DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2011
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
JUN 27 2011
Division of Health Facilities

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 _____	05/25/2011

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 05/23/11 and completed on 05/25/11, 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 concerns during the survey.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, record review, and staff interview, the facility failed to review and revise the careplan for 2 of 9 sampled residents	F 280	F 280 The careplans for Resident #7 and resident #9 were revised on 5/25/11 to address the needs of the resident as outlined by facility policy. All residents have the potential to be affected should the facility fail to properly address resident needs or changes in condition as they occur. The fall log forms were revised to include a care plan change column to assure changes are made in a timely manner. Standardized temporary infection care plans were revised to include isolation precautions associated with a given infection. The MDS nurse or designee will randomly audit four charts per month to assure completion when circumstances trigger a necessary change to the careplan. Results of the audits will be reported to the QA committee quarterly by the MDS nurse.	7/11/11

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

Administrator — 6/24/2011

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 _____	05/25/2011

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 280	Continued From page 1	F 280		

(Resident #7 and #9) to reflect the residents' current status. Failure to update the careplan related to falls (Resident #9) and isolation precautions (Resident #7) limited the facility's ability to ensure consistency and continuity of care.

Findings include:

Review of the facility policy titled "Resident Falls" occurred on 05/25/11. The policy, undated, stated, "Purpose: To assure the appropriate follow-up and documentation and communication of falls. Procedure: . . . 13. The charge nurse working on the shift that the resident falls will modify the care plan as necessary to try to prevent additional falls/injuries of a similar nature/circumstance from occurring."

- Review of Resident #9's medical record occurred on 05/25/11. Diagnoses included dementia, visual hallucinations, macular degeneration, osteoporosis, and history of unresponsive spells. The resident's quarterly Minimum Data Sets (MDSs), dated 04/18/11 and 01/16/11, indicated impaired vision, short and long-term memory problems, moderately impaired decision-making ability, extensive assist of two or more staff for bed mobility and transfers, and no falls since admission or the prior assessment. The annual MDS, dated 10/11/10, indicated one fall since admission or prior assessment.

Resident #9's nurses' notes revealed the following:
* 05/13/11 at 6:30 a.m. - "Res (resident) found laying on [left] side on floor. Bed in low position

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 _____	05/25/2011

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 280	Continued From page 2 [and] fall mat in place. . . ." * No date entered, time is 3:30 a.m. - "Res. found laying on back on floor mat. Bed in lowest position. . . ." * 05/16/11 at 10:50 a.m. - "Phone call placed to . . . resident's daughter to report resident fell to floor at 3:30 this A.M. Resident's daughter states that this concerns her as this makes 2x (times) this week. . . . she stated that she would like us to check on [Resident #9] [every] 30 minutes at night and put her legs back in bed as she gets restless and put a pillow in front of her legs . . ." The incident/accident reports for Resident #9's falls included: * 05/13/11 at 6:30 a.m. - "Recommended new intervention: frequent checks of resident" and "Care plan changed as needed: frequent checks on resident." *05/16/11 at 3:30 a.m. - " . . . Recommended new intervention: Remind res. to use call light. Frequent checks." and "Care plan changed as needed: [every] 30 min [minute] checks, pillow in front of leg." Review of Resident #9's careplan, dated 04/26/11, failed to show a careplan for falls. During an interview on 05/25/11 at 11:03 a.m., an administrative nurse (#1) stated communication during shift report included Resident #9's daughter's suggestions on preventing falls and these interventions have helped prevent further falls. The nurse (#1) agreed she failed to update the careplan with the interventions. This nurse agreed a careplan addressing falls should be included on Resident #9's careplan.	F 280		

