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 _____	04/24/2013

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 For the standard Medicare/Medicaid survey, started on 04/22/13 and completed on 04/24/13, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of manufacturer's recommendations, and staff interview, the facility failed to ensure staff appropriately utilized an assistive device for 1 of 3 sampled residents (Resident #5) observed transferring with a mechanical sit-to-stand lift. Failure to utilize the lift per the manufacturer's recommendations may result in residents experiencing pain and/or injury. Findings include: Review of the manufacturer's instruction manual titled "Stand Up Patient Lift," stated, ". . . Stand Assist Slings: The belt MUST be snug, but comfortable on the patient, otherwise the patient	F 323	F 323 Resident #5 will be re-evaluated by physical therapy on 5/13/2013 for proper transfer techniques. All residents requiring a mechanical lift for transfers have the potential to affected should the facility fail to use mechanical lifts correctly. All nursing staff will be inserviced on mechanical lift use and proper sling placement by 5/22/2013. The Director of Nursing or designee will complete three random observations of mechanical lift use three times per week for one month. If no problems are found the observations will be performed 3 times per month for the next 6 mos. Results of the observations will be reported at the quarterly QA committee meeting by the Director of Nursing. 5/15/13 9:20 AM T.C. per Tim Kennedy QA start date 5/16/13	5/22/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/10/13

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.

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 _____	04/24/2013

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 323	Continued From page 1 can slide out of the sling during transfer, possibly causing injury. . . ." - Review of Resident #5's medical record occurred on April 22-24, 2013. Diagnoses included dementia, multiple sclerosis, osteoarthritis, and peripheral neuropathy. Resident #5's most recent Minimum Data Set (MDS), dated 01/07/13, identified the resident required extensive assistance of one person for transfers. Resident #5's care plan, reviewed 04/18/13, stated, ". . . Mobility impairment R/T [related to] weakness M/B [manifested by] needs assist [with] transfers . . . Assist of 2 [with] transfers. Uses stand-up lift. . . Res [Resident] unable to ambulate D/T [due to] progression of MS [multiple sclerosis]. . . ." A physical therapy evaluation, dated 07/18/12, stated, ". . . Non-Ambulating pivot transfers [with] mech. [mechanical] lift. Presents [with] inversion, plantar flexion [left] foot. . . ." Observation on 04/22/13 at 4:15 p.m. showed two certified nursing assistants (CNAs) (#6 and #7) applied the sling of a mechanical sit-to-stand lift around the resident's waist then attached it to the lift. The CNAs fastened the sling's chest strap and the lift's leg strap. When the CNAs raised the resident to an upright position to transfer the resident from the bathroom to her recliner the sling slipped upward under her axilla (armpits), her elbows extended, and the chest strap loosened. The CNAs failed to lower Resident #5 and reposition the sling and failed to tighten the	F 323		

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 _____	04/24/2013

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 323	Continued From page 2 belt. Observation on 04/23/13 at 10:10 a.m. showed two CNAs (#3 and #8) applied the sling of a mechanical sit-to-stand lift around the resident's waist. The CNAs fastened the chest strap but not the leg strap. The resident complained of pain in her neck and toe. When the CNAs raised the resident to an upright position, the sling slipped upward under her axilla causing her elbows to extend outward, and the chest strap to loosen. The CNAs failed to lower Resident #5 and reposition the sling and failed to tighten the chest strap. Observation on 04/23/13 at 12:45 p.m., showed two CNAs (#3 and #8) applied the sling of a mechanical sit-to-stand lift around the resident's waist. The CNAs fastened the chest strap but not the leg strap. When the CNAs raised the resident, she did not stand but remained in a seated position with her legs at a 90 degree angle. The sling slipped upward under her axilla causing her elbows to extend and the chest strap to loosen. When the CNAs transferred the resident from the bathroom to her recliner, the sling again slipped upward under her axilla causing her elbows to extend outward, and the chest strap to loosen. The CNAs failed to lower Resident #5 and reposition the sling and failed to tighten the chest strap.	F 323		
	Observation on 04/24/13 at 8:15 p.m. showed two CNAs (#3 and #9) applied the sling of a mechanical sit to stand lift around the resident's waist. The CNAs fastened the chest strap and leg strap. When the CNAs raised the resident, the sling slipped upward under her axilla causing her			

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 _____	04/24/2013

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 323	Continued From page 3 elbows to extend outward, and the chest strap to loosen. The CNAs failed to lower Resident #5 and reposition the sling and failed to tighten the chest strap as they elevated Resident #5. During an interview on the afternoon of 04/24/13, an administrative nurse (#1) confirmed staff should utilize the leg strap and tighten the chest strap during transfers with a mechanical sit-to-stand lift.	F 323		
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide safety equipment to prevent backflow of contaminated water into 1 of 1 food preparation sink used to wash ready-to-eat foods in the kitchen. The lack of a safety device has the potential to increase the risk of foodborne illness and can affect all residents who eat food prepared in this area. Findings include: A tour of the main kitchen occurred on 04/24/13	F 371	F 371 The three compartment sink in the kitchen was equipped with a back flow prevention device on 5/9/2013. No other sinks in the facility are used for preparation or washing of raw or ready to eat foods. Thus this sink is the only sink having the potential to be affected by this deficient practice, and no further monitoring is required at this time. 5/15/13 9:20 AM JF T.C. This is only sink available Tim toured	5/9/13

