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 _____	05/30/2019

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 started on 05/28/19 and concluded 05/30/19.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		6/28/19

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

Electronically Signed | 06/19/2019

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to provide care for 4 of 15 sampled residents (Resident #20, #22, #29, and #33) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors/announce themselves, and wait for permission prior to entering residents' rooms, does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: Review of the facility policy titled, "Quality of Life - Dignity" occurred on 5/30/19. This policy, revised October 2009, stated, ". . . Residents' private space and property shall be respected at all times . . . Staff will knock and request permission before entering residents' rooms. . ." Observations identified the following: * 05/28/19 at 1:57 p.m., An unidentified staff member knocked on the door as she was entering Resident #29's room and reported, "I need to check the calendar." The unidentified staff member entered the room without announcing herself or waiting for Resident #29's	F 550	F 550 All residents including Residents #20, #22, #29 and #33 have the potential to be affected should the facility fail to provide care in a manner and environment that maintains, enhances and respects each resident□s dignity and individuality. The facility policy quality of Life- Dignity was reviewed on 6/19/2019 all employees will be in-serviced on said policy on 6/19/2019. Starting on or before 6/24/19 the Director of Nursing(DON) or designee will conduct 5 random observations per week of staff entering resident rooms over the next three months, to ensure staff are promoting and maintaining resident dignity and privacy in accordance with the facility policy. If 100% compliance is achieved 10 observations will be done per month for the next three months. The Don will report findings of the observations to the QA committee on a quarterly basis. The observations will continue until 100% compliance has been achieved for 3 consecutive months and the QA committee deems the deficient practice has been corrected.	

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F 550	Continued From page 2 permission to enter. * 05/28/19 at 2:31 p.m., An unidentified staff member knocked on the door as she was entering Resident #22's room and reported, "I need to check something in the bathroom." The unidentified staff member entered the room without announcing herself or waiting for Resident #22's permission to enter. * On the morning of 05/29/19, two certified nursing assistants (CNAs) (#2 and #3) entered Resident #20 and #33's room without announcing themselves or waiting for either resident to give them permission to enter. * 05/29/19 at 9:57 a.m., Staff exited the bathroom after transferring Resident #33 onto the toilet, allowing him privacy while he had a bowel movement. A CNA (#2) picked up a washbasin and a box of gloves from the bedside table in Resident #33's room, knocked on the door as she entered the bathroom, and stated, "I just need to put these away." The CNA failed to wait for Resident #33's permission to enter.	F 550		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the	F 608		6/28/19

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F 608	Continued From page 3 State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to immediately report an injury of unknown origin to the administrator of the facility/the State survey and certification agency and failed to investigate the origin of the injury for 1 of 1 sampled resident (Resident #12) with bruising to the inner thigh. This failure placed all residents at risk of potential abuse. Findings include: Review of the facility policy titled "Resident Abuse and Reporting" occurred on 05/30/19. This policy, revised 06/10/00, stated, ". . . Any staff . . . witnessing or possessing reliable knowledge of any act (or suspected act) involving mistreatment, neglect, or abuse, including injuries of unknown origin where mistreatment, neglect, or abuse is suspected . . . must	F 608	F 608 All resident□s including resident #12 have the potential to affected should the facility fail to investigate injuries of unknown origin as a possible abuse that led to the injury. A complete investigation of the injury of unknown origin will be conducted and reported to the ND Dept. of health by 6/28/19. The facility policy Resident abuse and Reporting was reviewed on 6/13/2019. All facility staff will be in-serviced on said policy on 6/19/2019. beginning on or before 6/28/19, the Director of Nursing (DON) or designee will audit 5 residents and/or charts per week for one month to ensure that injuries are identified, investigated, and properly reported to the appropriate people or agencies. Should 100% compliance been	

