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 _____	04/26/2017

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 recertification survey, started on 04/24/17 and completed on 04/26/17, 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 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of	F 226		5/26/17

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

Electronically Signed | 05/12/2017

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 _____	04/26/2017

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 226	Continued From page 1 abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy/procedure, and staff interview, the facility failed to implement their policies/procedures regarding abuse and failed to report 1 of 2 abuse allegations to administrative staff, and immediately to the State Agency (SA). Failure to implement the abuse policy/procedure may have attributed to the delay in reporting to the SA and placed all residents at risk of further abuse and possible injury. Findings include: Review of the facility policy and procedure "Resident Abuse And Reporting Policy & Procedure" occurred on 04/26/17. This policy, dated 06/10/00, stated, ". . . REPORTING ABUSE . . . Any staff, resident, or family member witnessing or possessing reliable knowledge of any act (or suspected act) involving mistreatment, neglect, or abuse, . . . must immediately notify the charge nurse. The charge nurse will immediately notify the Administrator, Social Service Designee and/or Director of Nursing. The ND Department of Health will also be notified immediately of reports of allegations of abuse and that an investigation is pending. . . ." An abuse allegation reviewed on 04/26/17 at 7:50 a.m., showed an incident involving Resident	F 226	FF226 The facility did conduct a thorough investigation of the incident involving resident #10, and found the allegation to be unsubstantiated. All residents have the potential to be affected should the facility fail to ensure proper reporting of impending investigations, and protect the resident(s) from further possible abuse/ neglect during the investigation process. On 5/24/17 all staff will be in-serviced on the facility's abuse/neglect policies and the necessity of immediate reporting. The Director of Social Services will Audit all abuse allegations to ensure that 1) it was reported to Administration immediately, and 2) it is reported to the ND Dept. of Health immediately, and 30 that the investigation is completed per facility policy and compliant with Federal rules and regulations. Results of the Audits will be reported by the Social Service Director at the quarterly QA meeting.	

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 _____	04/26/2017

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 226	Continued From page 2 #10 occurred on 03/17/17 (Friday) and the facility reported the allegation to the SA on 03/20/17 (Monday). Documentation failed to show the charge nurse immediately informed the appropriate facility staff of the allegation as per policy. The facility investigated the allegation March 20-21, 2017 and submitted the report to the SA. During an interview on 04/26/17 at 12:30 p.m., an administrative nurse (#1) confirmed handling abuse allegations is important and staff have been instructed to notify administrative staff even if an incident occurs on the weekend.	F 226		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 10 sampled residents (Resident #2)	F 274	F274 The timeframe to do a retroactive MDS for resident #2 has expired, thus no correction is possible for this specific incident. All residents have the potential to be affected should the facility fail to	5/26/17

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 _____	04/26/2017

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 274	Continued From page 3 reviewed. Failure to determine the need for and complete a SCSA in response to a resident's decline or improvement limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate interventions. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), dated October 2015, page 2-20 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-23 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . [such as] . . . Any decline in an ADL [activity of daily living] physical functioning area where a resident is newly coded as Extensive assistance . . ." Review of Resident #2's medical record occurred on all days of survey. An annual Minimum Data Set (MDS), dated 03/03/16, identified the resident required limited assistance with bed mobility, transfers, walking in the room, required supervision walking in the corridor, and locomotion on and off the unit. A quarterly MDS, dated 06/19/16, identified the resident required extensive assistance of one for bed mobility, transfers, walking in the room, walking in the corridor, and locomotion on and off the unit. During an interview on 04/26/17 at 8:20 a.m., a staff member (#3) verified staff should have	F 274	ensure accurate coding of significant change MDS's. The facility implemented an electronic medical record system for MDS completion on 7/1/16. This new system alerts the user if there is a change of status and the potential for a significant change MDS. All residents flagging for possible significant changes will be reviewed by the interdisciplinary team. The DON or designee will audit all MDS' for potential significant changes for 1 month. If 100% compliant the audits will be conducted on five random charts per month for the next six months. The DON will report the audit results to the QA committee at the quarterly QA meeting. The audits will continue at the said rate until 6 consecutive months of 100% compliance is achieved at which time the decision to continue the audits and the frequency of the audits will be determined by the QA committee.	

