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 _____	05/14/2015

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 05/11/15 and completed on 05/14/15, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.	F 000	F 278 The MDS for Resident #9 was corrected to accurately reflect sections "C and "D" for mood and delirium. All residents have the potential to be affected should the facility fail to accurately code based on documented delirium or mood. The current MDS's of all residents were reviewed. Eight records were corrected. The corrected records were submitted to CMS on 5/20/15. The RAI manual for the SSD and the MDS coordinator were updated on 5/19/15 to include all revisions. The MDS coordinator and the SSD will be attending the NDLTCA sponsored MDS training on 6/9/15 and 6/10/15. The MDS coordinator will randomly audit 6 MDS's per month for the next 6 months and verify if mood and/ or delirium are coded anything greater than 0 (zero), and that the proper documentation to support the coding is charted and the location of said charting. If no discrepancies are found after 6 months the audits will be conducted on 6 residents per quarter and the QA committee will determine the necessity of ongoing audits after one year. Results of the audits will be reported by the MDs coordinator to the QA committee at the quarterly QA meeting.	6/10/15
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/4/15

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 9 sampled residents (Resident #9) and as identified in 1 of 1 closed record (#10). Failure to accurately complete portions of these MDSs does not allow each resident's assessment to reflect the resident's current status/needs, and may affect the accuracy of the care plan and the level of care provided to the resident. Findings include: The Long-Term Care Facility RAI Manual, October 2014, Chapter 3 stated: Page C-1 - "Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions." Page C-27 - ". . . Steps for Assessment . . . Evidence of inattention may be found during the resident interview, in the medical record, or from family or staff reports of inattention during the 7-day look-back period . . . ." Page D-12 - ". . . Steps Steps for Assessment. Look-back period for this item is 14 days." Page E-21 - ". . . Steps for Assessment 1. Review responses provided to items E0100-E01000 on the current MDS assessment. . . . 3. Taking all of these items into consideration, make a global assessment of the change in behavior from the most recent to the current MDS. 4. Rate the overall behavior as same,	F 278		

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F 278	Continued From page 2 improved, or worse. . ." - Review of Resident #9's medical record occurred on May 13-14, 2015. Resident #9's quarterly MDS, dated, 02/19/15, identified Resident #9 displayed continuous inattention and disorganized thinking (C1300A coded as 1 and C1300B coded as 1); and had trouble falling or staying asleep, or sleeping too much for 2-6 days (D0500C coded as 1), had trouble concentrating on things, such as reading the newspaper or watching TV for 12-14 days (D0500G coded as 3), and being short-tempered, easily annoyed for 2-6 days (D0500J coded as 1). During the look-back periods, Resident #9's medical record lacked evidence for coding continuous inattention, disorganized thinking, and trouble concentrating; and showed trouble falling or staying asleep, or sleeping too much on 1 day and being short-tempered, easily annoyed on 1 day. Resident #9's quarterly MDS, dated, 11/20/14, identified Resident #9 displayed continuous inattention and disorganized thinking (C1300A coded as 1 and C1300B coded as 1); had trouble concentrating on things, such as reading the newspaper or watching TV for 12-14 days (D0500G coded as 3), and being short-tempered, easily annoyed for 2-6 days (D0500J coded as 1). During the look-back periods, Resident #9's medical record lacked evidence for coding continuous inattention, disorganized thinking, and trouble concentrating; and showed being short-tempered, easily annoyed on 1 day. Resident #9's annual MDS, dated, 08/11/14, identified Resident #9 displayed continuous	F 278		

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F 278	Continued From page 3	F 278		

inattention and disorganized thinking (C1300A coded as 1 and C1300B coded as 1); and had trouble concentrating on things, such as reading the newspaper or watching TV for 12-14 days (D0500G coded as 3). During the look-back periods, Resident #9's medical record lacked evidence for coding continuous inattention, disorganized thinking, and trouble concentrating.

During an interview on 05/13/15 at 3:10 P.M., a social service staff member (#6) verified the medical record for Resident #9 failed to reflect the above coded MDS items of C1300A, C1300B, D0500C, D0500G, and D0500J.

