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 _____	06/14/2018

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 06/11/18 and concluded on 06/14/18.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to review and revise	F 657	Care Plans for residents #9, #22, #27, #30 and #32 were updated on 6/13/2018	7/17/18

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

Electronically Signed | 06/28/2018

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F 657	Continued From page 1 the comprehensive care plan to reflect the current status for 7 of 12 sampled residents (Resident #4, #9, #11, #22, #27, #30, and #32) related to assistive devices and Resident #27 for dialysis interventions. Failure to review and revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: - Observation on all days of survey showed Resident #4, #9, #11, #22, #27, #30, and #32 had assistive devices attached to their beds. Review of the care plans for the above listed residents showed the care plans failed to identify the presence, type, and purpose of the assistive devices. During an interview the afternoon of 06/14/18, an administrative staff member (#1) confirmed staff failed to update the residents' care plans to reflect the intended use of the assistive devices. - Review of Resident #27's medical record occurred on all days of survey. The current care plan stated, ". . . the resident needs dialysis (hemo) r/t [related to] renal [kidney] failure. . . Check and change dressing at access site. Document. Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis 3x [times] a week. Monitor labs and report to doctor as needed. Monitor/document report PRN [as needed] any s/sx [signs/symptoms] of infection to access site: Redness, swelling, warmth or drainage. . . ."	F 657	to identify the type and the purpose of assistive devices attached to their beds. Side-rails were removed from the beds of resident #4 and resident #11. All residents requiring the use of an assistive device attached to their bed have the potential to be affected should the facility fail to ensure proper care planning of said devices. The facility policy for bedrails was revised on 7/5/2018, All nursing staff will be in-serviced on said policy by the Director of Nursing on 7/17/2018. The MDS coordinator in conjunction with the interdisciplinary team shall be responsible to update care plans as changes are made in relation to bedrails and their use. The Director of Nursing or designee will audit 3 residents having attachments (assistive devices) on their beds per week for the next 2 months at which time the audits will be conducted on 4 residents per month for the next two quarters to ensure that the care plans reflect the purpose and type of devices. Results of the audits will be reported by the Director of Nursing at the quarterly facility QA meeting. The QA committee shall determine the need of continued audits and the frequency of those observations after two consecutive 100% compliant quarterly reviews. The Care Plan for resident #27 was updated to reflect the facilities responsibilities for interventions as it pertains to dialysis treatment as well as the arrangements for transportation to and from the dialysis clinic. This is the	

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F 657	Continued From page 2 The care plan failed to include interventions such as, transportation arrangements, which arm to use for blood pressure monitoring, who to contact for dialysis related emergencies, concerns, or complications, etc. During an interview the afternoon of 06/14/18, an administrative nurse (#1) confirmed Resident #27's care plan lacked specific treatment interventions for dialysis care.	F 657	only resident receiving dialysis services, hence the only potential resident to be affected by this deficient practice. The DON or Designee shall check monthly that the required information pertaining to dialysis treatment is included in the residents care plan. Results of the checks will be reported to the QA committee by the Director of Nursing on a quarterly basis.	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy	F 700	F700	7/9/18

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F 700	Continued From page 3 review, and staff interview, the facility failed to attempt appropriate alternatives to bed rails, assess resident safety with the use of bed rails, review risks and benefits with the resident/representative, and obtain informed consent prior to installation of a side/bed rail or a grab bar attached to the bed for 7 of 7 sampled residents (Resident #4, #9, #11, #22, #27, #30, and #32). These failures did not allow the resident/representative to make an informed decision. In addition, the bed rails increased the residents' risk of injuries. Findings include: Review of the facility policy titled "Proper Use of Side Rails" occurred on 06/14/18. This policy, revised October 2010, stated, ". . . General Guidelines: . . . 3. An assessment will be made to determine the resident's symptoms or reason for using side rails. . . . 7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. 8. The risks and benefits of side rails will be considered for each resident. 9. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks. . . . 10. The resident will be checked periodically for safety relative to side rail use. . . ." Observation throughout the survey identified rails/bars attached to the head of the bed for the following residents: * Resident #4 - grab bar on the right side of the bed * Resident #9 - grab bar on the left side of the bed * Resident #11 - one-half side rail on the right	F 700	Assessments were completed on residents #4, #9, #11, #22, #27, #30, and #32 on or before 7/3/2018, by nursing staff. The facility policy for bedrails was revised on 7/5/2018, All nursing staff will be in-serviced on said policy by the Director of Nursing on 7/17/2018. in the event a side rail is determined to be needed the charge nurse will complete the assessment and obtain consent for the device. The charge nurse will then notify the Director of Maintenance to install the device. The assessments will be conducted at each quarterly MDS review or with a significant change in resident condition by the Director of Nursing or designee. Side-rails determined to not be needed were removed from the beds of residents #4, #9 and #11. For residents #22, #27, #30, and #32, the assessments showed that the grab bars/side-rails were the least restrictive form yet increased the resident's mobility and independence. Alternatives were discussed and informed consent was given by each resident and/or family for those residents requiring the use of said devices. All residents requiring the use of a grab bar or side rail have the potential to be affected should the facility fail to conduct proper assessments and inform the resident of the risks versus benefits of having such devices attached to the bed. The DON or designee will perform observations of 4 random beds per week for the next 3 months looking for the presences of grab bars/side-rails. If one is present the	