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 _____	04/26/2017

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 274	Continued From page 4 completed a significant change MDS to reflect the decline in Resident #2's status.	F 274		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to ensure staff completed quarterly Minimum Data Set (MDS) assessments at least once every three months for 1 of 10 sampled residents (Resident #2) in the facility greater than three months. Failure to complete assessments as scheduled may result in the residents' care plans not reflecting their current status and needs. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual Version 1.13, revised October 2015, page 2-30 stated, "The Quarterly Assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. . . ." Review of Resident #2's medical record occurred on all days of survey. The record showed staff completed a quarterly assessment on 06/09/16	F 276	F276 The timeframe to do a retroactive MDS for resident #2 has expired, thus no correction is possible for this specific incident. All residents have the potential to be affected should the facility fail to ensure MDS's are completed per the RAI 3.0 user's manual. Upon admission all residents will be placed on an excel spreadsheet tracking form. The MDS coordinator will update the tracking form as MDS's are completed, to track and ensure that a quarterly MDS is completed and coded correctly even if there is a simultaneous PPS and/ or State required MDS. The DON or designee will audit 5 random charts per month for the next six months to ensure that a Quarterly MDS is completed on all residents residing in the facility for more than 3 months. Results of the audits will be reported by the DON at the quarterly QA meeting. The audits will continue at the said rate until 6 consecutive months of 100% compliance is achieved at which time the decision to continue the audits and the frequency of	5/26/17

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 _____	04/26/2017

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 276	Continued From page 5 and the next quarterly assessment on 10/31/16, 112 days later. On the morning of 04/26/17, a staff member (#3) confirmed staff had not completed a quarterly assessment between 06/09/16 and 10/31/16.	F 276	the audits will be determined by the QA committee.	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: ELOPEMENT	F 323	F323 SMOKING	5/26/17

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 _____	04/26/2017

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 6 1. Based on observation, record review, staff interview, and review of facility policy, the facility failed to ensure adequate supervision and assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #6) who eloped from the facility. Failure to investigate the elopement, develop and implement interventions to address the elopement, may have contributed to Resident #6's second unwitnessed elopement. Findings include: Review of the facility policy "LOST/ELOPED RESIDENTS" occurred on 04/25/17. This policy, not dated, stated "Policy: it is the policy of Parkside Lutheran Home that an immediate search will be conducted to determine the whereabouts of lost residents. METHODS OF PREVENTION: 1. Be aware of residents who tend to wander and where those residents are as frequently as possible. 2. When buzzers on EXIT doors sound, be aware of who is coming in or going out. 3. Residents who tend to wander will wear Code Alert bracelets. 4. Potential wandering residents are identified upon admission. . . ." Review of Resident #6's medical record occurred April 24-26, 2017 and identified an admission date of 08/05/16. The resident's admission diagnoses included dementia with behavioral disturbances, anxiety, and depression. An admission Minimum Data Set (MDS), dated 08/17/16, identified severe cognitive impairment, for one to three days of the assessment period the resident wandered, rejected care, and showed verbal behavior symptoms directed towards others, independent with transfers and walking in room, and supervision required for	F 323	A smoking assessment was completed for resident #3 on 5/8/17 by nursing. The care plan for resident #3 was reviewed on 5/11/17 by the interdisciplinary team to ensure the care plan is consistent with the recommendations of the assessment, and the resident's capabilities. This resident is the only current resident that smokes, hence the only resident having the potential to be affected by this deficient practice. The Director of Nursing or designee will review the care plan each quarter or if there is a significant change to ensure that the assessments and the care plan are consistent. Results of these reviews shall be reported at the quarterly QA meeting by the Director of Nursing. ELOPEMENT The care plan for resident #6 was revised on 5/12/17 to reflect the specific problem of Elopement with appropriate/ specific interventions for said problem. All wandering residents have the potential to be affected should the facility fail to implement resident specific interventions for wandering residents who are at increased risk of elopement or who are exit seeking. The facility policy for elopement was reviewed and revised on 5/11/17 to include interventions for high risk wandering elopement potential residents. The elopement incident report was revised to include more detailed information for follow-up and to better track intervention changes as elopements are attempted, this form now also includes potential cues that may lead to	

