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 _____	08/01/2023

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 07/30/23 and concluded 08/01/23.	F 000		
F 657 SS=D	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 record review, review of facility policy, and resident and staff interview, the facility failed	F 657	F657	8/25/23

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

Electronically Signed | 08/14/2023

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 657	Continued From page 1 to review and revise comprehensive care plans to reflect the current status for 2 of 12 sampled residents (Resident #13 and #16). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Plan - Comprehensive" occurred on 08/01/23. This undated policy stated, ". . . care plans are revised as information about the resident and the resident's condition change. . ." - During an interview on 07/30/23 at 2:19 p.m., Resident #13 stated, "They used to use the stand lift now they use the hoyer [full body mechanical lift] because they say the stand lift isn't safe." When asked when the change was made Resident #13 stated "about 3 weeks ago." Review of Resident #13's medical record occurred on all days of survey. The current care plan stated, ". . . I need assist of 2 staff to transfer in & [and] out of bed with the Standup lift. . . " A progress note dated 07/06/23, stated, ". . . transfer eval [evaluation] completed today with 2 CNAs [certified nurse aides] transferring pt [patient] with a standing lift. Concerns raised by staff re [regarding] safety of the lift for pt. . . . guidelines to use a standing lift pt needs to be able to bear weight thru LE [lower extremities] as well as have UE [upper extremities] strength. If these guidelines are not met then a standing lift not indicated and pt should be transferred via hoyer full body sling. Pt does not have adequate	F 657	It is the practice of Parkside Lutheran Home to ensure resident's comprehensive care plans are reviewed and revised to reflect the current status of the resident and to ensure continuity of care for each resident. Resident #13's care plan was reviewed and revised on 8/1/23 to include proper transfer status. All residents requiring assist with transfers could potentially be affected. All residents requiring assistance with transfers care plans will be reviewed and revised as needed on or before 8/14/23 to include the proper transfer status. Resident #16's care plan was reviewed and revised on 8/11/23 to include the diagnosis of Diabetes, insulin, blood glucose monitoring and diabetic nail care. All residents who have the diagnosis of diabetes could potentially be affected. All residents having the diagnosis of diabetes care plans will be reviewed and revised as needed on or before 8/18/23 and include diabetes diagnosis, insulin, blood glucose monitoring and diabetic nail care. Education will be provided to all professional nursing staff on 8/15/23 on timely care plan review and revision to reflect resident current plan of care and status. Comprehensive care plan policy will be reviewed on 8/15/23.	

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F 657	Continued From page 2 UE strength . . . He cannot appropriately and safely bear wt [weight] thru LE. . . ." During an interview on 08/01/23 at 5:00 p.m., administrative staff (#1 and #2) confirmed the change in transfer methods for Resident #13 due to safety concerns and agreed they expected the care plan to reflect the appropriate transfer method. - Review of Resident #16's medical record occurred on all days of survey and included a diagnosis of Diabetes Mellitus. The physician's orders included long and short-acting insulin, blood glucose monitoring, and diabetic nail care. Resident #16's current care plan lacked problem, goals and interventions related to diabetes mellitus. During an interview on 08/01/23 at 5:40 p.m., an administrative nurse (#1) confirmed staff failed to update Resident #16's care plan.	F 657	The MDS nurse and IDT shall be responsible to update care plans as changes occur and will be reviewed at a minimum of quarterly or the quarterly MDS, or with any admission/readmission, and any significant change. The Director of Nursing or designee will be responsible for auditing 5 random resident's comprehensive are plans. Audits will occur weekly x3 weeks then monthly x2 months. Results of monitoring will be reported at the facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results. Director of Nursing will be responsible to report audit results to quality assurance quarterly.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		9/1/23

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F 686	Continued From page 3 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment/services to promote the healing of pressure ulcers for 1 of 1 sampled resident (Resident #35) and 1 of 1 closed record (Resident #38) identified with a pressure ulcer. Failure to routinely assess, monitor, and measure pressure ulcers may result in delayed healing of the pressure ulcer. Findings include: Review of the facility policy titled "Pressure Sores - General" occurred on 08/01/23. This undated policy stated, ". . . 3. Document wound in IDP [interdisciplinary plan] notes and initiate a weekly pressure ulcer record; with all treatment recorded in the treatment sheets. . . . 8. All pressure sores with be monitored weekly by wound care nurse . . ." Review of the facility policy titled, "Skin Assessment" occurred on 08/01/23. This undated policy stated, ". . . 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission. . . and weekly there after. . . ." Review of Resident #35's medical record occurred on all days of survey. Medical diagnosis included a stage 4 pressure ulcer to the sacral region. The care plan stated, ". . . Follow facility policies/protocols for the prevention/treatment of	F 686	F686 It is the practice of Parkside Lutheran Home to ensure that residents receive care including routine assessment to prevent pressure ulcers and they do not develop pressure ulcers unless their clinical condition demonstrates that they were unavoidable. Staff will provide appropriate care and services to prevent injuries, promote healing and/or prevent the development of additional issues. Resident #35's care plan was reviewed on 8/14/23 and updated for current wound treatment/prevention interventions. Resident was evaluated at the wound clinic in Fargo on 8/1/23 orders/interventions carried out. Resident will have a follow up appointment in a month from this appointment Resident #38 no longer resides in the facility. All residents with current skin issues or identified at risk for skin issues could be affected by this deficient practice. Care plans will be reviewed and revised as needed on or before 8/18/23. Weekly skin audits will be completed and documented on all residents on their bath day by a licensed nurse.	

