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	12/22/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, review of the facility report incident (FRI) investigation, and review of facility policy, the facility failed to ensure residents remained free from abuse for 1 of 1 sampled resident (Resident #4) who displayed physical behaviors towards another resident. Failure to protect residents from physical abuse may result in injury, fear, anxiety, and mental anguish. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include:Review of the facility policy, Prohibition and Prevention of Resident Abuse, Neglect, Exploitation Mistreatment and Misappropriation of Property, occurred on 12/22/25. This policy, dated 10/02/24, stated, . Policy A. Every resident has the right to be free from abuse . mistreatment . Residents must not be subject to abuse by anyone, including, but not limited to: . other residents . E. Definitions 1. Abuse - the willful infliction of injury . intimidation . with resulting physical harm .or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse may also occur . regardless of the resident's cognitive status.The surveyor determined a deficient practice existed on 09/14/25. The facility implemented and completed corrective action on 09/25/25.Review of Resident #4's medical record occurred on all days of survey. The care plan stated, I have potential for behaviors directed at others r/t [related to] cognitive impairment, disorientation and decreased impulse control r/t Lewy Body Dementia. I have impaired social interaction and may misinterpret others' actions leading to aggressive behaviors.Review of the facility's FRI investigation, dated 09/15/25, stated, At approximately 9:40 a.m. [Resident #4] was sitting . in a recliner. [Resident #7] began walking down the hallway in [Resident #4's] direction. Per camera review, upon noticing [Resident #7], [Resident #4] raised his hand and gestured in a 'shooing' manner towards [Resident #7]. As [Resident #7] continued to approach, [Resident #4] began to rise from his recliner . He then made physical contact with [Resident #7] by pushing him on the left arm and shoulder and grabbing his left wrist which caused [Resident #7] to momentarily lose his balance. [Resident #4] continued to push [Resident #7], who eventually sat down onto the nearby recliner. [Resident #4] then sat in the recliner adjacent to [Resident #7]. Shortly thereafter, [Resident #7] began to stand again. [Resident #4] stood as well. [Resident #7] did not appear to respond verbally or physically and was nonreactive. [Resident #4] then made a fist and raised it toward [Resident #7's] face but did not strike him . [Name of nurse] observed the incident from the hallway and began approaching to help intervene. As [name of nurse] neared, [Resident #4] shoved [Resident #7] with both hands in his stomach. [Resident #7] was able to maintain his balance and did not fall as he had a hold of [Resident #4's] left hand. The nurse was able to separate [Resident #7] from [Resident #4]. No further altercations or interactions between these two residents the remainder of the day. Nursing reports neither resident has recall of the event.Based on the following information, non-compliance at F0600 is considered past non-compliance. The facility implemented corrective actions for residents affected by the deficient practice as follows:Immediate Actions Taken:* Staff intervened and separated the two residents to prevent further escalation and assessed for injury. No injuries noted. * Other residents in vicinity redirected to ensure safety.* Incident reported to charge nurse and on-call administration. Report made to the North Dakota Department of Health and Human Services on 09/14/25. * Responsible parties of both residents and the Medical Doctor on-call notified of the incident on 09/14/25 by the charge nurse.* Both residents monitored the remainder of the day. Follow-Up Actions: * Completed initial meeting and investigation of incident on 09/15/25* Documented 72-hour status monitoring of both residents in electronic medical record system.* Resident #4 and #7's care plans reviewed and revised on 09/15/25. * Psychiatric Nurse Practitioner continues to conduct health consultations/medication reviews for both residents. Provider saw both residents on scheduled provider rounds on 09/17/25. * Staff education provided on 09/19/25 to the dementia unit staff on de-escalation strategies for dementia behaviors and resident-to-resident altercations.* Registered Nurse Care Coordinator provided information concerning therapeutic response techniques at the neighborhood Quality of Care meeting on 09/25/25.

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(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 - Minimal harm or potential for 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 standard of care policy, the facility failed to properly utilize assistive devices necessary to prevent accidents for 1 of 1 closed record resident (Resident #7) who sustained a fall. Failure to remove the wheelchair foot pedals may have contributed to Resident #7's fall. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include:Review of the facility Standards of Care occurred on 12/22/25. This form, dated 10/06/25 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 #7s medical record occurred on 12/22/25. The care plan, dated 11/04/25, stated, Ambulation: I need assist of 1 with a gait belt, hand held assist. Review of the FRI investigation, dated 11/05/25, stated, At approximately 7:50 AM CNA [certified nurse aide] [CNA #1] brought [Resident #7] to the dining room table in a wheelchair. [CNA #1] left [Resident #7] at the table with wheelchair pedals in place and then returned to the residents room down the hall to retrieve a bag of garbage. On his way to throw the garbage he stopped to speak to the RN [registered nurse] [nurse name]. In [CNA #1] written report of the incident, he indicated that on the wheelchair pedals there was a sticker that stated pedals stay on at all times. [Nurse name] confirmed that [CNA #1] had asked her about this and she clarified to [CNA #1] that the pedals should be removed. [CNA #1] did not return to [Resident #7] to remove the wheelchair pedals, instead walking to the utility room to discard the garbage. As [CNA #1] was returning toward the dining room, [Resident #7] stood up and fell, striking the back of his head on a dining room chair. [Resident #7] had been hospitalized for pneumonia and returned to our facility on 11/4/25. The wheelchair was left in his room as it was used to transport him back from the hospital. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions for residents affected by the deficient practice as follows:*The nurse immediately assessed Resident #7.*Completed an investigation related to Resident #7's fall. *Resident #7's primary decision maker and physician notified. *Monitoring of Resident #7 for any signs of injury, distress or change in condition. *Incident reported to the Department of Health and Human Services. *CNA (#1) terminated on 11/11/25. *Resident #7's care plan reviewed. *Staff education provided on 11/05/25 regarding foot pedals removed from wheelchair when resident is stationary.*Wheelchair positioning audits completed.