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F 700	Continued From page 4 side of the bed * Resident #22 - grab bar on both sides of the bed * Resident #27 - half rail on the left side of the bed. * Resident #30 - grab bar on the right side of the bed. * Resident #32 - grab bar on both sides of the bed Review of the above listed residents' medical records occurred on all days of survey. The records lacked evidence staff attempted alternatives to the rails, completed an assessment for safety and appropriate use of the rails, explained the risks/benefits of the rails, including a risk of entrapment, or obtained consent from the resident/resident representative for the use of the side/bed rails or grab bars. During an interview on 06/13/18 at 2:30 p.m., an administrative nurse (#1) stated they do not complete assessments or obtain consents for bed rails.	F 700	observer will verify that an assessment has been completed and that consent for the device was obtained. Results of the observations will be reported by the DON at the facility quarterly QA meeting. The QA committee shall determine the need of continued observations and the frequency of those observations after two consecutive 100% compliant quarterly reviews.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of education records for twelve months and staff interview, the facility failed to	F 730	F730 Performance reviews will be completed	7/9/18

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F 730	Continued From page 5 provide twelve hours of in-service education per year for 2 of 2 certified nursing assistants (CNAs) (#2 and #3). Failure to provide twelve hours of in-service education per year to CNA's may result in staff being ill-prepared to provide care and services addressing special resident needs. Findings include: Review of education records for twelve months occurred on 06/14/18. The records showed the facility failed to provide twelve hours of in-service education for 2 CNA's (#2 and #3) reviewed. During an interview the afternoon of 06/14/18, an administrative nurse (#1) confirmed the facility failed to ensure the staff members were provided and/or completed twelve hours of in-service education yearly.	F 730	for all CNA's found to be delinquent in annual training requirements. In-service education will be provided on 6/28/2018 to successfully complete annual training requirements. All residents have the potential to be affected should the facility fail to ensure proper CNA education is completed on an annual basis. An audit of all CNA performance reviews and education was conducted to assure on-going competence including annual education requirements. The Director of Nursing or designee will provide a minimum of 12 hours of annual in-service education for all CNA's to include topics based on the performance reviews and our resident's needs. The Director of Nursing will conduct performance reviews for all CNA's during the month prior to their annual employment date to ensure 12 hours of education have been completed annually by each CNA. The facility Policy, "Required training, certification, and continuing education for Certified nursing assistants" was reviewed and revised on 7/9/2018, to include remedies up to and including termination for CNA's failing to comply. The Director of Nursing or designee will complete continuing education reviews on a semi-annual basis according to hire date. If a nurse aide is found to be out of compliance with education requirements, they will be allowed a 14-day period to become compliant. If unsuccessful, the nurse aide will not be allowed to perform the duties of a nurse aide until verification of such successful completion of	

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F 730	Continued From page 6	F 730	in-service training is obtained. The DON will report quarterly to the QA committee the CNA's who have had performance reviews, and if any of those individuals are causing the facility to be noncompliant with the continuing education requirement.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		7/9/18

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F 880	Continued From page 7 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced	F 880		

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F 880	Continued From page 8 by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 1 of 2 sampled residents (Resident #22) observed during a dressing change. Failure to perform hand hygiene at the appropriate steps of a dressing change has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 06/14/18. This policy, dated October 2009, stated, "Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: . . . * Before and after changing a dressing; . . . * After handling soiled or used linens, dressings, . . . * After removing gloves . . ." On 06/14/18 at 7:59 a.m., observation showed a nurse (#4) donned gloves, removed Resident #22's wound dressing, removed the gloves, and without performing hand hygiene donned new gloves. The nurse cleansed and measured the wound, removed the gloves, and without performing hand hygiene donned new gloves. The nurse then dressed the wound, removed the gloves, and washed her hands. During an interview on 06/14/18 at 8:37 a.m., an administrative nurse (#5) stated staff should perform hand hygiene after removing a dressing and before/after providing cares.	F 880	F880 Nurse #4 was immediately in-serviced on proper hand hygiene, by the infection control nurse. All residents have the potential to be affected should the facility fail to ensure proper hand washing is performed by all nursing staff. All nursing personnel were in-serviced on the facility policy “hand hygiene” on 6/27/2018. Each week for the next two months The DON or designee will complete random audits of 4 staff members performing hand hygiene, to ensure proper procedures are being followed. If 100% compliance is achieved the audits will then be done of 6 staff members performing hand hygiene per month for the next 4 months. Results of the observations will be reported by the DON at the facility quarterly QA meeting. If substantial compliance is obtained for 3 months (1 quarter) the QA committee shall determine if continued observations are necessary.	