STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. Building B. Wing	06/19/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 35 sampled residents (Resident #36). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current 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 2024, page A-32, stated, . Coding Instructions. Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . Review of Resident #36's medical record occurred on all days of survey. The record included diagnoses of bipolar disorder, Tourette's disorder, and autistic disorder. A comprehensive MDS, dated [DATE], showed the facility failed to code Section A1500 for a serious mental illness. During an interview on 06/19/25 at 10:12 a.m., an administrative nurse (#1) confirmed staff failed to accurately code section A on Resident #36's MDS.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, review of the facility reported incident (FRI) investigation, and review of facility policy, the facility failed to properly utilize assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #150) who fell during a staff assisted transfer. Failure to utilize the gait belt resulted in Resident #150's fall/fracture and placed all residents transferred with a gait belt at risk for injury. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include: The surveyor determined a deficient practice existed on 02/26/25. The facility implemented corrective action immediately, completed corrective action on 03/03/25, and continues with staff education and monitoring. Review of the facility policy titled Gait Belt Use occurred on 06/19/25. This policy, revised August 2023, stated, . Use an underhand grasp to hold on to the gait belt . Review of Resident #150's medical record occurred on all days of survey. Diagnoses included right femur fracture. The care plan stated, . TRANSFER: assist by 1 staff with gait belt . I am at risk for falls r/t [relate to] cognitive impairments, gait/balance problems, deconditioning . I have parkinsonism affecting my balance and mobility. A FRI investigation, dated 03/03/25, stated, . [Resident #150] was being assisted by [CNA [#3] in her room. [The] Resident is care planned as assist of one with [a] gait belt for transfers and ambulation. [CNA #3] had the gait belt in place and had assisted [the] resident from the bathroom to the sink in her room. LBSW [Licensed Baccalaureate Social Worker #4] came into the room and was talking to resident [#150]. At that time, [CNA #3] let go of the gait belt to throw trash in the bathroom. LBSW [#4] noted [the] resident starting to tip backward and yelled to notify [CNA [#3]. [The] Resident then fell backwards, hitting her head on the sink and fell to the ground. Resident [#150] complained of pain, was transferred to the ER [emergency room], and subsequently diagnosed with a displaced, right femur fracture. She required surgical repair. The facility failed to ensure staff utilized the gait belt while assisting Resident #150. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the following corrective actions to ensure all residents affected by the deficient practice were transferred in an appropriate manner: * Completed an investigation into Resident #150's fall/right femur fracture. * Suspended CNA (#3) following the incident and terminated him/her after completing the investigation. * Provided staff education regarding staff-assisted transfers/gait belt use via electronic messages and/or posted memos. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	* Completed competency testing to ensure staff met the requirements for staff-assisted transfers/gait belt use. * Updated resident care plans as necessary. * Updated policies and procedures addressing staff-assisted transfer/gait belt use. * Initiated a four-stage (plan-do-study-act) quality improvement plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 12 sampled residents (Resident #30, #153, and #275) observed during cares/wound care. Failure to practice infection control standards related to enhanced barrier precautions (EBP), perineal care, catheter cares, dressing changes, and hand hygiene, has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Dressings: Dry and Moist-to-Dry occurred on 06/18/25. This policy, dated April 2022, stated, . Apply antiseptic ointment (if ordered) with sterile cotton-tipped swab or gauze . Dispose of gloves and perform hand hygiene. Review of the facility policy titled Enhanced Barrier Precautions occurred on 06/19/25. This policy, dated April 2025, stated, . EBPs apply when: A resident . has a wound. Indwelling medical devices include . urinary catheters . EBPs employ targeted gown and glove use in addition to standard precautions during high-contact resident care activities . Examples of high-contact resident care activities . providing hygiene or grooming; changing briefs or assisting with toileting; transferring; bed mobility; wound care . Review of the facility policy titled Handwashing/Hand Hygiene occurred on 06/19/25. This policy, dated October 2024, stated, . Hand hygiene is indicated: after contact with . body fluids or contaminated surfaces; after touching a resident; after touching the resident's environment . - Review of Resident #30 medical record occurred on all days of survey. Diagnoses included us of a urinary device. The quarterly Minumum Data Set (MDS), dated [DATE], identified an indwelling catheter. The care plan stated, . I require the use of Enhanced Barrier Precautions d/t [due to] indwelling medical device. Observation on 06/16/25 at 2:28 p.m. showed two certified nurse aides (CNAs) (#6 and #7) applied a gown and gloves before entering Resident #30's room. One of the CNAs (#6) repositioned the resident's wheelchair, touched the resident's personal items, and without removing her gown and gloves exited the room to obtain an incontinence pad. The CNA (#6) returned to the room, transferred Resident #30 into bed, obtained a graduate, placed the resident's urinary catheter leg bag into the graduate, allowing the bag and the tip to touch the sides of the graduate, and drained the urine. Without removing the soiled gloves the CNA (#6) removed the resident's pants, ace wraps, and compression stockings. The CNA (#6) then removed the soiled gloves, applied new gloves, transferred the resident to a shower chair, exited the room, and transported Resident #30 to the shower room. The CNA failed to follow proper infection control standards for draining a urinary catheter bag, failed to remove her gown/gloves, and failed to complete hand hygiene. - Review of Resident #275's medical record occurred on all days of survey. Diagnoses included a left heel ulcer with a physician's order for Silvadene cream (topical ointment), xeroform (mesh gauze), absorbent dressing, and gauze. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/17/25 at 8:13 a.m. showed the nurse (#2) applied gloves and applied Silvadene ointment to the Resident's 275's wound with a gloved finger, covered the wound with xeroform, and an absorbent dressing, and wrapped the area with gauze. The nurse (#2) failed to change gloves after applying ointment with gloved finger. - Review of Resident #153 medical record occurred on all days of survey. Diagnosis included a pressure injury to the left heel with a physician's order for xeroform, absorbent dressing, and wrap every day and evening shift. Observation on 06/17/25 at 10:25 a.m. showed two nurses (#2 and #5) performed Resident #153's dressing change. During the dressing change the nurses placed the bottle of wound cleanser and hand sanitizer directly on the floor and returned the items to the basin of supplies a few minutes later. The nurses failed to set the items on a clean barrier. During an interview on the afternoon of 06/18/25 an administrative nurse (#1) confirmed she expected staff to utilize a barrier for clean supplies and follow infection control policies.