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 _____	05/25/2011

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 280	Continued From page 3 Failure to add falls to Resident #9's careplan, including interventions to prevent falls, has the potential to affect consistency of care and increases the risk for injury to Resident #9. - Review of Resident #7's medical record occurred on May 24-25, 2011. An "Admission Nursing Assessment," dated 05/17/11, stated "open area to penis - MRSA [Methicillin Resistant Staphylococcus Aureus]." Physician's orders identified an order, dated 05/17/11, for Gentamycin [an antibiotic] cream to the area twice a day for seven days. Observation of cares, on 05/24/11 at 5:20 p.m., identified two Certified Nursing Assistants (CNAs) (#3 and #4) assisted Resident #7 to lie down. Observation showed, prior to assisting the resident, the CNAs donned gowns, gloves, and masks. Review of Resident #7's care plan, dated 05/22/11, identified a problem "Alteration in skin integrity R/T [related to] open areas on penis." The approach to the problem stated, "Tx [treatment] as ordered." The care plan failed to identify the MRSA and/or precautions staff should use when caring for Resident #7. On 05/25/11 at 9:30 a.m. an administrative nurse (#5) provided a "Skin Infection" care plan, dated 05/17/11, which identified the MRSA infection and the treatment with Gentamycin cream, but failed to identify precautions staff should use when caring for Resident #7. The nurse (#5) stated she found the "Skin Infection" care plan in the medical records in-box. She stated the medical records staff member periodically files items in the in-box	F 280		

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 _____	05/25/2011

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 280	Continued From page 4 to the resident's charts. The nurse (#5) agreed staff should have placed the care plan directly on the medical record. Failure to include the MRSA infection and precautions for staff to implement in the resident's care plan could result in the multi-drug resistant organism spreading to other residents, if staff failed to use appropriate precautions when providing cares for Resident #7.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to assess and monitor wound healing for 1 of 1 sampled resident (Resident #7) with an ulceration of the penis. Failure to assess and monitor healing limited staff's ability to determine if the current treatment plan was effective and could result in delayed healing. Findings include: Review of the facility policy, "Pressure Sores - General" occurred on 05/25/11. The policy, dated 03/09/09, stated "Routine skin checks will be	F 309	F- 309 The wound on resident #1 was assessed on 5/25/11. All residents with wounds have the potential to be affected should the facility fail to properly do skin assessments and ongoing evaluation of wounds. During the week of 5/30/11, all residents at risk of skin breakdown were assessed and potential concerns were addressed. A reassessment schedule for said residents was established. The facility policy for "Pressure Sores general" was reviewed on 5/27/11. All licensed nursing staff were inserviced on the policy on 6/8/11. The "skin nurse" will give a weekly report to the interdisciplinary team. The Director of Nursing or designee will compile data from the weekly skin reports. A quarterly data analysis summary will be reported by the Director of Nursing to the QA committee.	7/11/11

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 _____	05/25/2011

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 309	Continued From page 5 done on all resident at admission, during cares and on bath day. Any reddened or open areas will be reported to the Charge Nurse and the Skin Nurse. Orders will be obtained for treatment. The course of treatment will be documented until the problem is resolved." Observation of cares for Resident #7 occurred on 05/24/11 at 5:20 p.m. Two Certified Nursing Assistants (#3 and #4) assisted the resident to lie down. During cares, observation identified two open areas with irregular edges and yellow wound beds on the resident's lower anterior penis. Observation showed bloody drainage on the incontinence pad. Review of Resident #7's medical record occurred on May 24-25, 2011. An "Admission Nursing Assessment," dated 05/17/11, stated, "open area to penis - MRSA [Methicillin Resistant Staphylococcus Aureus]." IDP notes, dated 05/17/11, stated, "Resident has an open area to his penis and this is MRSA." The record failed to identify an assessment of the open area, including measurements, condition of wound bed, drainage, wound edges, and/or condition of the surrounding skin. Admission documentation on 05/17/11 identified one open area. Observation on 05/24/11 identified two open areas, indicating a worsening of the skin breakdown. An interview with a licensed nurse (#6) occurred on 05/25/11 at 7:40 a.m. The nurse stated staff do not complete wound healing records for residents, but record all documentation of wounds in the IDP notes. She stated she planned to call the practitioner that day because,"It's not getting better" (referring to the open areas).	F 309		

