| 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 _____ | 04/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on April 22, 2014 and completed on April 24, 2014 the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey. | F 000 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>·Based on observation, record review, and staff interview, the facility failed to review and revise | F 280 | F 280<br>The Careplan for resident #1 was updated on 5-1-2014 to include MRSA infection and precautions staff are to take with cares.<br>The care plan for resident #5 was updated on 5-13-2014 to include the addition of Seroquel and the possible side effects.<br>The care plan for resident #4 was updated on 4-24-2014 to include incontinence and voiding in inappropriate places.<br>All residents having specific medical conditions such as infections use of antipsychotic medications or urinary incontinence have the potential to be affected should the facility fail to ensure individualized care plans are written for resident specific conditions. Care plans of all residents were reviewed the week of 5-13-2014 to ensure compliance. The Director of Nursing will review 3 random care plans per month to ensure interventions deemed appropriate are include in the care plans of audited residents. Discrepancies found will be discussed with the care plan team and said discrepancies will be reported by the Director of nursing at quarterly QA meeting. | 5/13/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/23/14

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.

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| F 280 | Continued From page 1 | F 280 | | |

the care plans for 3 of 9 sampled residents (Resident #1, #4 and #5). Failure to include information and staff approaches regarding methicillin resistant staphylococcus aureus (MRSA) infection (Resident #1), incontinence (Resident #4), and the use of an antipsychotic medication (Resident #5), limited the staff's ability to communicate care needs and ensure continuity of care for the residents.

Findings include:

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included history of urinary tract infection (UTI) and urinary retention.
A quarterly Minimum Data Set (MDS), dated 01/26/14, identified the resident had an indwelling catheter.

Resident #1's medical record identified a urine culture report, dated 11/24/13, with a finding of MRSA infection.

Resident #1's current care plan, dated 01/30/14, lacked information regarding the MRSA infection and/or any precautions staff are to implement during resident care.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included psychomotor agitation, dementia, anxiety, and depression.

The resident's current physician's orders included Seroquel (an antipsychotic medication) 25 milligrams (mg) once a day with a starting date of 03/17/14. The facility failed to review and revise the care plan to include the addition of Seroquel

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and any side effects that may occur with use.

During an interview on the morning of 04/24/14, a administrative nurse (#1) agreed the care plans for Resident #1 and Resident #5 lacked the above information.

- Review of Resident #4's medical record occurred on April 22-24, 2014. Medical diagnoses included dementia and confusion. Resident #4's admission MDS identified extensive assistance of one person with toilet use and occasionally incontinent.

Observation on 04/22/14 at 4:05 p.m. and 04/23/14 at 8:05 a.m. showed Resident #4 assisted by facility staff with toileting.

Resident #4's nurses' notes identified voiding in inappropriate places as follows:
04/01/14, 8:00 p.m. - "Resident had pants down in roomate's bed - voided on roommate's bed . . ."
04/02/14, 1:00 a.m. - 4:00 a.m. - "Res [resident] awake going into other residents' rooms went into dirty linen room went to bathroom on floor and hooper . . ."
04/02/14, 11:30 a.m. - ". . . now found in another resident's room [with] pants down [and] pull-up off . . ."

Resident #4's current care plan, dated 03/31/14, failed to identify incontinence and voiding in inappropriate places as problems and the approaches for addressing the problem.

During an interview on 04/24/14 at 11:30 a.m., an administrative nursing staff member (#1) confirmed facility staff should have updated Resident #4's care plan to reflect her