- Review of Resident 10's medical record occurred on May 13-14, 2015. A quarterly MDS, dated 04/03/15, identified constant inattention, disorganized thinking, and altered level of conscious (C1300A, C1300B, and C1300C coded as 2). During the look-back periods, Resident #10's medical record lacked evidence for coding constant inattention, disorganized thinking, and altered level of conscious.

Resident #10's significant change MDS, dated 03/26/15, identified constant altered level of conscious (C1300C coded as 2); feeling down, depressed, or hopeless for 2-6 days (D0500B coded as 1), indicating that s/he feels bad about self, is a failure, or has let self or family down for 2-6 days (D0500F coded as 1), states that life isn't worth living, wishes for death, or attempts to harm self (D0500I coded as 1), and being short-tempered easily annoyed for 2-6 days (D0500J coded as 1); and change in behavior or other symptoms coded as non-applicable (N/A) (E1100 coded as 3). During the look-back periods, Resident #10's medical record lacked

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F 278	Continued From page 4 evidence for coding constant altered level of conscious, feeling down, depressed, or hopeless, feeling bad about self, stating life isn't worth living, and being short-tempered on 1 day. Staff failed to code behavior or other symptoms in E1100 as same, improved, or worse compared to the previous MDS. During an interview on 05/14/15 at 9:30 a.m., a social service staff member (#6) stated the medical record for Resident #10 failed to reflect the above coded MDS items of C1300A, C1300B, C1300C, D0500B, D0500F, D0500I, and D0500J, and staff failed to compare a previous MDS to correctly code E1100.	F 278	F281 The outdated insulin vials were discarded and current vials were dated with the proper expiration date on 5/14/15. A labeling system was acquired from the consultant pharmacists to label all multi-dose drug vials as all multi-dose drug vials have the potential to be affected by this deficient practice. The Nursing Staff was in-serviced on new labeling system on 6/3/15. The Director of Nursing will verify that all multi-dose drug vials are properly labeled including an expiration date 1 time per month for the next twelve months. Any vials found not to be compliant will be immediately remedied and reported to the QA committee by the Director of Nursing.	6/10/15
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow current standards of practice regarding dating of insulin vials in 2 of 2 medications carts (east and west units). Failure to date insulin vials may result in the administration of expired insulin to residents. Findings include: Review of the facility policy titled "Multi Dose Drug Vials" occurred on 05/14/15. This undated policy stated, ". . . All multi dose vials will have an open date written on them . . . These bottles will be	F 281		

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F 281	Continued From page 5 dated when opened and discarded in . . . 28 days for insulin, after the open date." Observation of the east and west unit medication carts occurred on the afternoon of 05/14/15. Observation showed three insulin vials in the east unit cart and 10 insulin vials in the west unit cart lacked an expiration date. During an interview on the afternoon of 05/14/15, a supervisory nurse (#4) confirmed the vials lacked expiration dates.	F 281	F325 The Care plan was reviewed and revised following an interview with Resident #3 on 6/1/15. All residents at risk for weight loss have the potential to be affected should the facility fail to implement interventions and carry out said interventions in a timely manner. The Facility Policy for providing supplements was reviewed on 6/1/15, and all direct care staff will be in-serviced on said policy on 6/18/2015. The Dietary manager will monitor one household per week (total of 4) for the next month to ensure that the dietary supplements or interventions that are care planned for residents of that household are provided and that the intake of food or supplements is accurately recorded. Any deviations found will be immediately corrected with the direct care staff involved and will be reported by the Dietary Manager at the quarterly QA meeting.	6/18/15
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to implement and monitor interventions to prevent weight loss for 1 of 3 sampled residents (Resident #3) identified with weight loss. Failure to consistently implement existing interventions and re-evaluate and modify the interventions as needed resulted in severe weight loss for Resident #3.	F 325		