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 _____	05/25/2011

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 309	Continued From page 6 An interview with an administrative nurse (#1) occurred on 05/25/11 at 10:10 a.m. The nurse stated she expects staff to assess and measure all open areas weekly and to record the assessment. During an interview, on 05/25/11 at 10:50 a.m., a licensed nurse (#6) stated she had measured Resident #7's ulcers. She stated the ulcers measured 1 x 1.1 cm and 0.7 x 0.5 cm. She stated Resident #7 had purulent drainage from the meatus, not from the open areas. Failure to assess and document the ulcers limited staff's ability to monitor healing and limited the practitioner's ability to make an informed decision regarding treatment.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, policy and procedure review, and professional reference review, the facility failed to ensure 1 of 1 sampled resident with current	F 314	F 314 The pressure sore on resident #3 was assessed on 5/26/11, and reassessed on 6/1/11 , when it was noted that wound was healed. All residents with wounds have the potential to be affected should the facility fail to properly do skin assessments and ongoing evaluation of wounds. During the week of 5/30/11, all residents at risk of skin breakdown were assessed and potential concerns were addressed. A reassessment schedule for said residents was established. The facility policy for "Pressure Sores general" was reviewed on 5/27/11. All licensed nursing staff were inserviced on the policy on 6/8/11. The "skin nurse"	

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 _____	05/25/2011

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 314	Continued From page 7 pressure sores (Resident #3) received the necessary treatment and services to promote healing of the pressure sore. Failure of facility staff to assess, monitor, and evaluate Resident #3's pressure sore has the potential to delay the healing of the pressure sore. Findings include: Review of the facility policy, "Pressure Sores - General" occurred on 05/25/11. This policy, dated 03/09/09, stated "Routine skin checks will be done on all residents at admission, during cares and on bath day. Any reddened or open areas will be reported to the Charge Nurse and the Skin Nurse. Orders will be obtained for treatment. The course of treatment will be documented until the problem is resolved . . . 7. If a decubitus develops or if a resident is admitted with a decubitus, follow special cleansing, positioning, and skin protector measures outlined above as well as the following: a. Any reddened or open areas are to be documented by the licensed staff in the resident's record including size, location, [and] action taken . . . d. Nurses charting for residents are to address treatment progress or deterioration of decubitus. ESSENTIAL POINTS . . . Pressure ulcers will be measured weekly by Charge Nurse or Wound Care Nurse. Wound Care Nurse or charge nurse will initiate and document wound care progress on pressure ulcer record. . . ." Review of the facility policy, "Pressure/Decubitus Ulcers, Documentation Sheet" occurred on 05/25/11. This undated policy stated, "It is the policy of Parkside Lutheran Home to have a central, consistent, flow sheet to enable staff to evaluate status of ulcers . . . Pressure sores will	F 314	F-314 Continued will give a weekly report to the interdisciplinary team. The Director of Nursing or designee will compile data from the weekly skin reports. A quarterly data analysis summary will be reported by the Director of Nursing to the QA committee.	7/11/11

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 _____	05/25/2011

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 314	Continued From page 8	F 314		

be identified on the weekly pressure ulcer healing record. It will be started as soon as a pressure sore is identified. All information will be completed immediately . . . Each pressure sore will be measured in cm [centimeters] weekly by the Skin Nurse and PRN [as needed]. Measurements, size depth, drainage, odor, color and a short statement on progress (or lack of) will be documented on the Weekly pressure ulcer healing record as well as in the IDP [interdisciplinary progress] notes. . . ."

Review of Resident #3's medical record occurred on May 23-25, 2011. The facility admitted Resident #3 in February 2010 with diagnoses of dementia, depression, and parkinsonism.

