Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

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	01/08/2025

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** 46963 Based on record review, review of the facility reported incident and investigation documents, and review of facility policy, the facility failed to provide appropriate supervision and devices to prevent an accident for 1 of 9 sampled residents (Resident #87) investigated for falls. Failure to ensure staff utilized footrests properly on the wheelchair caused facial injuries to Resident #87 and placed all residents transferred via wheelchair at risk for falls and/or 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 09/07/24. The facility completed the corrective action on 09/13/24. The final facility reported incident report, dated 09/13/24, stated, . [Resident #87] was being pushed in her wheelchair by CNA [certified nurse aide #8] and [Resident #87's] foot pedals were on her wheelchair but moved off to the side and not in position. When [CNA #8] started to push the wheelchair forward, [Resident #87] placed her feet down on the floor and as a result she fell face first onto the floor. The wheelchair foot pedals were not in the proper position nor used during this transport. [Resident #87] suffered a small laceration on the bridge of her nose from her glasses . She had a laceration and a hematoma to her forehead as well as swelling under her R [right] eye. Review of the facility policy titled Standards of Care occurred on 01/08/25. This policy, dated 05/01/24, stated, . Foot pedals will be used for all residents being transported for extended distances and removed when stationary or unless Care Planned. Review of Resident #87's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated [DATE], identified dependance on staff for wheelchair transfers. The current care plan stated, . Locomotion . I use a manual WC [wheelchair] for locomotion. staff assist of one for longer distances . Foot pedals need to be on my WC when pushing the WC. The progress notes stated the following: * 09/07/24 at 1:57 p.m., . Resident on floor in hallway . (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	* 09/10/24 at 10:14 a.m., . Res [resident] had a fall from her wheelchair 9/7/2024 and was injured. Further investigation of the fall revealed that foot pedals were on the wheelchair but not in proper position and not utilized while res was being transported in the hallway. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions to ensure the deficient practice does not recur by: * Completed an investigation on 09/13/24, including an interview with the CNA #8 who transferred Resident #87 via wheelchair. * Determined the CNA #8 provided wheelchair transport to Resident #87 without the foot pedals in the proper position. * Placed CNA #8 on administrative leave on 09/10/24 until further investigation and education was provided. * Email education to all staff, dated 09/10/24, stated, Foot pedals or leg rests always need to be used when pushing a resident in a wheelchair. It is never acceptable to allow a resident's feet to dangle when pushing them, not even for a short distance. * Memo dated 09/13/24 addressed to all staff, stated, ANYTIME a resident is being pushed in their wheelchair the foot pedals MUST BE ON. * CNA #8 and all other nursing staff signed rosters indicating review and understanding of the 09/13/24 memo. * The charge nurses were responsible for reviewing education provided in the 09/13/24 memo after the 09/07/24 fall. * Continue weekly quality assurance audits to ensure resident safety during wheelchair transport.

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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. 40488 45873 Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 1 of 1 sampled resident (Resident #126) observed during tracheostomy cares and 1 of 1 supplemental resident (Resident #283) observed during insulin administration. Failure to practice infection control standards related to glove use/hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Handwashing/Hand Hygiene occurred on 01/08/25. This policy, dated October 2024, stated, . Hand hygiene is indicated . After contact with blood, body fluids or contaminated surfaces; After touching a resident; After touching the resident's environment . The use of gloves does not replace hand washing/hygiene. Review of the facility policy titled Insulin Pen Injections occurred on 01/08/25. This policy, dated January 2023, stated, . Technique . Gather equipment . Perform hand hygiene . Preparing insulin pen . Apply clean gloves . Select appropriate site . Administer injection. - Review of Resident #126's medical record occurred on all days of survey. The record identified a tracheostomy, enhanced barrier precautions, and a recent Influenza A infection. Observation on 01/09/25 at 11:38 a.m. showed a staff nurse (#5) applied a gown and gloves, prepared for the sterile portion of Resident #126's tracheostomy cares, and handed the resident a paper napkin to cough into during care. The nurse (#5) completed the sterile portion of the care, removed the sterile gloves, performed hand hygiene, and applied clean gloves to complete the non-sterile portion of the care. The nurse removed the used paper napkin from Resident #126's hands, cleansed the ostomy site with cotton swabs and a solution of peroxide and saline, and threw the cotton swabs into the garbage. The nurse (#5) handed the same used paper napkin to the resident, and with the same gloves, touched many items in the resident's room, then removed the gown and gloves, performed hand hygiene, and exited the room. The nurse (#5) failed to remove the soiled gloves, perform hand hygiene, and apply new gloves before moving on to other tasks. During an interview on 01/08/25 at 2:35 p.m., two administrative nurses (#6 and #7) stated they expected staff to remove their contaminated gloves and perform hand hygiene before moving on to other tasks. - Review of Resident #283's medical record occurred on 01/08/25. Physician's orders showed Insulin Glargine 12 units and Novolog 3 units sub-cutaneous injections daily. Observation on 01/08/25 at 8:41 a.m. showed a nurse (#4) performed hand hygiene and without applying gloves, administered Resident #283's insulin injections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 4:53 p.m., an administrative staff member (#2) confirmed she expected nurses to wear gloves while administering an injection.