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F 325	Continued From page 6 Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia. The current Minimum Data Set (MDS), dated 03/17/15, identified limited assistance from one person for eating, and a weight loss which was not physician-prescribed. The current care plan stated, ". . . Alteration in nutrition d/t [due to] Dx [diagnosis] dementia, depression, HTN [hypertension] . . . Wt [weight] loss . . . Approaches . . . Wishes to have skim milk w/ [with] meals . . . 8 oz [ounce] shake made w/ supplement D & S [dinner and supper] . . ." Review of Resident #3's weekly weights identified a weight of 132 pounds (#) on 11/13/14, and a current weight of 116 pounds on 05/07/15. This represented a 16 pound weight loss over six months (a 12% weight loss). Dietary progress notes stated the following: *10/15/14: ". . . Wt 132#. Wt loss 8# past month. . . . Sleepy at some meals. . . ." *10/16/14: ". . . Consulted nursing staff and will offer 8 oz supplement [with] meals. . . ." *10/24/14: ". . . Nursing states Resident refusing supplement [with] meals. Requests skim milk [with] meals and at times will request up to 3 glasses of skim milk. Will D/C [discontinue] supplement at meals and offer skim milk. . . ." *12/17/14: ". . . Wt. 130 lbs [pounds]. [down] 2 lbs from 1 month ago, [down] 7 lbs from 6 months ago. . . . Receives 8 oz skim milk [with] meals, 8 oz shake made [with] supplement D &S. . . ." *02/17/15: ". . . Wt 123# and down 7# past month. States pleased [with] meals and likes the shake at noon [and] supper. . . ."	F 325		

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F 325	Continued From page 7 *03/11/15: ". . . Wt - 127 lbs, [down] 15 lbs in 6 months. Visited [with] Resident. 'Meals are going fine! I get enough to eat [and] it's good!' Resident agreed to let us know if has a special request. . . ." *03/25/15: ". . . [Significant] wt loss 13# past 6 months. Wt 125#. 8 oz shake supplement [with] din [dinner] & supper. Taken [over] 75%. Wt. stable past month. Nurse reports behavioral issues. [complains of] foods being too salty even the fruit. . . ." *05/05/15: ". . . Wt 121#. Down 3# past 2 weeks. [Significant] wt loss 13# past 6 months. . . . 8 oz supplement shake [with] din & supper. . . . States no complaints about the food [and] gets more than enough to eat. States likes the supplements. Has pm [afternoon] snack, does not want HS [bedtime] snack. . . ." *05/11/15: ". . . Wt 116#. Wt loss 5# past week. . . . Meal intake has improved. 8 oz shake supplement din & supper . . ." A fluids sheet (used by staff to identify types of beverages provided to residents at meal times) identified Resident #3 should receive an 8 oz shake made with a supplement at the dinner and supper meals. During an interview on 05/14/15 at 8:50 a.m., a dietary supervisor (#5) identified Resident #3 should receive ice cream with 4 oz of Boost supplement at dinner and supper. The dietary supervisor indicated the staff members on the units are responsible for preparing and distributing the shakes to residents. Observation during the noon meals on 05/12/15 and 05/13/15, and during the evening meal on 05/13/15 identified staff failed to offer Resident #3's shake supplement. Intake records for the dinner meal on 05/13/15 identified Resident #3	F 325		

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F 325	Continued From page 8 consumed 240 milliliters (ml) of Boost supplement; however, observation showed the only fluids Resident #3 consumed was 240 ml of milk. Failure to consistently implement existing weight loss interventions, evaluate their effectiveness, and initiate additional dietary interventions as needed resulted in a severe weight loss for Resident #3.	F 325	F 356 The nurse staffing/census identified in the 2567 were corrected on 5/14/15. All residents and visitors have the potential to be affected should the facility fail to post the accurate nurse staffing/census information. A new daily nurse staffing/census form was developed and implemented on 6/1/15. All nurses were instructed on how to complete the new forms. The Director of Nursing or designee will audit the accuracy of all completed nurse staffing/census forms for the next 3 weeks. If no errors are found the audits will be conducted on 4 random forms per month for the next year. Results of the audits will be reported by the Director of Nursing at the quarterly QA meeting.	6/10/15
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		

