STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355116	A. BUILDING _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE LUTHERAN HOME	501 3RD AVE W LISBON, ND 58054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 03/08/21 and concluded on 03/11/21.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 1 of 3 sampled residents (Resident #8) with an unwitnessed fall. Failure to complete neurological checks after a fall may lead to ineffective management of a resident's condition and adverse health effects. Findings include: Review of the facility policy titled "Neurological Assessment" occurred on 03/11/21. This policy, dated 2010, stated, ". . . Neurological assessments are indicated: . . . Following an unwitnessed fall; . . . Steps in the Procedure: . . . 3. Perform neurological checks with the frequency as ordered or per falls protocol or as stated below: TO INCLUDE FULL SET OF VITAL SIGNS . . . UNWITNESSED FALL - IF NO BUMP, BRUISE, LACERATION TO HEAD[:] Initial neuro check with full set of vital signs. If NO abnormal findings; then, Every shift until 72 hours. . . ."	F 658	F658 Time frames to complete neurological assessments for the incident involving resident #8 has elapsed. All residents having an unwitnessed fall have the potential to have adverse health effects should the facility fail to follow its "Neurological Assessment Policy" The Director of Nursing reviewed said policy on 3/23/2021. All nurses will be in-serviced on the reviewed policy on 3/31/2021. The DON or designee will audit all resident incident reports weekly to ensure that incidences requiring Neurological checks were completed per policy. Results of the audits will be reported by the DON at the quarterly QA meeting. If 100% compliance is achieved the QA committee may reduce the audits to 6 per quarter for the next three quarters. Nurse #4 was immediately in serviced on	4/9/21

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

Electronically Signed | 03/29/2021

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F 658	Continued From page 1 Review of Resident #8's medical record occurred on all days of survey. Nurses' notes stated the following: * 12/17/2020 at 09:33 p.m., "Nurse alerted by CMT [certified medication technician] [medication assistant] of resident fallen to floor in room at 1800 [6:00 p.m.]. Resident had been sitting in recliner in preparation for supper approx. 10 minutes prior, when CMT returned to room to ask resident about a supper substitution, resident laying on the floor on her back on the side of her bed closest to the bathroom, appears to have used bedside table as a "walker" to ambulate so far. Resident told CMT she was getting back in bed. No obvious injuries noted while on floor. . . . Vitals stable during assessment. Neurological function at baseline. . . ." * 02/19/2021 at 07:26 p.m., "Res was found laying next to her bed on the floor. CNA [certified nurse aide] reported she had been taken to the toilet 15 minutes before the fall. Res had been found walking in her room earlier in the shift as well. Res was reminded to call for assistance and wait for staff to come. Res denied any pain on movement, but was crying when staff would touch her. Res was assisted to her feet with 2 staff and put into her recliner. Res vitals charted and will monitor. . . ." Review of the record identified the following: * Staff completed neurological checks on 12/17/20 at 6:38 p.m. and 10:41 p.m. and on 12/18/20 at 1:03 a.m. Staff failed to complete all the neurological checks as required per the policy after Resident #8's unwitnessed fall on 12/17/20.	F 658	proper insulin priming procedures. All residents have the potential to be affected if the facility fails to ensure proper insulin pen priming prior to administration. The facility policy entitled, “Insulin Injection per Flexpen” was reviewed by the DON on 3/23/2021. All licensed nurses and medication aides will be in serviced on the “Insulin Injection per Flexpen” policy on 3/31/2021. The DON or designee will complete 3 weekly observations of insulin administration per Flex Pen for a period of 12 weeks. Results of the observations will be reported to the QA committee on a quarterly basis by the DON. If 100% compliance is achieved, the QA committee may decrease the frequency of audits to 10 audits for the following quarter. If 100% compliance is achieved during quarter 2, the QA committee may discontinue these audits.	

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F 658	Continued From page 2 * Staff failed to complete any neurological checks following Resident #8's unwitnessed fall on 02/19/21. During an interview on the afternoon of 03/10/21, an administrative nurse (#3) stated staff should have completed neurological checks after both falls per policy. 2. Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice when priming an insulin pen (injection device) for 2 of 3 observations of insulin administration (Resident #9 and #30). Failure to properly prime the insulin pen prior to administration may result in the resident receiving an inaccurate dose of insulin. Findings include: Review of the facility policy titled "Insulin Injection per Flex Pen" occurred on 03/11/21. This undated policy, stated, "Preparing the flex pen: . . . 7. Pull off the big outer needle cap and then pull off the inner needle cap . . . Priming the flex pen before each injection: . . . 2. Hold the Flex Pen with the needle pointing up, and tap the cartridge gently a few times. 3. Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle. 4. If no drop appears, try again, if still no drop change the needle and repeat. . . ." Observation on 03/10/21 at 8:00 a.m. showed a licensed nurse (#4) primed Resident #30's insulin pen prior to administration. The nurse held the device horizontally, and without removing the cap to visualize the insulin, pressed the dose knob.	F 658		