Review of Resident #3's significant change Minimum Data Set, dated 05/09/11, identified the resident with moderately impaired cognition and a Brief Interview for Mental Status (BIMS) score of 9, required extensive one person physical assistance with bed mobility, dressing, toilet use and personal hygiene, and limited one person physical assistance with ambulation. This MDS failed to identify the presence of any pressure ulcers.

During the initial tour of the facility on 05/23/11 at 1:15 p.m., a staff nurse (#8) stated Resident #3 "has a new open area to his right buttock" and she planned on assessing this area later on during her shift.

Observation of Resident #3's buttock area, with staff member (#8) on 05/25/11 at 12:15 p.m., showed a crusted over area to the left buttock which measured approximately 0.50 cm by 0.50

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 _____	05/25/2011

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 314	Continued From page 9	F 314		

cm and an open area to the right buttock which measured approximately 0.25 cm by 0.25 cm with pink surrounding tissue.

Random observations throughout all days of survey showed Resident #3 sitting in his recliner and the presence of a gel cushion placed on the seat of his recliner.

Review of Resident #3's care plan, dated 05/16/11, identified a problem of "At risk for alteration in skin integrity r/t [related to] decline in condition," a goal of "Res [resident] will have minimal to no breakdown TNR [through next review], and intervention of "Gel cushion in recliner."

Review of Resident #3's Interdisciplinary Progress Note (IPN) dated 05/04/11 at 2:30 p.m., stated, "Noted 0.4 cm open area in [left] buttock. Peri-wound blanches well. Gel cushion in recliner. Res amb [ambulates] [with] assist [of one]. Up per request [and] PRN. Able to voice needs." Facility staff notified Resident #3's physician via fax that same day and received an order for Dimethicone ointment twice daily to open area until healed.

On the afternoon of 05/24/11, an administrative nurse (#1) stated the facility documents and tracks all pressure ulcers using a standardized "Pressure Ulcer Record." The surveyor requested to review Resident #3's "Pressure Ulcer Record" for the two areas located on the resident's buttock. On the morning of 05/25/11, an administrative nurse (#1) stated the only documentation regarding Resident #3's buttock pressure ulcers is the IPN from 05/04/11. This

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 _____	05/25/2011

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 314	Continued From page 10 administrative nurse confirmed facility staff failed to consistently evaluate and document the condition and progression of healing regarding Resident #3's pressure sore on a weekly basis. Failure to assess and document the pressure ulcers limited staff's ability to monitor healing and limited the practitioner's ability to make an informed decision regarding treatment.	F 314	F-323 The Clorox disinfecting spray cans in whispering winds and Cozy Cottage were placed in the locked cabinets in their respective soiled utility rooms. The locks on the cabinets in all kitchen under the counter sinks were changed to require a key to open either side of the cabinet doors. The steak knives in all household kitchens were place in a drawer that was equipped with a child proof locking device. The facility policy for chemical storage was reviewed and all staff were inserviced on the policy on 6/7/11. A facility policy, Knives and sharp storage was developed on 5/27/11. All staff were inserviced on the new policy on 6/7 and 6/8/11. The Director of Housekeeping or designee will do an observation of all units to ensure that chemicals are stored properly and knives or sharp objects are secured properly. The observations will occur weekly for a period of three months, if 100% compliance is achieved the observations will be done monthly for the next year. Results of the observations will be reported to the QA committee quarterly, by the Director of Housekeeping.	7/11/11
F 323 SS=B	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 policy, and staff interview, the facility failed to ensure the residents' environment remained as free of accident hazards as possible in 3 of 3 resident care households (Cozy Cottage, Whispering Winds, and Meadowlark Lane). Failure to secure cleaning chemicals and sharp knives increases the risk of injury to residents, especially residents who wander and have dementia. Findings include: Review of the facility policy "Chemical Storage" occurred on 05/25/11. The policy, undated,	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 _____	05/25/2011