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| F 280 | Continued From page 3<br>incontinence and voiding in inappropriate places. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>1. Based on record review, observation, policy and procedure review, and staff interview, the facility failed to follow interventions to maintain safe swallowing for 2 of 2 residents (Resident #2 and #3) who received thickened liquids. Failure to follow swallowing interventions places residents at risk for aspiration and/or pneumonia.<br><br>Findings include:<br><br>Review of the facility's policy titled "Free Water Protocol Rules" occurred on 04/23/14. The policy stated, "1. Water between meals only, away from food or pills. 2. NO OTHER THIN LIQUIDS . . .3. Ensure thorough oral cares before drinking water (Brush teeth, tongue, and rinse mouth). 4. Sit upright with all intake. 5. Take small sips. 6. Ice chips are ok, away from meals, after oral cares. . . . Several disease, conditions, or surgical interventions can result in swallowing problems. General signs may include: coughing during or right after eating or drinking . . . food or liquid leaking from the mouth or getting stuck in the | F 309 | F 309<br><br>The facility "Free water protocol rules" was reviewed on 4-29-14. All nursing staff were in-serviced on the protocol on 5-6-14 and 5-7-14. All dysphasia residents requiring thickened liquids have the potential to be affected should the facility fail to ensure safe consumption of non-thickened water. including The facility constipation policy and procedure was reviewed and revised on 5-19-14 to include the utilization of electronic generated reports. All nurses were in-serviced on the revised policy on 5-23-14. All residents have the potential to be affected should the facility fail to ensure that interventions for constipation are implemented in a timely manner. For the next year the Director of Nursing or designee will randomly audit 2 charts 2 times per month (total of 4) to ensure that residents at risk of constipation are identified and proper interventions are implemented. For the next year the Director of Nursing will observe 3 staff per month while they are providing free water to ensure the facility procedure is followed and the water is given in a safe manner. The Director of nursing will report results | 5-29-14 Per TC Education Residents #2 + #3 KB 5/23/14 |

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| F 309 | Continued From page 4<br>mouth . . . As a results, adults may have . . . risk of aspiration (food or liquid entering the airway), which can lead to pneumonia and chronic lung disease . . ."<br><br>Review of Resident #3's medical record occurred April 22-24, 2014. Medical diagnoses included dementia, anxiety, and dysphagia. The quarterly Minimum Data Set (MDS), dated 04/07/14, identified limited assistance of one person with eating and provision of a mechanically altered diet.<br><br>Resident #3's current care plan stated, "Problem: Alteration in Nutrition R/T [related to] . . . video swallow done 12/11/12 . . . Approaches: . . . nectar thick liquids [diet], free water protocol, no straws, liq [liquids] by sip/spoon . . ."<br><br>Resident #3's "SLP [speech language pathology] Discharge Summary," dated 01/09/14, stated ". . . Thin liquids tolerated in small controlled quantities, tsp or less. . . ."<br><br>Resident #3's nurses' notes identified the following:<br>*01/09/14, 8:00 p.m. - "Returned from swallow eval [evaluation] [with] orders to [change] diet to thin liquids by spoon [with] pudding/pureed food."<br>*01/10/14, 10:20 a.m. - ". . . family request 'Res [resident] needs to be on thickened liquid d/t [due to] coughing and choking episodes [after] drinking thin liquids . . . '[change] diet back to diabetic, dysphagia III, nectar liquids, may have toast.'"<br><br>Observation showed the following:<br>*04/23/14 9:00 a.m., a CNA (#7) provided Resident #3 a drink of unthickened water from a glass. The staff member failed to provide oral | F 309 | of the audits and observations at the quarterly QA meeting | |

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cares prior to offering thin liquids and failed to provide the water via spoon.

*04/23/14 at 11:00 a.m., a CNA (#8) provided Resident #3 a drink of unthickened water from a glass prior to providing cares. The staff member failed to provide oral cares prior to offering thin liquids and failed to provide the water via spoon. Observation showed Resident #3's drooling and coughing repeatedly with her face turning red.

*04/24/14 at 8:50 a.m. and 10:20 a.m., CNAs (#7 and #9) each provided Resident #3 a drink of unthickened water from a covered mug with a straw. The staff members failed to provide oral cares prior to offering thin liquids and failed to provide water via a spoon.

- Review of Resident #2's medical record occurred April 22-24, 2014. Medical diagnoses included confusion, history of cerebral vascular accident (CVA), and dyspaghia. The quarterly MDS, dated 03/06/14, identified a mechanically altered diet.

Resident #2's Speech Therapy Daily/Weekly Progress Note, dated 02/10/14, stated ". . . tolerated restricted diet of nectar liquids and soft diet. Discharge from skilled ST [speech therapy]. "

Resident #2's current care plan stated, "Problem: Alteration in Nutrition D/T DX [diagnoses] of CVA . . . Approaches: . . . nectar thick liq, free water protocol . . ."

Observations showed the following:
*04/22/14 at 4:30 p.m., showed CNA (#4) provided the resident a drink of unthickened

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water. The staff member failed to provide oral cares prior to offering thin liquids.