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F 356	Continued From page 9 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to post and/or maintain the total and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, and the resident census. In addition, the facility failed to post accurate nursing staffing data on at least 16 of 44 days reviewed (April 1, 2015 through May 11, 2015). Failure to post/maintain the number of licensed and unlicensed nursing staff on duty daily, for each shift; and the failure to post accurate nurse staffing data denied residents/visitors the opportunity to be informed regarding the staffing levels. Findings include: On May 12-14, 2015, review of a binder containing daily nurse staffing data sheets for the time period of April 1, 2015 through May 11, 2015 occurred. On May 13, 2015, two administrative nurses (#7 and #8) also reviewed these nurse staffing data sheets, and provided accurate nursing staffing hours using the facility time cards. Review of the nursing staffing data revealed the facility either failed to post and/or maintain the total and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, and the resident census;	F 356		

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F 356	Continued From page 10 or failed to post accurate nursing staffing data. Examples include, but are not limited to, the following: * For 05/11/15 - The document identified hours worked during the evening shift by one licensed practical nurse (LPN) as 42 hours and the full-time equivalent (FTE) as 6. Rather, the hours should have been recorded as 8 and the FTE as 1. * For 05/10/15 - The document identified hours worked during the evening shift by certified nursing assistants (CNAs) as 32 hours and the full-time equivalent (FTE) as 4. Rather, the hours should have been recorded as 36 and the FTE as 4.5. * For 04/27/15 - no document maintained. * For 04/25/15 - The document showed no hours worked during the evening shift by CNAs and the full-time equivalent (FTE) as 6.5. Rather, the hours should have been recorded as 44 and the FTE as 5.5. * For 04/24/15 - The document identified hours worked during the evening shift by LPNs as 8 hours and the full-time equivalent (FTE) as 6.5. Rather, the hours should have been recorded as 12 and the FTE as 1.5. * For 04/24/15 - The document identified actual hours worked during the evening shift by CNAs as 8 hours. Rather, the hours should have been recorded as 48. * For 04/19/15 - The document identified 4 certified medication assistants (CMAs) worked during the evening shift and the full-time equivalent (FTE) as 1.25. Only one CMA worked for 4 hours. Rather, the hours should have been recorded as 44 hours worked by unlicensed staff and the FTE as 5.5. On May 13, 2015, two administrative nurses (#7	F 356		

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F 356	Continued From page 11 and #8) compared these nurse staffing data sheets to the facility time cards, and verified verbally and in writing these nurse staffing data sheets were not completed and/or were not completed accurately.	F 356		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to ensure medications available for administration to residents were not expired in two of two emergency kits (east and west units) and 1 of 2 medication carts (west unit).	F 425	F 425 The two Emergency kits were addressed on 5/14/15. The Emergency drug kit on the East medication room was removed from service. The emergency drug kit located in the West medication room was resupplied with non-expired medications and a current accurate label was affixed to the outside of the container by the provider pharmacist. All resident have the potential to be affected should the facility fail to ensure current medications are available for emergency use. The consulting Pharmacist will verify each month during their pharmacy review that the medications are current and the label is accurate. Any outdated medications or inaccuracies of the label will be immediately brought to the attention of the Charge Nurse on duty as well as to the attention of the provider pharmacy. The Director of Nursing and the Administrator receive a copy of the monthly pharmacy review. Any non-compliance issues found on these reports will be immediately corrected,	6/10/15

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 _____	05/14/2015

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) COMPLETIO DATE
F 425	Continued From page 12 Findings include: Review of the facility policy titled "Multi Dose Drug Vials" occurred on 05/14/15. This undated policy stated, ". . . All multi dose vials will have an open date written on them . . . These bottles will be dated when opened and discarded in . . . 28 days for insulin, after the open date." Observation of the east and west unit emergency medication kits on the afternoon of 05/14/15 showed 12 expired medications contained within the kits. Observation of the west unit medication cart on the afternoon of 05/14/15 showed three insulin vials with expiration dates past 28 days. Failure to ensure expired medications are unavailable for administration may result in residents receiving expired medications.	F 425	and verification of the corrections will be noted on the pharmacy review documentation, which is reviewed by the Medical Director. The insulin Vials were discarded and new vials introduced on 5/14/15. See correction for F-281.	