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	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodside Village	4000 24th 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and review of facility policy, the facility failed to provide appropriate supervision and/or assistance to prevent an accident for 1 of 1 discharged resident (Resident #4) who fell while ambulating. Failure to apply a gait belt around the resident's waist prior to ambulation resulted in Resident #4's fall with major injury. This citation is considered past non-compliance based on review of the corrective actions the facility implemented following the incident.Findings include: Review of the facility policy titled Standards of Care occurred on 07/01/26. This policy, dated 05/01/24, stated, . Routine Care . Each of the following is part of the routine care provided by care givers . A gait belt will be used for all assisted transfers and ambulation. The gait belt must be pulled snug for the resident's safety. Review of Resident #4 medical record occurred on all days of survey. Diagnoses included chronic fatigue syndrome, fracture of the right humerus, osteoarthritis of the right shoulder and bilateral knees, and repeated falls. The quarterly Minimum Data Set (MDS), dated [DATE], identified functional limitations in upper and lower extremity range of motion [ROM], required substantial assistance during transfers, utilized a walker, and sustained a major injury during a fall.The progress notes identified the following:* 06/08/26 at 9:11 a.m., At 0635 [6:35 a.m.] this nurse heard someone crying. This nurse went to the tub room and saw resident sitting on her bottom with her legs outstretched towards the entrance of the tub room. Staff member was supporting resident's upper back. When asking resident what happened, resident stated, I fell down. It seemed like my walker handle came out or something. [NAME] brakes/handles assessed and determined to be in safe, working condition. resident rates pain a 9 on a scale of 0-10. This nurse called [daughter] and explained the situation to her. This nurse stated that resident was having a lot of pain to her shoulder and felt that she should be seen at the ER [emergency room]. This nurse called and updated [physician]. Resident left facility at 0720.* 06/08/26 at 13:28 [1:28 p.m.], . [Facility] is reviewing the incident this AM concerning resident. Preliminary review indicates res [resident's] CP [care plan] was not followed . Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the corrective actions for other residents who may be affected by the deficient practice as follows:* Completed an investigation into Resident #4's fall with major injury,* Determined the CNA transferred Resident #4 without placing a gait belt around her waist, resulting in a fall with major injury, and placed all residents at risk for falls with/without injury,* Placed the CNA who transferred Resident #4 on administrative leave,* Re-educated staff on their standards of care/gait belt use,* Completed quality assurance audits to ensure resident safety during transfers.

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