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F 608	Continued From page 4 immediately notify the charge nurse. The charge nurse will immediately notify the Administrator, Social Service Designee, and/or Director of Nursing. The ND [North Dakota] Department of Health will also be notified immediately of reports of allegations of abuse and that an investigation is pending. . . ." Review of Resident #12's medical record occurred on May 28-30, 2019. The quarterly Minimum Data Set (MDS), dated 03/31/19, identified moderately impaired cognition and the need for extensive assistance from two or more staff members for bed mobility and transfers. The progress notes identified the following: * 3/12/19 at 12:11 p.m., "Observed large bruise to res.' [resident's] right inner thigh. Noted to center of bruise a large, hard, swollen painful lump. Res. hitting and pushing writer away while trying to observe and measure area. Noted. res. having increased difficulty standing d/t [due to] pain. Attempted to call res. POA [Power of Attorney]/wife to notify of findings - no answer, no voicemail set up on phone. MD [Physician] faxed to notify." * 3/13/2019 at 9:57 a.m., "Bruise to rt [right] thigh is exceeding mark from last pm. FMC [Family Medical Clinic] notified. Requested res to make appt. [appointment] this writer did notify res wife. She is refusing res to have anymore appt and labs. . . . notified . . ." * 3/17/2019 at 12:59 p.m., "Residents bruise to right inner thigh is improving at the top near groin, but has now spread to below the knee and behind the knee. Bruise has been marked with permanent marker and will monitor. Resident denies pain."	F 608	found the audits will be conducted on 5 resident□s per month. Results of the audits will be reported by the DON to QA committee on a quarterly basis. The audits will continue until such time that 100% compliance has been achieved for 2 consecutive quarters and the QA committee deems the deficient practice has been corrected.	

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F 608	Continued From page 5 On 05/30/19 at 12:30 pm, an administrative nurse (#1) confirmed the facility failed to report/investigate Resident #12's injury of unknown origin (bruising to the inner thigh). The administrative nurse (#1) stated, "Nursing thought the bruise was due to behaviors, not abuse. The nurse measured the bruise and contacted the doctor. I was not notified at the time." The administrative nurse (#1) confirmed the facility "should have reported this to the State." Failure to immediately report Resident #12's injuries of unknown origin (bruising to the inner thigh) to the Administrator of the facility and to the State survey and certification agency limited the facility's ability to ensure his safety and placed other residents at risk of potential abuse.	F 608		
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: §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	F 644		6/28/19

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F 644	Continued From page 6 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, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled residents (Resident #8) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with the resident's needs. Findings include: The North Dakota PASARR Provider Manual, page 13, stated, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC] was not identified at the Level 1 screen process, and condition later emerged to was discovered . . ." Review of Resident #8's medical record occurred on all days of survey, and identified an original PASARR completed on 12/13/16. The record	F 644	F644 A new screening was completed for resident #8 on 6/17/2019. PASSAR determined a Level II screening was not warranted due resident #8□s primary diagnosis of dementia. All residents with a possible serious mental disorder, intellectual disability or related condition have the potential to be affected should the facility to ensure a new screening is completed upon a significant change in status or the addition or change in diagnosis. All resident charts were reviewed on or before 6/18/2019 to ensure compliant screenings were completed. Beginning the week of 6/24/19 the Director of Social Services or designee will review the diagnosis associated with all new orders on a weekly basis for all resident□s to ensure a new screening has been completed upon a significant change in status or the addition of a new diagnosis. The Director of nursing or designee will audit 5 resident charts per week for the next three months to verify that if a diagnosis was added that would require a new screening that it was completed in a timely manner. If 100% compliance is achieved for three consecutive months the audits will be done on 3 residents per	

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F 644	Continued From page 7 showed Resident #8 received a new diagnosis of psychosis on 05/16/18, but lacked evidence the facility completed an updated Level I screening/change in status assessment following the new diagnosis. During an interview on 05/29/19 at 2:17 p.m., a social services staff member (#4) confirmed the facility failed to submit another PASARR for Resident #8 following the new diagnosis.	F 644	week for the next 3 months. The DON will report results of the audits to the QA committee on a quarterly basis. These audits will continue until 100% compliance is achieved and the QA committee deems the deficient practice is corrected.	