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 stated, "Purpose: to keep residents safe. Policy: It is the policy of Parkside Lutheran Home to keep all chemicals behind locked doors and/or cabinets to keep residents away from using them or hurting themselves. 1. Keep all chemicals-sprays, cleaners, etc [etcetera] behind locked doors and/or in locked cabinets. . . ." On 05/23/11, the facility provided a list of residents who wander into other resident rooms and/or outside of the facility. This list included five residents. Review of Resident #4's medical record occurred on 05/23/11 to 05/24/11. Diagnoses included Alzheimer's dementia. Resident #4's quarterly Minimum Data Set (MDS), dated 03/07/11, indicated moderately impaired decision making skills, wandering behavior occurred 1 to 3 days of 7-day lookback period, independent with walking in her room and in the corridor, independent with locomotion on the unit, and supervision with locomotion off the unit. The current careplan stated, ". . . wanders, if found in others rooms . . . check if she's taken anything . . ." Observation on all days of the survey showed Resident #4 wandered around the unit. A tour of the environment occurred on 05/24/11 from 4:35 p.m. to 5:20 p.m. with an administrative staff member (#2) and a maintenance staff member (#7). Observation showed the following: * Cozy Cottage soiled utility room - One can of Clorox disinfecting spray labeled "Keep out of reach of children." *Cozy Cottage cabinet below the kitchen sink - Several boxes of Finish machine warewashing detergent labeled "Harmful if swallowed; severe	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 _____	05/25/2011

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 eye and skin irritant," Dawn dishwashing liquid labeled "Keep out of reach of children" and "May cause eye irritation," one bucket of Wet Task wiping system labeled "Keep out of reach of children," and one bottle of Clorox Formula 409 labeled "Keep out of reach of children." * Cozy Cottage kitchen drawer - Three sharp knives. * Whispering Winds clean utility room linen closet - Two cans of Clorox disinfecting spray and one tub of Oxivir wipes labeled "Keep out of reach of children." *Whispering Winds kitchen drawer - Two sharp knives. * Meadowlark Lane cabinet below the kitchen sink - Seven boxes of Finish machine warewashing detergent, Dawn dishwashing liquid, and one bucket of Wet Task wiping system. *Meadowlark Lane kitchen drawer - Three sharp knives. During an interview, while on the environmental tour on 05/24/11, the administrative staff member (#2) agreed the chemicals and sharp knives should be locked up.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, facility	F 333		

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 _____	05/25/2011

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 13 nursing staff failed to administer the correct medication dosage to 1 of 1 resident (Resident #8) observed receiving Lasix (a diuretic) during medication pass. Findings include: Review of the facility policy titled "Administration of Medication" occurred on 05/25/11. This undated policy stated, "PURPOSE: . . . To administer medications correctly . . . PROCEDURE: 1. Using the specific facility's medication system, administer medication to the resident according to the 'Five Rights': Right drug, Right dose, Right route, Right time, Right resident . . . ." Observation of medication administration pass with a staff nurse (#8) occurred on 05/24/11 at 8:25 a.m. This nurse administered Lasix 40 milligrams (mg) to Resident #8. Resident #8's Medication Administration Record (MAR) for May 2011 stated "Lasix 40 mg PO [orally] q [every] AM." Resident #8's medical diagnoses included congestive heart failure, atrial fibrillation, diabetes and pulmonary hypertension. Review of Resident #8's current Physician Orders Sheet, included an order for Lasix which stated,"Order date [identifies the date the medication order originated], 04/14/11- Lasix 20 mg along w/ [with] 40 mg PO QD [everyday]." During interview on 05/24/11 at 11 a.m., a staff nurse (#8) confirmed the current physician order for Resident #8, as printed on the Physician	F 333	F- 333 The physician order for resident #8's Lasix was clarified on 5/24/11. All residents requiring drug changes have the potential to be affected should the facility fail to accurately record the order and transcribe it correctly to the Medication administration record. The facility policy titled "Administration of medication" was reviewed on 5/27/11. All Licensed nursing staff were inserviced on the policy on 6/8/11. The facility Night nurse each night shift will review and verify all orders received during the past 24 hours, to ensure accuracy. The MDS nurse or designee will randomly audit 4 charts per month to verify accuracy of physician orders against the Medication Administration Record. The results of the audits will be reported quarterly to the QA committee by the MDS nurse.	7/11/11