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 _____	04/26/2017

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 7 walking in the corridor and locomotion on/off the unit. Initial information received from the facility upon entrance, identified Resident #6 as a resident who wanders into other resident rooms and/or outside the facility. Review of the current care plan stated, * Initiated 08/01/16: "Focus: The resident has a behavior problem d/t [due to] res. [resident] wanders, yells, resistive with cares, and makes threats to staff at times m/b [manifested by] dx [diagnosis] dementia with behavioral disturbance. . . . Interventions: . . . When res. wanders attempt to redirect. If res. becomes more upset with redirection, ensure safety, know res. whereabouts, but attempt to redirect at a later time. . . ." * Initiated 01/09/17: "Focus: The resident has a mood problem d/t dx depression and anxiety . . . Interventions: Resident seems to get upset when wife visits and leaves-anticipate these behaviors/mood symptoms. Sit and talk with resident. Go for a walk with him." * The care plan failed to identify the problem of elopement and appropriate/specific interventions. Observations of Resident #6 showed the following: * 04/24/17 at 5:17 p.m.: a wander guard attached to the resident's walker * 04/25/17 at 7:56 a.m.: a wander guard on the resident's left ankle and walker Review of August 2016 progress notes revealed the following: * 08/27/16 at 5:54 a.m.: "Res has been up wondering [sic] throughout the hallways most of the night and has slept very little. Has been	F 323	wandering and/ or exit seeking. All staff will be in-serviced on said policies and forms on 5/24/17. The Administrator and an interdisciplinary team will review all elopement incident reports. The Director of Social Services will track all elopement incident reports and will report to the QA committee at the quarterly meeting.	

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 _____	04/26/2017

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 8	F 323		

yelling for his wife, trying to find his car . . . At [5:50 a.m.] res went into his room thinking that his car and wife were in there and shut the door."
* 08/27/16 at 3:35 p.m.: "resident found walking by the fair gounds [sic] by Parkside employee and redirected back to facility. Res cooperative about coming back. No apparent injury noted. Res alert and confused about where abouts [sic] and time per usual. Wander guard on and flashing, but did not alarm. new [sic] wander guard placed on res' [resident's] right leg."

Observation on 04/24/17 at 5:45 p.m. identified the fairgrounds approximately two to three blocks away from the facility.

During an interview on 04/26/17 at 7:46 a.m., an administrative nurse (#5) identified the incident report for Resident #6's elopement on 08/27/16 lacked any further information.

The facility failed to complete an investigation to identify how Resident #6 exited the facility unobserved, where he exited the facility, and when staff last observed Resident #6 to determine how long he was outside. Failure to complete an investigation prevented the facility from implementing resident specific interventions to prevent elopement and/or identify resident specific cues that might lead to wandering behavior. The medical record failed to identify if the staff who found the resident were currently on duty or not when the found the resident walking by the fairgrounds.

Progress notes from 09/15/16 through 10/12/16 showed Resident #6 exited from the building 15 times on 10 different days. The notes showed

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 _____	04/26/2017

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 9	F 323		

facility staff stayed with the resident until he returned to the facility.

During an interview on 04/25/17 at 3:17 p.m., regarding the August through October elopements, two administrative staff members (#6 and #7) stated when Resident #6 approached the door in the front entrance, the wander guard triggered the magnetic lock of the inner automatic sliding door. A warning sign on the door stated, "wait 15 seconds and push the door open," this is an emergency feature. Resident #6 approached the inner door of the front entrance, waited 15 seconds, pushed the door open and the resident could then exit the outer door without setting off the alarm. Documentation showed the facility placed an alarm wand between the two doors of the entrance on 10/21/16.

Review December 2016 progress notes revealed the following:
* 12/25/16 at 12:47 a.m.: "earlier this shift, resident was yelling out his wife's name, '[Wife's name], we need to get going...[Wife's name]!!' resident calm, but yelling out. . . ."
* 12/30/16 at 11:40 p.m.: "State radio called at 2250 [10:50 p.m.] stating that a man was on the ground outside the facility and the front doors were locked. Nurse went to see what was going on and seen [sic] police officer with resident. Resident has laceration to forehead and not wearing winter clo thes [sic]. Resident walked in to [sic] facility with officer and by stander. Resident states that he is cold. Resident was shaking but able to communicate. Resident stripped of wet clothes and covered with blankets. EMS [Emergency Medical Service]

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 _____	04/26/2017

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 10	F 323		

arrived and took resident to [name of hospital] for MD [medical doctor] assessment. When asked where he was going resident states to see my wife she works here at the school. Residents [sic] norm [normal] is alert but not oriented. Resident was see [sic] by nurse at 2215 [10:15 p.m.] sitting at living area watching TV [television] and having snack prior to notification of fall. By stander states that his wife heard some yelling for help and then went over to find man on ground and by stander called 911. Police then showed up and called state radio to notify of resident outside. Resident taken by EMS for evaluation by MD. Attempt times two to notify wife . . ."

