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 _____	04/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey survey started on 04/25/22 and concluded on 04/28/22.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 1 of 1 resident (Resident #86) with medications observed on the bedside table. Failure to determine whether SAM is a safe practice has the potential to limit a resident's right to SAM or result in a medication error and/or harm to a resident. Findings include: Observation on 04/26/22 at 1:50 p.m. showed a medication cup located on Resident #86's bedside table contained three 1/2 pills. Resident #86 identified the medications as "gabapentin(for nerve pain), a water pill (Bumex, antidiuretic), and hydralazine (for hypertension)." The resident stated they were her "2:00 o'clock" pills and she would take them. When asked, at 2:15 p.m., Resident #86 stated she would take the medication at 2:30 p.m. Review of Resident #86's medical record	F 554	F554 Resident #86 was assessed on 5/19/2022, and it was determined she is not appropriate for self-administrating her medications. All residents that self-administer their medications would have the potential to be affected by this deficient practice. Currently there are no residents self-administering their medication. The facility Self-Administration of Drugs Policy and the facility Administering Medications policies were reviewed 5/19/2022. All Nursing staff will be in-serviced on said policy on 5/31/2022. The DON or designee will audit 10 random medication administrations per month for the next 3 months, to ensure medications are properly administered and not left for a resident to self-administer his/her own medication. If after 3 months 100% compliance is achieved the audits will be reduced to 5 times per month, for at least the next 6 months. Results of the audits will be reported to the QA committee by	6/1/22

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

Electronically Signed | 05/23/2022

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F 554	Continued From page 1 occurred on all days of survey. The record lacked a SAM assessment, a provider order, and documentation on the care plan indicating Resident #86 can safely self-administer medications. The current care plan stated, "Nsg [nursing] to give meds." During interviews on 04/28/22 at 9:20 a.m. and 12:15 p.m., an administrative nurse (#1) stated "[Resident #86] does not do her own medications." The nurse (#1) stated staff should not leave medications with the resident, they do not have a policy for SAM, and they have not completed SAM assessments in the over four years she has been with the facility. The facility failed to provide the necessary process to assess Resident #86's ability to self-administer medications.	F 554	the DON until such time it is determined that substantial compliance is maintained.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 (Version 1.17.1) and staff interview, the facility failed to complete a Minimum Data Set (MDS) that accurately reflected the residents' status for 1 of 12 sampled residents (Resident #20). Failure to accurately code the MDS may negatively affect the development of a comprehensive care plan and the care provided to the residents.	F 641	F641 The MDS for resident #20 was corrected and resubmitted on 4/28/2022, and it was accepted on 5/2/2022. All residents being treated for an infection have the potential to be affected should the facility fail to remove active infection diagnosis when the infection is resolved and treatment is discontinued. On 5/20/2022 The MDS nurse crosschecked all current MAR's and all active/ current Diagnosis to ensure	6/1/22

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F 641	Continued From page 2 Findings include: Section I: Active Diagnosis The Long-Term Care Facility RAI Manual, revised October 2019, page I-8, stated, ". . . I: Active Diagnoses in the last 7 days . . . Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period . . . " Review of Resident #20's medical record occurred on all days of survey. A quarterly MDS, dated 03/28/22, identified an active diagnosis of wound infection (other than foot). Resident #20's record lacked a diagnosis and/or documentation of an active infection in the seven-day look-back period (March 22 - 28, 2022). During an interview on 04/28/22 at 9:45 a.m., a nurse coordinator (#3) confirmed staff incorrectly coded Section I of the MDS for Resident #20.	F 641	that They were current and accurate, as these diagnosis automatically populate MDS inputs. At the end of each month the DON or designee will now utilize the Infection Preventionist's monthly infection report, (which tracks all resident infections) to audit the infected resident's diagnosis and or MAR to ensure they are accurate and current, and that a resolved infection diagnosis is not still an active diagnosis. Results of the monthly audits will be reported by the DON to the QA committee, for the next 6 months and thereafter until such time it is determined by the QA committee that substantial compliance is maintained.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		6/1/22

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F 644	Continued From page 3 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) for 1 of 1 sampled resident (Resident #1) with diagnoses of major mental illness. Failure to complete the PASARR screening with the current list of diagnoses may result in the residents not receiving necessary psychiatric services. Findings include: Review of the medical record for Resident #1 occurred on all days of survey. Diagnoses included anxiety disorder, major depressive disorder, and delusional disorders. A Level 1 PASARR screening completed on 04/20/21 failed to identify Resident #1's diagnosis of delusional disorders. The record lacked evidence facility staff completed a PASARR at the time of the diagnosis or any time thereafter. During an interview on the morning of 04/28/22, a social service staff member (#4) acknowledged the delusional disorders had not been captured on the 04/20/21 Level 1 PASARR or any time	F 644	F644 A new PASRR for resident #1 with all current diagnoses was submitted on 5/19/2022. On 5/20/2022 it was determined that a Level II PASRR was not necessitated. All residents with a serious mental disorder, intellectual disability, or related condition for Level II have the potential to be affected upon a significant change in status should the facility fail to submit new PASRR screening when changes occur. A full review will be conducted of current/active resident charts containing a serious mental health disorder, intellectual disability, or other related mental health condition; whom may have the potential to be affected by a Level II screening not being completed. These results will be brought to the QAA committee next quarter to verify compliance. If 100% compliance is not achieved, continued quarterly audits of all resident charts containing a serious mental health disorder, intellectual disability, or other related mental health	

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F 644	Continued From page 4 thereafter.	F 644	condition will be conducted for need for Level II screening quarterly until 100% compliance has been achieved for 4 consecutive quarters. Upon admission all PASRR screenings will be audited for accuracy and/or need for Level II screening with the provided admission medical record by the SSD or designee. If found to be inaccurate, they will be immediately corrected by performing the Level 1 Status Change screening prior to admission. These audits will be documented and brought to the quarterly QAA meetings to ensure compliance for the next 2 quarters of QAA meetings. If 100% compliance is obtained, 3 random audits of admission PASRR screenings will be completed per quarter for the next 4 quarters and brought to the quarterly QAA until 100% compliance is achieved.	
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to	F 868		6/1/22

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F 868	Continued From page 5 identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the Medical Director (physician) actively participated on the Quality Assurance (QA) committee for 3 of 4 quarters (July 2021-April 2022). Failure to ensure the medical director participated in the facility's QA activities deprived the committee of the physician's unique contributions for analyzing and correcting problems with identified resident care areas. Findings include: The facility provided documentation showing the QA committee met on a quarterly basis between July 2021 and April 2022. The documentation showed the Medical Director failed to attend the October 2021-April 2022 meetings. During an interview on the morning of 04/28/22, an administrative staff member (#5) reported he failed to locate the attendance roster for the meeting on 10/28/21. The Medical Director failed to attend the meeting on 01/24/22 and attended but failed to sign the attendance roster for the meeting on 04/11/22.	F 868	F868 Meeting minutes from 4/11/22 were reviewed with the Medical Director on 5/16/22. All residents have the potential to be affected should the facility fail to ensure the Medical Director is an active member of the QA committee. The Director of Nursing and the Medical Director derived a plan to communicate the dates and times of future QA committee meetings. Attendance and participation of all QA members including the Medical Director will be taken at each meeting. For the next year the Administrator will incorporate Medical Director participation/ attendance in his quarterly report to the facility Board of Directors.	