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 _____	05/25/2011

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 14 Orders Sheet, showed a total Lasix dosage of "60 mg every morning." This staff nurse confirmed the MAR incorrectly identified 40 mg. On 05/25/11 at 12:00 p.m., a staff nurse (#8) provided a hand-written physician order, dated 04/14/11 at 1:08 p.m. which identified "Lasix 20 mg along with Lasix 40 mg." A staff nurse (#8) stated Resident #8 "received 60 mg of Lasix for only four days." Review of Resident #8's April 2011 MAR showed the following hand-written entry of "04/14/11 Lasix 20 mg po along [with] 40 mg qd [everyday] [times] 4 days." Review of Resident #8's April 2011 MAR showed the resident received 60 mg from April 15-19 and 40 mg from April 20-30. The information printed on the April 2011 MAR conflicted with the hand-written physician order, dated 04/14/11, and with the current Physician Orders Sheet. On 05/24/11 at 5:00 p.m., the facility received a telephone order from Resident #8's physician which stated, "Clarification of Lasix order-Continue [with] Lasix 40 mg po Q AM. DC [discontinue] Lasix 20 mg along [with] 40 mg po QD." Nursing staff failed to follow the written physician's order, dated 04/14/11, pertaining to Lasix and administered the incorrect dose of Lasix to Resident #8 from April 20-May 24, 2011 (for a period of 35 days). This error had the potential to have a significant impact on Resident #8's health due to her medical diagnoses.	F 333		
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE	F 454		

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 _____	05/25/2011

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 454	Continued From page 15 The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to comply with Life Safety Code requirement NFPA 99 for Health Care Facilities to protect the health and safety of the residents, staff, and public regarding oxygen storage in 1 of 2 oxygen storage rooms (Whispering Winds). Failure to store the oxygen tank in a secure manner has the potential for the tank to fall and become a projectile missile potentially causing injury to residents, visitors, and staff. Findings include: Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with NFPA 99, 13-5.1, 7-1.2, NFPA 70." Standard for the Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 states "Securing Compressed Gas Containers Cylinders, and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and	F 454	F- 454 The oxygen canister in Whispering Winds was secured in the oxygen storage rack to ensure it could not be knocked over or tipped. Both oxygen storage rooms were inspected to verify proper storage of oxygen canisters. The facility policy for oxygen storage was reviewed on 5/27/11. All licensed and certified nursing staff were inserviced on the policy on 6/7 and 6/8/11. The Director of Maintenance or designee will do a weekly audit of oxygen storage for three months. If 100% compliance is achieved the audits will be done monthly for the next year. Results of the audits will be reported quarterly to the QA committee by the Director of Maintenance.	7/11/11

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 _____	05/25/2011

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 454	Continued From page 16 7.1.4.2.7." Review of the facility policy titled "Policy for Oxygen Storage" occurred on 05/25/11. The policy, undated, stated, "Purpose: To have oxygen at our residents [sic] disposal when needed, and ordered and to keep oxygen canisters safe. Procedure: . . . 2. All oxygen canisters will be kept in their holding containers at all times. On 05/24/11 at 4:50 p.m., observation showed a free-standing oxygen tank on the floor in the oxygen storage room on Whispering Winds household. The oxygen tank lacked any method of corralling or securing it. This storage room contained racks holding oxygen tanks. During an interview on 05/24/11 at 4:50 p.m., an administrative staff member (#2) and a maintenance staff member (#7) agreed the oxygen tank should be secured in a rack.	F 454		