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F 658	Continued From page 3 The nurse failed to hold the insulin pen with the needle pointing up and to remove the cap to visualize the insulin after priming. Observation on 03/10/21 at 9:00 a.m. showed a licensed nurse (#4) primed Resident #9's insulin pen prior to administration. The nurse held the device horizontally, and without removing the cap to visualize the insulin, pressed the dose knob. The nurse failed to hold the insulin pen with the needle pointing up and to remove the cap to visualize the insulin after priming. During an interview on the morning of 03/11/21, an administrative nurse (#3) stated she expected staff to prime an insulin pen with the needle pointing up and the cap off.	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed	F 761		4/9/21

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F 761	Continued From page 4 compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe medication storage for 1 of 1 emergency medication kit. Failure to discard expired medications increases the risk of residents receiving outdated medications with reduced efficacy. Findings include: Review of the facility policy titled "Emergency Kit Box" occurred on 03/11/21. This policy, dated February 2018, stated, ". . . Pharmacy is to check the box for expired dates." Observation of the medication room and the emergency drug kit (E-Kit) occurred on the morning of 03/11/21 with a licensed nurse (#5). Observation identified the following expired medications: * Haldol expiration date 12/2020 * Atropine sulfate eye drops expiration date 11/07/2019 * Xylocaine injection expiration date 02/2021 * Promethazine injection expiration date 08/2020 * Diphenhydramine expiration date 01/2021 During an interview on the morning of 03/11/21 an administrative nurse (#3) confirmed facility	F 761	F 761 The Emergency drug kit was addressed on 03/11/202. The emergency drug kit located in the medication room was resupplied with non-expired medications and a current accurate label was affixed to the outside of the container by the provider pharmacist. All resident have the potential to be affected should the facility fail to ensure current medications are available for emergency use. The consulting Pharmacist will verify each month during their pharmacy review that the medications are current and the label is accurate. Any outdated medications or inaccuracies of the label will be immediately brought to the attention of the Charge Nurse on duty as well as to the attention of the provider pharmacy. The Director of Nursing and the Administrator receive a copy of the monthly pharmacy review. Any non-compliance issues found on these reports will be immediately corrected, and verification of the corrections will be noted on the pharmacy review documentation. Results of the E-kit pharmacy reviews will be reported by the DON at the Quarterly	

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F 761	Continued From page 5 staff failed to remove the expired medications.	F 761	QA meeting, for the next year.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		4/9/21

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F 880	Continued From page 6 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to ensure staff follow standard infection control practices for 3 of 5 sampled residents (Resident #3, #5, and #22) observed during perineal cares. Failure to follow	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected	

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F 880	Continued From page 7 standard infection control practices related to hand hygiene has the potential for to spread infections within the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 03/11/21. This policy dated, October 2009, stated, "Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: . . . Before and after entering isolation precaution settings; . . . Before and after assisting a resident with toileting; . . . After removing gloves . . . ." - Observation on 03/10/21 at 1:30 p.m. showed two certified nursing assistants (CNAs) (#1 and #2) assisted Resident #3 to the bathroom using a mechanical sit to stand lift. The CNA (#1) performed bowel movement (BM) care and removed her gloves. After placing the resident in the recliner, the CNA (#1) adjusted the resident's clothing and provided a drink of water. The CNA (#1) failed to perform hand hygiene after perineal care before completing other tasks. - Observation on 03/09/21 at 4:30 p.m. showed two CNAs (#6 and #8) assisted Resident #5 to the bathroom using a sit to stand lift. The CNA (#8) performed perineal care and removed her gloves. After placing the resident in the wheelchair, the CNA (#8) removed the lift sling, adjusted the resident's clothing, put a pillow behind the resident's head, tilted the wheelchair back, and performed hand hygiene. The CNA (#6) failed to perform hand hygiene after perineal care before completing other tasks.	F 880	resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff perform hand hygiene or handwashing after removing gloves and after performing perineal care, in accordance with CDC guidelines. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 04/09/2021 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to complete hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-E	

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F 880	Continued From page 8 - Observation on 03/09/21 at 5:10 p.m. showed two CNAs (#6 and #7) assisted resident #22 to the bathroom using a sit to stand lift. The CNA (#6) performed perineal care and removed her gloves. After placing the resident into the wheelchair, the CNA (#6) removed the lift sling, unbuckled the leg strap, collected the garbage, and performed hand hygiene. The CNA (#7) who assisted with Resident #22's transfer and toileting exited the room without performing hand hygiene. The CNA (#7) transferred Resident #22 to the dining room, placed the clothing protector on the resident and left the dining room. The CNA (#6) failed to perform hand hygiene after perineal care before doing other tasks and CNA (#7) failed to perform hand hygiene when exiting the resident's room. During an interview on 03/11/21 at 8:45 a.m., an administrative nurse (#3) stated she expected staff to perform hand hygiene after glove removal and after perineal cares.	F 880	nrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, IP or suitable designee will ensure the following: a. by 4/9/2021 all nursing staff will receive education regarding keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of certified nursing staff to ensure performance of proper hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be	

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F 880	Continued From page 9	F 880	reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 04/09/2021	