*04/23/14 at 10:30 a.m., CNA (#11) provided the resident a drink of unthickened water. The staff members failed to provide oral cares prior to offering thin liquids.

During an interview on 04/23/14 at 4:30 p.m., an administrative nursing staff member (#1) confirmed facility staff should provide oral cares to any resident on the free water protocol before offering unthickened water.

During an interview on 04/24/14 at 11:00 a.m., a speech therapist (#12) access to free water should be preceded by oral cares. He further explained, spoons are recommended due to the fact straws bypass a person's normal swallow pattern and may cause liquids to be injected into the back of the throat.

During an interview on 04/24/14 at 11:30 a.m., an administrative nursing staff member (#1) agreed Resident #3 should be provided thin liquids via spoon.

2. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 1 of 1 closed record resident (Resident #10). Failure to implement appropriate and timely interventions to manage constipation may have resulted in unrelieved constipation.

Findings include:

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Review of the facility policy and procedure titled "Constipation" occurred on 04/24/14. This policy, dated 2013, stated, "1. If resident has not had a bowel movement for 3 days, the day nurse will give MOM [milk of magnesium] [laxative] or Bisacodyl [laxative] tablets per standing orders with am [a.m.] med [medication] pass. . . . 2. If resident does not have results from MOM or Bisacodyl tablets, a suppository will be administered per standing orders by the night nurse in the early a.m. of the fourth day. 3. If the resident does not have a medium to large result at any time during a five day period the physician will be consulted . . ."

Semla, Beizer, and Higbee "Geriatric Dosage Handbook," 12th edition, Lexi-Comp, Ohio, page 744 states, " . . . Hydrocodone . . . Adverse Reactions . . . constipation . . ."

Review of Resident #10's record occurred on 04/24/14. Diagnoses included constipation. Medications included hydrocodone 5/325 milligrams(mg) as needed which may cause constipation. Resident #10 received hydrocodone two or three times a day. A physician's order dated 06/09/13, stated, "Fleets enema or Bisacodyl suppository (R) [rectally] 1 or tap water enema if no BM [bowel movement] after 3 days, PRN"

Resident #10's nurses notes stated following:
* 06/15/13 12:55 p.m. "Resident had a small emesis. Has a hx [history] of c/o [complaints of] stomach discomfort. [No] BM in 5 days. Bisc [bisacodyl] 5 mg [one] po [by mouth] given. . . ."

Resident #10's activity of daily living flow sheet showed the resident had a BM on 06/09/13 and

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| F 309 | Continued From page 8<br>then on 06/16/13 (6 days later). Staff failed to initiate interventions on day 3 if no BM as per physician's orders or the facility's constipation policy.<br><br>During an interview on the afternoon of 04/24/14, an administrative nurse (#1) confirmed staff should have followed the resident's physician orders or the constipation protocol and initiated constipation medications in a timely matter. | F 309 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>1. Based on record review, policy and procedure review, and staff interview, the facility failed to ensure the safe transfer of 2 of 5 residents (Resident #2 and #6) requiring assistance to transfer. Failure to safely transfer residents has the potential to result in an injury.<br><br>Findings include:<br><br>Review of Resident #2's medical record occurred on April 22-24, 2014. Medical diagnoses included osteoarthritis, osteoporosis, and cerebral vascular accident. The quarterly Minimum Data Set (MDS), dated 03/06/14, identified Resident #2 as | F 323 | F323<br><br>The CNA involved during the fall of resident #2 was re-educated on safe ambulating and transfer procedures. The care plan for resident #2 was revised on 5-19-14 to reflect 2 person transfer assistance. All residents requiring extensive assistance have the potential to be affected should the facility fail to ensure safe transfers and ambulation. The facility policy for mechanical lift usage was reviewed and revised on 5-5-14. All nursing staff were in-serviced on revised policy on 5-6-14.<br>An hourly check form was implemented on 4-24-14 for resident #4. All residents identified for wandering and at significant risk of getting to a potentially dangerous place could be at risk should the facility fail to properly initiate individualized interventions to keep the resident safe. The communication process for care plan changes including the initiation of hourly | 5/19/14 |