* 12/30/16 at 11:46 p.m.: "Residents [sic] ankle alarm did not alarm until resident was brought back into the building. Will assess resident ankle alarm."

* 12/31/16 at 12:21 a.m.: "Notification from [name of hospital] that they are going to keep resident for observation. Per report from [name of staff member and hospital] Resident is warmed an [sic] laceration is minimal and cleansed with no sutures needed. Another attempt to call resident wife no an swer [sic]."

* 12/31/16 at 3:00 p.m.: "resident returned from [name of hospital], per private car and Parkside staff. No new orders. . . . Wife also arrived to facility at this time and updated . . ."

* 12/31/16 at 3:15 p.m.: "resident noted to have abrasion to left outer eyebrow, and also numerous small abrasions to top of head. hospital [sic] had applied antibiotic ointment to site and is open to air, no bleeding noted."

The emergency room (ER) documentation related to the 12/30/16 elopement stated, ". . . General Appearance: alert, no apparent distress,

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 _____	04/26/2017

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 11	F 323		

other (shivering) . . . Head: other (abrasion top of head, small laceration lateral left eyebrow) . . . Skin Exam: Dry, Cool, Other (abrasion noted top of head, small laceration lateral left eyebrow, bruises to left knee, minor abrasion left side.) . . . Temp [Temperature] 35.2 C [centigrade] L [low] [95.36 Fahrenheit] . . . 12/31/16 12:01 a.m. Rectal temp obtained using oral thermometer. Corrected temperature approximately 94.5 degrees. Mild hypothermia. . . . Warm blankets used . . . Will admit for hypothermia. Small laceration on left corner of left eyebrow does not need sutures. Will observe overnight and perform neuro [neurological] checks. . . . Departure . . . Disposition: Refer to Observation . . . Clinical Impression: Multiple contusions, Abrasions of multiple sites . . . Assessment: Elderly male with dementia involved in fall due to ice, subsequent hypothermia (mild). Requires observation, neuro checks, and rewarming. Stable for general supervision. . . . Plan: Neuro checks, monitor for changes. Bair Hugger for rewarming. Topical antibiotic ointment for abrasions. . . ."

During an interview on 04/25/17 at 5:17 p.m., two administrative staff members (#6 and #7) explained Resident #6 exited the front door, and fell near the street. The neighbor across the street heard the resident and went to his assistance. They determined the resident went out the front door with his alarm in place and the alarm failed to trigger. The manufacturer of the alarm system checked the alarm on 01/02/17 and increased the sensitivity of the alarm trigger.

The lack of adequate documentation/monitoring of Resident #6's exit seeking behavior did not allow for adequate assessment of the frequency

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 _____	04/26/2017

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 12	F 323		

the behavior occurred, pattern/trends in regard to times, places, etc. the behavior occurred, and circumstances/events which precipitated elopement behavior. The lack of planned and implemented interventions to situations/behavior which triggered the elopement resulted in Resident #6's second unwitnessed elopement.

SMOKING SAFETY

2. Based on observation, record review, review of facility policy, resident interview, and staff interview, the facility failed to ensure a resident's safety when smoking for 1 of 1 sampled resident (Resident #3) assessed as unsafe to smoke without supervision. Failure to ensure Resident #3 smoked only when supervised and did not have possession of smoking materials may result in the resident sustaining an injury while smoking.

Findings include:

Review of the facility policy titled "Smoking Policy - Residents" occurred on 04/25/17. The policy, revised April 2012, stated, "Policy Interpretation and Implementation . . .2. No-Smoking signs shall be prominently displayed throughout the campus. . . .4. The charge nurse will complete a Smoking Safety Assessment upon admission, or upon a resident taking up smoking. . . .6. Any Smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. . . . 8. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff

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 _____	04/26/2017

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 13	F 323		

member, family member, visitor or volunteer worker at all times while smoking. . . .11. . . . a. Residents without independent smoking privileges may not have or keep any types of smoking articles, including cigarettes, tobacco, etc, except when they are under direct supervision. . . ."

