. TOILET USE: I need assist of 1 with toileting. TRANSFER: I am able to transfer with assist of 1 with gait belt and my FWW. Focus: I am at risk for falls r/t Deconditioning, incontinence, near syncope . Goal: I will not sustain serious injury . Interventions: Be sure my call light is in reach and encourage me to use it for assistance as needed. I need a safe environment with even floors free from the spills and /or clutter, adequate reduced glare lighting .<br><br>Review of Resident #285's nurses notes identified the following:<br><br>* 11/29/24 at 9:03 p.m.; Resident was transferring to bed and lost balance fell and hit top of head. No injuries noted. Denies pain. Neuro [neurological] checks initiated.<br><br>* 11/29/23 at 11:32 p.m.; . Resident fell at 2016 [8:16 p.m.] . [Name of physician] notified of fall and aware resident hit head. Neuro checks initiated. No injuries noted. Resident Alert and Oriented. Primary decision maker . notified of fall.<br><br>* 11/30/23 at 2:30 a.m.; . Resident got up to go to the bathroom around 1:30am. Reported pain 10 out of 10. When resident sat in wheelchair she started gagging and spitting up thick sputum. Reported of feeling funny but couldn't explain. Action: Gave Tylenol 500 mg [milligrams] PRN [as needed]. Called [Name of physician] and notified of change in status. Resident primary decision maker [name] was notified. Resident sent to ER [emergency room ] via wheelchair at 0208 [2:08 a.m.] . Response: [Name of physician] stated, Send her in. [name of primary decision maker] stated, 'I'll go to the ER.' "<br><br>* 11/30/23 at 7:23 a.m.; . Resident returned from ER at this time. Per report from ER resident has TLSO [thoracic-lumbo-sacral orthosis] brace.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | * 11/30/23 at 11:22 a.m.; Resident Concern Progress Note . Resident had fall in room last evening and did not have gait belt on as care planned. Resident and CNA [certified nurse aide] reported that resident hit her head. No visible injury noted. At 1:30AM, resident woke up and vomited, provider updated and resident was sent to ER. RN [registered nurse] notified daughter of fall and notified her of change in status when she went to the ER. Daughter met resident in ER. Initial findings regarding Resident concern: CNA did not follow care plan for transfer/ambulation. Resident was assessed in ER, CT scan showed compression fracture of T-9. Resident returned to [nursing home].<br><br>Review of the Facility Reported Incident investigation identified a staff member assisted resident to the bathroom and the resident put the call light on when done. The staff member returned and assisted to pull her brief and pants up, then walked behind the resident to the sink where she was removed her dentures and put them away. The staff member left resident at the sink and moved to open the covers on resident's bed and set up her pillows. As the staff member turned around, the resident started to lean back and fell before he/she could get to her. The staff member did not have a gait belt on resident and reports that he/she didn't think the resident needed it.<br><br>The facility failed to ensure staff followed Resident #285's plan of care by utilizing a gait belt and this failure resulted in a fall and fracture.<br><br>46963<br><br>2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision necessary to prevent accidents for 1 of 1 sampled resident (Resident #165) who required one to one supervision with meals. Failure to stay with the resident while eating as care planned places the resident at risk for choking.<br><br>Findings include:<br><br>Review of the facility policy titled Care Plan, Comprehensive Interdisciplinary occurred on 05/16/24. This policy, dated March 2017, stated, . The services provided or arranged by the facility will meet professional standards of quality, be provided by qualified persons, and be culturally-competent and trauma-informed.<br><br>Review of Resident #165's medical record occurred on all days of survey. The current care plan stated, . EATING: I am to eat all my meals out of bed in the upright position. Encourage me to go to the family room. I require 1:1 assist for meals d/t [due to] hx [history of] coughing with meals. I am at increased nutrition risk r/t [related to] h/o [history of] CVA [cerebrovascular accident/stroke], aphasia, dysphasia [language disorder that affects speech production and comprehension], and FTT [failure to thrive]. Provide and serve Regular diet with regular texture/thin liquids, breads and straws are ok per SLP [speech language pathology] 12/8/23. Resident does require assistance/observance at meals h/o of choking. I have a history of swallowing problems. Report to the dietitian if I have any difficulty with chewing/swallowing my food.<br><br>A task that is completed by care staff stated NUTRITION - Snacks PM [afternoon] -encourage high calorie item; HS [bedtime] -choc milk or ice cream *needs 1:1 supervision-high choking risk.<br><br>During an observation on 05/14/24 at 10:55 a.m., the certified nurse aide (CNA) (#7) placed a supplement shake with a straw on the resident's bedside table and left the resident unattended.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/15/24 at 1:51 p.m., the nurse (#5) stated the resident could reach the protein shake independently but would expect the CNA who gave the shake to stay with the resident. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39685<br><br>Based on observation, record review, and staff interview, the facility failed to provide appropriate toileting for 1 of 29 sampled residents (Resident #98) who required staff assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed residents at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries.<br><br>Findings include:<br><br>Review of Resident #98's medical record occurred on all days of survey. Diagnoses included skin breakdown. The quarterly Minimum Data Set (MDS), dated [DATE], identified frequently incontinent of urine, extensive assist of two for toileting, and at risk for pressure ulcers. The current care plan stated, . at risk for alterations to skin integrity . TOILET USE: I need assist of 2 with total lift . I am incontinent of bowel and bladder .<br><br>* Observation on 05/13/24 at 4:09 p.m. showed Resident #98 sitting in the wheelchair in her room with urine on the floor under the wheelchair.<br><br>* Observation on 05/13/24 at 5:24 p.m. showed two certified nurse aides (CNAs) (#10 and #11) entered Resident #98's room and observed the resident's clothing, wheelchair, and floor wet with urine. The CNAs assisted Resident #98 with incontinence cares. Resident #98 stated she felt wet and uncomfortable.<br><br>Review of the CNA toileting task report stated, staff need to assist Resident #98 with toileting every 3 hours from 4:00 a.m. to 10:00 p.m.<br><br>Review of Resident #98's toileting task report, dated March 1st through May 15th, 2024, identified 76 occasions where staff failed to assist the resident with toileting every three hours from 4:00 a.m. to 10:00 p. m. The log showed gaps of approximately 3.5 to 7 hours between staff assistance with toileting.<br><br>During an interview on 05/14/24 at 2:49 p.m., an administrative nurse (#1) confirmed staff are expected to provide toileting assistance to all residents.<br><br>40489 |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>40489<br><br>Based on record review and staff interview, the facility failed to ensure residents' records contained the hospice election form for 1 of 5 sampled residents (Resident #79) receiving hospice services. Failure to obtain this document limits staff's ability to ensure coordination of care between the facility and the hospice.<br><br>Findings include:<br><br>Review of Resident #79's medical record occurred on all days of survey and identified Resident #79 elected Hospice services on 04/29/24. The medical record lacked the hospice election form.<br><br>During an interview on 05/15/24 at 5:07 p.m., an administrative nurse (#1) confirmed the medical record for Resident #79 lacked the hospice election form. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>46477<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for (2 of 21) sampled residents (Resident #49, and #154) and one supplemental resident (Resident #56) observed during personal cares. Failure to follow infection control standards related to hand hygiene and emptying of a urinary bag has the potential to spread infection throughout the facility and could transmit those infections to residents, staff, and visitors.<br><br>Findings Include:<br><br>Review of the facility policy titled Handwashing/Hand Hygiene occurred on 05/15/24. This policy, revised in May 2023, stated, . all personnel shall follow the handwashing/hand hygiene procedures . 2. Before and after direct contact with residents.<br><br>Review of the facility skills validation titled Emptying Urinary Drainage Bag occurred in 05/15/24. This skills validation, revised on February 2022, stated, . 8. Place graduate on paper towel. 9. Do not let spout or clamp touch the graduate. 11. Place graduate on a paper towel on a flat surface.<br><br>- Observation on 05/13/24 at 2:09 p.m., showed a certified nurse aide (CNA) (#2) carried his/her soiled gown out of an unidentified resident's room and placed it on a table outside of Resident #56's room. The CNA (#2) entered Resident 56's room to answer the call light, removed the resident's shoes, and exited the room. The CNA (#2) re-entered the room with a mechanical lift and transferred the resident into bed. The CNA adjusted Resident #56's socks and blanket, placed the call light and a stuffed animal next the resident, offered the resident a drink then exited the room. The CNA (#2) failed to perform hand hygiene before entering and before exiting Resident #56's room.<br><br>- Observation on 05/14/24 at 10:19 a.m., showed a CNA (#3) placed a graduated container on Resident #154's bedding and failed to place a paper towel barrier under the container. The CNA held the entire urine collection bag inside the container and the spout, clamp, and leg bag touched the urine contents and the sides of the container. The CNA (#3) emptied the urine, rinsed and dried the graduate container, and placed it on Resident #154's dresser without a barrier between the container and dresser. The CNA (#3) failed to disinfect the catheter spout after it had touched the inside of the container.<br><br>During an interview on 05/16/24 at 12:32 p.m., an administrative nurse (#1) confirmed staff should have performed hand hygiene and followed proper procedures for emptying the catheter drainage bag.<br><br>- During an observation on 05/14/24 at 9:08 a.m., a CNA (#6) transferred Resident #49 from the recliner to the bath chair. Without wearing gloves, the CNA (#6) removed a wet brief from the resident and discarded it in the garbage. The CNA stated, I should have had gloves on. Without performing hand hygiene, the CNA then wrapped a blanket around the resident, opened the resident's door, and wheeled the resident to the tub room.<br><br>During an interview on 05/16/24 at 11:00 a.m. administrative nurse (#1) confirmed staff should perform hand hygiene after handling a wet brief.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 19410 |