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| F 323 | Continued From page 9<br>requiring extensive assistance of two persons to transfer.<br><br>Resident #2's care plan, dated 12/12/13, stated Problem: ". . . Mobility impairment r/t [related to] decline in condition . . ." and Approach: " . . . Assist of 1-2 to transfer . . ."<br><br>Resident #2 nurses' notes revealed one person assisted Resident #2 to transfer on 04/19/14 at 8:15 p.m. The notes stated, "CNA [certified nursing assistant] was getting resident ready for bed. They were done in bathroom so CNA was walking [resident's name] from bathroom to the bed when they got out the bathroom door [resident's name] said she couldn't walk so the CNA step [sic] away to grab her wheelchair and as she did this [resident's name] fell on left side/butt area. The walker went over with her. CNA was not close enough to catch her but [resident's name] did hit her head on the front wheel of her wheelchair. She does have a lump the size of a 50 [symbol for cents] piece, bruised, did start [neurochecks] have been [within normal limits]. She is able to move extremities as before fall no other injuries are noted . . ."<br><br>Resident #2's ADL Flow Sheet Log for 04/19/14 identified all transfers completed with extensive assistance of two persons.<br><br>During an interview on 04/23/14 at 1:35 p.m., an administrative nurse (#1) confirmed facility staff should have transferred Resident #2 with two persons as identifed on the ADL Flow Sheet Log.<br><br>- Review of facility policy titled "Parkside Lutheran Home Policy/Procedure for Mechanical Lift Usage" occurred on 04/24/14. This policy, dated | F 323 | wandering checks was changed to ensure those changes are communicated and implemented in a timely manner.<br>For the next year The Director of Nursing or designee will randomly audit 3 charts per month to ensure care plan interventions have been implemented appropriately.<br>To ensure proper transfer techniques are followed for the next year, the Don or designee will make 3 random observations per month of mechanical lift usage and 3 random observations of 2 person transfers or ambulation done by CNAs. Results of the observations and results of the random chart audits will be reported by the Director of Nursing at the quarterly QA meeting. | |

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| F 323 | Continued From page 10<br>02/25/06, stated, ". . . 3. Care plans will reflect specifics of how the mechanical lift is to be used with each individual resident. . . . "<br><br>Review of Resident #6's medical record occurred on all days of survey. A quarterly MDS, dated 02/23/14, identified the resident required extensive assist of two persons with transfers.<br><br>A review of Resident #6's current care plan stated, ". . . PROBLEM Impaired mobility R/T OA [osteoarthritis] M/B [manifested by] slow & [and] slightly unsteady gait . . . APPROACHES Transfers W[with] /assist of 2. May use stand-up lift . . . "<br><br>During an observation on 04/22/14 at 3:50 p.m., a CNA (#2) used a mechanical stand-up lift to transfer Resident #6 in his room from his recliner to the toilet and then to his wheelchair.<br><br>During an interview on the morning of 04/24/14, an administrative nurse (#1), stated Resident #6 should be transferred with assist of two as stated on the care plan.<br><br>2. Based on record review, policy and procedure review, and staff interview, the facility failed to complete hourly checks for 1 of 2 residents who eloped outside the facility. Failure to implement the identified approaches may result in continued elopement from the facility and may result in harm to the resident.<br><br>Findings include:<br><br>Review of the facility's policy "Wandering Resident" occurred on 04/23/14. The policy, dated 10/03/12, stated "Residents that have the | F 323 | | |

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| F 323 | Continued From page 11 | F 323 | | |

potential to wander/elope are identified upon admission. The care plan team will write an individualized care plan to identify the problem. Interventions will be implemented to keep the wandering resident safe and to assure the safety of other residents who may be affected by the wandering. . . ."

Review of Resident #4's medical record occurred on April 22-24, 2014. Medical diagnoses included dementia and confusion. The admission MDS, dated 04/03/14, identified wandering occurred daily and placed the resident at significant risk of getting to a potentially dangerous place.

Resident #4's care plan, dated 04/17/14, stated a Problem: "Elopement Risk" and an Approach: " . . . D/T [due to] high risk elopement - check on resident every hour. . . ."