During an interview, on 04/24/17 at 4:30 p.m., Resident #3 stated she smokes independently and notifies staff when she exits the building to smoke. The resident stated she wears a coat when she goes out and she has not had any difficulty maneuvering her scooter on the sidewalk. She stated she does not keep her cigarettes in her room, but obtains them from the nurse, and smokes mostly "after meals."

Review of Resident #3's medical record occurred on all days of survey and identified diagnoses including chronic obstructive pulmonary disease, heart failure, and nicotine dependence. A "Smoking Safety Assessment," dated 05/10/16 identified the resident with impaired decision making or judgment skills, physical disabilities that would make it unsafe for her to light a cigarette, unable to smoke safely if she had her own cigarettes and matches, a history of unsafe smoking practice, and unable to smoke safely without direct supervision. In answer to the question: "Does the resident understand the danger of dropping a cigarette and matches?" the form stated, " . . . Res [resident] knows to pick up cigarette and matches, but does not have strength to pick up . . ."

A progress note, dated 07/12/16 at 10:59 a.m., stated, "Found resident outside smoking by

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 _____	04/26/2017

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 14	F 323		

herself. Per smoking policy resident requires a friend/family member to be outside with her when she is smoking due to safety concerns . . ."

Resident #3's most recent "Smoking Safety Assessment," dated 07/14/16, identified the resident remained unsafe to smoke unsupervised and stated, "Will light cigarette in room, bathroom, entry way, has dropped lit cigarette."

An annual Minimum Data Set (MDS), dated 03/22/17, identified moderate cognitive impairment, and independent in all Activities of Daily Living except transfers, for which she required one person assistance. This MDS showed an improvement from the quarterly assessment, dated 07/20/16, which identified the resident required one person physical assistance with bed mobility, transfers, walking the room, and personal hygiene. Observation on all days the survey showed Resident #3 propelled herself throughout the facility in an electric scooter.

The resident's care plan, revised 03/22/17, identified a focus: "The resident is a smoker. . . ." Interventions included: "Observe for unsafe smoking practices-smoking in non-smoking areas, burns on clothing, etc. Report unsafe practices to CN/SS [Charge Nurse/Social Services] . . . Res [Resident] receives cigarettes in am [morning] & [and] gives back at HS [hour of sleep] . . ."

During an interview on 04/25/17 at 2:15 p.m., an administrative nurse (#1) stated Resident #3 had a history of problems with smoking in her bathroom and dropping cigarettes. The nurse (#1) confirmed the resident gets her cigarettes

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 _____	04/26/2017

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 15 from the nurse in the morning and returns them in the evening. Resident #3's record lacked evidence the resident experienced burns to her body or clothing while smoking and failed to identify episodes in the past six months when the resident dropped a cigarette. The resident's care plan, which stated she may have possession of her cigarettes throughout the day, was inconsistent with the smoking assessment which indicated the resident would be unable to smoke safely if she had her own cigarettes and matches. Failure to ensure Resident #3 did not have possession of her cigarettes and lighter and smoked only when supervised by staff or a family member may result in the resident sustaining an injury while smoking.	F 323		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to ensure staff followed parameters established by the manufacturer for administration of intravenous (IV) medication for 1 of 1 supplemental resident (Resident #11) observed receiving intravenous Meropenem (an antibiotic).	F 333	F333 The IV policy was reviewed to ensure the use of manufacturer's instructions or pharmacy/physician orders. All residents receiving IV therapy have the potential to be affected should the facility fail to ensure safe accurate administration of IV	5/25/17