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 _____	04/24/2013

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 371	Continued From page 4 between 8:30 a.m.and 9:00 a.m. with an administrative dietary staff member (#10). During an interview on 04/24/13 at 8:45 a.m., regarding how dietary staff utilized the kitchen's three-compartment sink, a dietary staff member (#11) stated staff used the second sink compartment to wash raw vegetables. Observation of the noon meal on 04/24/13, showed CNA/Homemakers (#2 and #12) offering a choice and serving residents assorted raw vegetables. On the morning of 04/24/13, a consultant plumber (#13) observed the piping system and stated the three-compartment sink lacked a device to prevent backflow of contaminated water. During an interview on 04/24/13 at 9:30 a.m., an administrative staff member (#14) confirmed sinks used to prepare vegetables should have preventative backflow devices.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		

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 _____	04/24/2013

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 431	Continued From page 5 appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, review of medication labels, and staff interview, the facility failed to store medications under proper temperature controls in 1 of 2 medication refrigerators (West medication room). Failure to maintain the refrigerator within an acceptable temperature range may affect the potency and efficacy of the medications. Findings include: Review of medication storage in the West medication room occurred on 04/23/13 at 5:00 p.m. with a licensed nurse (#4). Observation	F 431	F 431 The west medication refrigerator was adjusted on 4/24/2013 to moderate the temperature in the desired range. Both medication refrigerators have the potential to not be in the desired temperature range should the facility fail to monitor and adjust refrigerator thermostats as needed. The refrigerator temperature logs were revised to include a range of desired temperature of 36-46 degrees. The facility procedure for refrigerator temperature monitoring was reviewed and revised on 4/25/2013. All nurses were inserviced on said procedure on 5/8/2013. The Director of Nursing will review the temperature logs monthly. Any variances from optimal temperature range will be reported to the QA committee quarterly by the Director of Nursing. 5/15/13 PA M T.C. Tinkenedy QA start 5/8/13 x 6m	5/8/13

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 _____	04/24/2013

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 431	Continued From page 6 showed the medication refrigerator temperature at 32 degrees F. Medications stored in the refrigerator included: * Lantus insulin - label stated "Do not freeze" * Humalog insulin - label stated "Do not freeze" * Novolog insulin - label stated "Avoid freezing" * Epogen - label stated "Do not freeze" * Levamir FlexPens - label stated "Avoid freezing" * Lantus Solostar pens - label stated "Do not freeze" * Novolog FlexPens - label stated "Avoid freezing" * Calcitonin nasal spray - label stated "Avoid freezing" * Flulavel vaccine - label stated "Do not freeze" Review of the refrigerator temperature logs identified temperatures of 30 to 32 degrees on 15 of 31 days in March and 6 of 24 days in April 2013. Instructions on the log stated, "Refrigerator must be 41 [degrees] F. or below . . ." An undated, handwritten note at the top of the page stated "*Temp 36 [degrees] - 46 [degrees]+" During an interview on 04/24/13 at 12:50 p.m., an administrative nurse (#1) agreed staff should adjust the medication refrigerator controls if the temperature falls outside the desired range of 36 to 46 degrees F.	F 431		
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has	F 494		

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 _____	04/24/2013

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 494	Continued From page 7 completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on review of the state nurse aide registry files, the facility nurse aide schedule, and staff interview, the facility failed to ensure a nurse aide working with residents in the facility remained certified for 1 of 3 travel staff (staff member #15) certification verifications reviewed. The nurse aide (#15) provided 16 hours of nursing related services without verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: A nurse aide (#15) contacted the state nurse aide	F 494	F 494 Nurse Aide #15 has renewed his certification, but has not worked at facility since 9/28/2012. All agency staff have the potential to become non compliant should the facility fail to verify licensure or certification prior to employment. A facility policy and procedure was developed on 5/6/2013 outlining an orientation and certification/ licensure verification protocol. The Director of Nursing will review all agency employee records for proper orientation and verification of employment eligibility. The Director of Nursing will report any non compliance issues to the Administrator immediately and to QA committee at their quarterly meeting. T.C. Tim Kennedy 5/15/13 9:22 am QA will start when Agency staff utilized	5/6/13

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 _____	04/24/2013

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 494	Continued From page 8 registry on 01/29/13 to renew his certification. The state nurse aide registry file review identified the nurse aide's certification expired on 09/20/12. Review of facility nurse aide schedules, on 04/24/13, identified the nurse aide (#15) provided nursing related services at the facility from 6:00 a.m. to 10:00 p.m. on 09/27/12. During an interview on 04/24/13 at 10:25 a.m., an administrative nurse (#1) verified the nurse aide (#15) worked on 09/27/12 without certification.	F 494		