Resident #4's nurses' notes revealed the resident eloped from the facility as follows:
*04/03/14, 3:45 a.m. - "Res [resident] rested on and off at [3:30 a.m.] staff doing [3:00 a.m.] rounds heard alarms going off resident went out North door. CNAs ran down when they got there she was turning around to come back in . . . ."
*04/07/14, 3:10 p.m. - ". . . Res left the building through the North door. Staff was able to redirect back into building through main entrance [without] difficulty. . . ."
*04/16/14, 8:30 p.m. - "Resident eloped out North door [with] some personal items [and] w/c [wheelchair]. Staff responded to alarm [and] found res around corner of building outside of [North] door. Redirected back into building [with] minimal difficulty. . . ."

An "Elopement Incident Report," dated 04/07/14,

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| F 323 | Continued From page 12<br>stated ". . . Res left building through North door. . . . Recommended interventions to be changed in Care Plan for resident: Continue with wanderguard. Continue hourly checks. Resident is easily re-directed. . . ." The record lacked evidence staff performed the hourly checks.<br><br>During an interview on 04/23/14 at 9:55 a.m., an administrative nurse (#1) provided no evidence of hourly checks for Resident #4 and stated facility staff should have implemented hourly checks and identified the location of this resident. | F 323 | | |
| F 371 SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to ensure a sanitary environment in 1 of 1 main kitchen and 1 of 3 (Cozy Cottage) household kitchens. Failure to identify environmental hazards in the kitchen has the potential to result in contamination of food and dishware.<br><br>Findings include: | F 371 | F371<br><br>The air conditioning unit in the main kitchen was cleaned on 4-23-14. All kitchen equipment has the potential to be affected should the facility fail to ensure proper / regular cleaning. Cleaning procedures were reviewed with all dietary staff on 5-8-14. The dietary manager will inspect the AC unit weekly for the next quarter to ensure it is clean. If no problems are found during the three months, inspections will be done once per month for the next 9 months. The cutting boards were removed from service on 4-23-14. Replacement boards were put into service on 4-28-14. The Dietary manager will inspect the cutting boards monthly to ensure they are free of deep cut marks or gouges. The facility policy for | 5/8/14 |

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| F 371 | Continued From page 13<br>Review of the facility policy titled "Cleaning Schedules" occurred on 04/23/14. This policy, dated January 2004, stated, ". . . 1. It will be the responsibility of the Dietary Manager/designee to provide and post daily, weekly and monthly cleaning schedules in the Dietary area. . . . 4. The Monthly cleaning duties are posted and will need to initial off by the staff person scheduled for that shift when done with cleaning. . . ."<br><br>Review of the facility policy titled "Handwashing Technique" occurred on 04/24/14. This policy, dated January 2004, stated, ". . . 3. Antiseptic hand cleaners will not be used in the Dietary Department or Household Kitchens."<br><br>Observation of the main kitchen and household kitchens occurred on 04/23/14 at 9:30 a.m. with two administrative dietary staff members (#14 and #15). Observation revealed the following:<br>* Black, greasy buildup of dirt on the air intake grille of the air conditioner producing airflow onto clean dishes.<br>*Three cutting boards with deep and discolored cut marks.<br><br>Observation of the Cozy Cottage household kitchen on the morning of 04/23/14 and 04/24/14 showed dietary staff member (#16) preparing fried eggs and toast. This staff member also dished plates of food and delivered them to the residents. The staff member used hand sanitizer (antiseptic hand cleaner) after delivering food to the residents, before preparing other food items.<br><br>During an interview on 04/23/14 at 10:45 a.m., two administrative dietary staff members (#14 and #15) confirmed staff should clean the air conditioner grille, remove the three cutting boards | F 371 | "Handwashing" was reviewed on 5-5-14. Nursing staff and Dietary staff were in-serviced on said policy on 5-6-14 and 5-8-14. All residents have the potential to be affected should the facility fail to ensure proper hand washing/ sanitizing procedures are followed. For the next year the Dietary Manager will make 4 random observations per month of hand washing/ food preparation done in the household kitchens. Results of these observations will be reported to the QA committee at the quarterly QA meeting. | |

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| F 371 | Continued From page 14<br>from use, wash their hands with soap and water, and not use hand sanitizer in the household kitchen. | F 371 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>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.<br><br>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.<br><br>The facility must provide separately locked, permanently affixed 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. | F 431 | F431<br><br>The facility policy titled "Counting Controlled Drugs" was reviewed and revised on 4-29-14. All nurses were in-serviced on the revised policy on 5-7-14. All controlled medications have the potential to be lost or diverted should the facility fail to ensure they are counted/ reconciled and stored properly at the end of each shift. The Director of Nursing or designee will inspect the "E" kit reconciliation report monthly and verify proper storage at least 1 time per month for the next 12 months. Results of the inspections will be reported by the DON at the facility quarterly QA meeting. | 5/7/14 |