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 _____	04/26/2017

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 333	Continued From page 16 Failure to follow manufacturer's instructions may result in a negative outcome for the resident. Findings include: Review of the manufacturer's instructions for intravenous Meropenem occurred on 04/25/17. The instructions, dated December 2014, stated, "MEROPENEM FOR INJECTION . . . DOSAGE AND ADMINISTRATION . . . 1 gram every 8 hours intravenous infusion over 15 to 30 minutes . . ." Observation on 04/25/17 at 9:32 a.m. showed a licensed nurse (#2) entered the medication room and obtained a vial of Meropenem from a box on the counter. Observation showed no manufacturer's instructions in the box. Using a syringe, the nurse withdrew 10 milliliters (mls) of sterile water from a single dose vial, injected the water into the Meropenem vial, shook it until the powder dissolved, then added the reconstituted solution to a 100 ml bag of Normal Saline 0.9%. During this process, the nurse referred to handwritten instructions on a piece of cardboard on the counter. The handwritten instructions stated, "Meropenem *10 ml sterile H2O (water) to Reconstitute *In 100 ml NS [normal saline] *Run over 30 min [minutes] 200 ml/hr [hour]." When asked who wrote the instructions, the nurse stated she "assumed" the pharmacist had written them. The nurse (#2) then took the prepared medication to Resident #11's room. After flushing the resident's IV access, the nurse (#2) attached the tubing for the Meropenem solution, set the IV pump to infuse a volume of 200 ml at a rate of	F 333	medications. All nurses will be in-serviced on 5/24/17 to re-educate them on current IV pump and proper rate setting will be reviewed. The DON or designee will audit all IV medication orders to ensure the Manufacture's informational flyer is posted or available with the medication and the DON or designee will observe 3 IV antibiotic administrations if the facility has a resident receiving IV therapy. Results of the audits and observations will be reported by the DON to the QA committee on a quarterly basis.	

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 _____	04/26/2017

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 333	Continued From page 17 100 ml per hour, and started the pump. The surveyor then informed the nurse she had transposed the volume and rate settings, which would result in the infusion lasting one hour rather than 30 minutes. The nurse (#2) then reviewed the settings and reset the pump for a volume of 100 ml to infuse at a rate of 200 ml per hour (the correct volume and rate). Later that day the nurse (#2) provided the above referenced manufacturer's instructions. During an interview on 04/25/17 at 6:00 p.m. an administrative nurse (#1) stated a nurse, not the pharmacist, had prepared the handwritten instructions regarding the Meropenem, and confirmed the nurse (#2) administering the Meropenem had incorrectly programmed the IV pump.	F 333		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2);	F 441		5/26/17

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 _____	04/26/2017

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 441	Continued From page 18 (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; (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective	F 441		

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 _____	04/26/2017

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 441	Continued From page 19 actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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, review of facility policy, and staff interview, the facility failed to follow infection control practices for 1 of 2 whirlpool tubs (Meadowlark Lane). Failure to follow infection control practices related to disinfecting the tub has the potential to spread infection to residents and within the facility. Findings include: Review of the facility "DISINFECTING TUB POLICY" occurred on 04/26/17. The policy, dated 02/25/13, stated "IN BETWEEN BATHS: 1. Put chair back into tub. 2. Close door. 3. Spray all around tub and chair with disinfectant sprayer. 4. Use white brush to clean sides of the tub and under tub chair. 5. Let sit for 10 minutes. 6. Spray everything off with plain water sprayer." During observation on 04/26/17 at 10:35 a.m., a certified nursing assistant (CNA) (#4) demonstrated cleaning of the whirlpool tub located within the Meadowlark Lane nursing unit. The CNA, using a Neutral Disinfectant Cleaner spray, sprayed the solution over the entire area of the tub, scrubbed the surfaces with a brush, and rinsed off the solution within three minutes.	F 441	F441 CNA # 4 was re-educated on the proper use of sanitizer and procedure for cleaning of the whirlpool tub. All residents have the potential to be affected should the facility fail to ensure proper sanitation according to manufacturer's recommendations. All nursing staff will be in-serviced on proper cleaning/disinfecting of whirlpool tubs on 5/24/17. The infection prevention nurse or designee will observe the CNA's during the cleaning/ sanitizing of the whirlpool tub three times per week on varying shifts, to ensure proper procedure is followed. If 100% compliance is achieved for 6 consecutive weeks, the observations will be conducted 3 times per month for the next 6 months. The infection prevention nurse will report results of the observations to the QA committee at their quarterly meeting. If after the 6 months 100% compliance is continued it will be the referred to the QA committee for the necessity of the observations and the frequency of those observations if relevant based on achieved compliance.	

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 _____	04/26/2017

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 441	Continued From page 20 During interview on 04/26/17 at 11:10 a.m., an administrative staff member (#2) stated she expects all CNAs to provide residents' baths in the whirlpool tubs and confirmed staff should leave the disinfectant on the tub for 10 minutes before rinsing.	F 441		