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This REQUIREMENT is not met as evidenced by:
Based on observation, review of the controlled medication log, review of facility policy and procedure, and staff interview, the facility failed to ensure periodic reconciliation for controlled narcotic medications for 2 of 2 (Whispering Winds/Cozy Cottage and Meadowlark Lane) emergency kits. Failure to periodically reconcile narcotic medications has the potential to result in loss or diversion of medications.

Findings include:

Review of the facility policy titled "Counting Controlled Drugs" occurred on 04/23/14. This undated policy, stated, " It is the policy of Parkside Lutheran Home that all narcotics will be entered on the Controlled Drug Count Sheet. . . . They are then stored under double lock, in the locked medication room. All controlled narcotics are counted at the end of each shift . . ."

Review of the medication room for Cozy Cottage and Whispering Winds occurred on 04/22/14 at 4:20 p.m. with a licensed nurse (#17). Observation showed the emergency medication kit stored in a cabinet in the medication room. The kit contained the following controlled medications:
* Morphine sulfate (pain medication) 100 mg (milligram) vial
* Demerol (pain medication) 50 mg/ml (milliliter), two vials
* Hydrocodone 5/500 (pain medication) mg, nine tablets
* Tylenol with codeine (pain medication), 12

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| F 431 | Continued From page 16<br>tablets<br>* Diazepam (antianxiety medication) 10 ml vial<br>During reconciliation of controlled medications the current monitoring log lacked inclusion of the above controlled medications. The licensed nurse (#17) confirmed the lack of monitoring/counting of the above medications.<br><br>Review of the medication room for Meadowlark Lane occurred on 04/22/14 at 5 p.m. with a licensed nurse (#13). Observation showed the emergency medication kit stored in a cabinet in the medication room. The kit contained the following controlled medications:<br>* Morphine sulfate 100 mg vial<br>* Demerol 50 mg/ml, four vials<br>* Hydrocodone 5/500 mg, nine tablets<br>* Tylenol with codeine, 14 tablets<br>* Diazepam 10 ml vial<br>During reconciliation of controlled medications the current monitoring log lacked inclusion of the above controlled medications. The licensed nurse (#13) confirmed the lack of monitoring/counting of the above medications.<br><br>During an interview on 04/22/14 at 5:20 p.m., an administrative staff member (#1) confirmed staff failed to reconcile/count the controlled narcotic medications contained in the emergency kit. | F 431 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. | F 441 | | |

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| F 441 | Continued From page 17<br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) 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.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, policy and procedure review, and staff interview, the facility failed to follow standard infection control practices for 1 of 1 resident with MRSA (Methicillin-resistant Staphylococcus aureus) (Resident #1) and 2 of 2 residents (Resident #3 and #7) who received | F 441 | F 441<br><br>The care plan for resident #1 was updated on 5-1-14 to include MRSA and necessary precautions. (See plan of correction for F280).<br>The Facility policy "Peri Care" was reviewed on 4-29-14. All nursing staff were in-serviced on said policy on 5-6-14. All resident have the potential to be affected should the facility fail to ensure an effective infection control program is implemented. The Infection Control Nurse or designee will review all infection surveillance forms to ensure the proper precautions were initiated with associated care plans. If interventions were not implemented appropriately the Infection Control Nurse will implement the necessary precautions and re-educate affiliated nurse. The Infection Control Nurse will also report any variances discovered at the quarterly QA committee meeting. The Infection Control Nurse or designee will make 3 random observations per month of nursing staff performing peri care to ensure proper procedures are followed. Results of these observations will be reported by the Infection Control Nurse at the quarterly QA committee meeting. | 5/6/14 |

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perineal care. Failure to follow infection control practices has the potential to spread infection to residents and staff.

Findings include:

Review of the facility policy titled "Contact Precautions" occurred on 04/24/14. This policy, dated 03/16/10, stated, "PURPOSE; To minimize exposure to potentially infectious materials via direct contact . . . Gowns 1. Wear a gown whenever anticipating that clothing will have direct contact with the resident or potentially contaminated surfaces. . . ."

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included history of urinary tract infection (UTI) and urinary retention.
A quarterly Minimum Data Set (MDS), dated 01/26/14, identified the resident had an indwelling catheter.

During an observation on 04/23/14 at 9:30 a.m., a certified nurse aide (CNA) (#8) entered Resident #1's room. The CNA gathered the equipment and prepared to empty the resident's catheter bag. She donned a pair of gloves and drained the urine into a graduate. She then emptied the urine into the toilet, cleaned the graduate, removed her gloves and washed her hands. The CNA failed to put on a gown prior to emptying the resident's catheter bag.

Review of Resident #1's medical record identified a urine culture report, dated 11/24/13, with a positive finding of MRSA infection, treated with Doxycycline (an antibiotic medication) 100 milligrams (mg) twice a day for seven days. The

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record lacked any current information indicating whether the resident continued with an active MRSA infection and/or colonization. The current care plan, dated 01/30/14, also lacked information regarding the MRSA infection and/or any precautions staff are to implement during resident care.

During an interview on the morning of 04/24/14, an administrative nurse (#1) reported a lack of awareness regarding the current status of Resident #1's MRSA infection. She agreed it should be on the care plan, and during catheter cares staff should follow contact precautions.

Review of the facility's policy titled "Peri Care" occurred on the afternoon of 04/24/14. The policy stated, ". . . 8. Clean the rectal area by wiping from front to back, rinse and dry area. 9. Remove gloves 10. Apply clean briefs/pads 11. Wash hands . . ."

- Observation on 04/22/14 at 3:10 p.m. showed certified CNAs (#3 and #4) removed Resident #3's brief. One of the CNAs donned gloves and provided perineal cares to the resident following an incontinent bowel movement. After the CNA removed her gloves and assisted the resident to a safe position, she failed to complete hand hygiene. The CNA then touched the resident's hand and the resident's glasses before washing her hands.

- Observation on 04/24/14 at 10:55 a.m. showed two CNAs (#18 and #19) assisted Resident #7 onto the toilet. The resident voided and had a bowel movement. The CNA (#18) donned gloves and provided perineal care. Both CNAs removed their gloves and assisted Resident #7 into the

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| F 441 | Continued From page 20<br>wheelchair. The CNA (#18) handed the resident a wipe to cleanse her hands, unlocked the resident's wheelchair, turned the oxygen tank on, and applied Resident #7's oxygen per nasal cannula. The CNA (#18) failed to wash her hands after perineal care before doing other tasks.<br><br>During an interview on 04/24/14 at 11:30 a.m., an administrative nursing staff member (#1) confirmed facility staff should complete hand washing after providing perineal care before doing other tasks. | F 441 | | |
| F 456 SS=F | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br><br>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure a safe environment on 1 of 2 nursing units (Meadowlark Lane) when staff could not identify the location of a suction machine on the unit. Failure to locate a suction machine in a timely matter may lead to injury or death of a resident requiring suctioning.<br><br>Findings included:<br><br>Request for observation of the suction machine on Meadowlark Lane occurred on the afternoon of 04/23/14 with a licensed nurse (#13). This nurse walked down the hall to a small storage are stated,"its usually there." Unable to locate the suction machine, the nurse stated she could find | F 456 | F456<br><br>Nurse #13 was informed of suction machine location on Meadowlark Lane on 4-23-14. All residents have the potential to be affected should the facility fail to ensure essential equipment is maintained and staff are aware of its location. All nursing staff were in-serviced on the suction machine and their locations on 5-6-14 and 5-7-14. The Director of Nursing or designee will randomly quiz 3 staff per month on the location of essential patient care equipment, including the suction machine. Results of these interactions will be reported by the Director of Nursing at the quarterly QA committee meeting for the next year. | 5/7/14 |

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| F 456 | Continued From page 21<br>one in the central area. The nurse (#13) left the unit, walk up the ramp, crossed the commons area, down the hall into a different unit and located a suction machine.<br><br>During an interview on the afternoon of 04/23/14, an administrative nurse (#1) stated the suction machine on Meadowlark Lane is in the bath area. She expects licensed staff to know the location and not to leave the unit to locate a suction machine. | F 456 | | |