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F 686	Continued From page 4 skin breakdown. . . ." The medical record showed the facility staff completed a weekly wound record on 06/29/23 and again on 07/30/23, four weeks later. Review of Resident #38's medical record occurred on 08/01/23. Medical diagnosis included a stage 3 pressure ulcer to the sacral region. The care plan stated, " . . . Dressing change as ordered. . . Reposition every 2hrs [hours] or more freq [frequently]. . . When in bed position side to side. . . ." The medical record showed the facility staff completed a weekly wound record on 04/24/23 and again on 06/08/23, six weeks later. The facility staff failed to complete weekly pressure ulcer documentation for Resident's # 35 and #38. During interview on 08/01/23 at 5:45 p.m., an administrative nursing staff member (#1) stated she expected staff to follow facility policy and complete weekly wound records with measurements and documentation for all residents with pressure ulcers.	F 686	A Braden scale for prediction of pressure sore risk assessment will be completed and documented upon admission, readmission or with a significant change then weekly x3 and quarterly thereafter. Pressure sores – general policy and skin assessment policy will be reviewed with all professional nursing staff on 8/15/23. Education will be provided to all professional nursing staff regarding how to complete a head to toe body audit, skin observations, and the skin management program on 8/15/23. The Director of Nursing or designee will be responsible for auditing 3 random residents noted to have pressure ulcers, skin issues, and/or identified as at risk for pressure ulcers. Audits will occur weekly x3 weeks then monthly x2 months. Results of monitoring shall be reported at the facility quality assurance meeting with on-going frequency and duration to be determined by the IDT through analysis and review of audit results. Director of Nursing will be responsible to report audit results to quality assurance quarterly.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		9/1/23

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F 689	Continued From page 5 §483.25(d)(2)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 facility policy, and staff interview, the facility failed to provide adequate assistance for 1 of 1 sampled resident (Resident #17) observed during a sit-to-stand mechanical lift transfer and failed to provide adequate assistive devices for 1 of 8 sampled resident (#33) and one supplemental resident (#30) requiring staff assistance to transport/transfer. Failure to properly use the lift and use proper assistive devices placed the residents at risk for accidents with/without injury. Findings include: Review of the facility policy titled "WHEELCHAIR" occurred on 08/01/23. This undated policy, stated, ". . . PURPOSE: To provide safe and comfortable transportation for the sick and mobility impaired residents . . . Foot pedals if resident unable to propel per self. . . ." - Review of Resident #17's medical record occurred on all days of survey and included a diagnosis of dementia. The current care plan stated, ". . . I need assist of 2 to transfer & [and] use of lift . . ." Observations showed the following: * On 07/30/23 at 4:58 p.m., two certified nurse aides (CNAs) (#4 and #5) assisted Resident #17 from the recliner using the sit-to-stand lift. The CNA (#4) placed the resident's left hand on the	F 689	F689 It is the practice of Parkside Lutheran Home to provide all residents with a safe environment as free of accident hazards as possible. Resident #17 will be evaluated by therapy for safe transfer and handling on or before 8/18/23. Care plan of said resident will be reviewed as revised per therapy recommendations once evaluation is completed. All residents requiring assistance with transfers could be affected should the facility fail to ensure proper evaluation and transfer of residents. All care plans for residents requiring assistance with transfers will be reviewed and revised on or before 8/18/23. Mechanical lift policy will be reviewed will all nursing staff on or before 8/16/23. Resident #33's care plan will be reviewed and revised to include the use of foot pedals on wheelchair when assistance is needed for propelling on or before 8/18/23. Resident #30's care plan will be reviewed	

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F 689	Continued From page 6 lift's handle. Due to an adaptive device on the resident's right hand he could not hold onto the lift's handles. The resident did not bear weight and hung from the harness in a semi-seated position. As the harness straps pulled upward into the axillae, Resident #17's shoulders raised to ear level and elbows extended horizontally. * On 07/31/23 at 9:08 a.m., two CNAs (#8 and #9) assisted Resident #17 from the recliner to the toilet using the sit-to-stand lift. The CNA (#8) placed the resident's left hand on the lift's handle. Due to an adaptive device on the resident's right hand he could not hold onto the lift's handles. The resident did not bear weight and hung from the harness in a semi-seated position. As the harness straps pulled upward into the axillae, Resident #17's shoulders raised to ear level and elbows extended horizontally. * On 07/31/23 at 5:12 p.m., two CNAs (#6 and #7) assisted Resident #17 from the recliner to the toilet using the sit-to-stand lift. The CNA (#6) placed the resident's left hand on the lift's handle. Due to an adaptive device on the resident's right hand he could not hold onto the lift's handles. The resident did not bear weight and hung from the harness in a semi-seated position. As the harness straps pulled upward into the axillae, Resident #17's shoulders raised to ear level and elbows extended horizontally. - Review of Resident #33's medical record occurred on all days of survey. The current care plan stated, ". . . I use a w/c [wheelchair] for long distances with assist of 1 . . ." Observation on 07/31/23 at 9:51 a.m., showed a CNA (#3) transported Resident #33 in the wheelchair to the whirlpool room. The CNA cued	F 689	and revised to include the use of foot pedals on wheelchair when assistance is needed for propelling on or before 8/18/23. All residents who use a wheelchair primarily for locomotion could be affected should the facility fail to ensure proper use of foot pedals. All care plans for residents who use a wheelchair will be been reviewed and revised to include the use of foot pedals on wheelchair when assistance is needed for propelling on or before 8/18/23. Facility wheelchair policy will be reviewed with all staff on or before 8/16/23. Education will be provided to all nursing staff on the proper use and safety of mechanical lifts on or before 8/16/23. Education will be provided to all staff on the use of proper assistive devices during assistance when propelling a resident in a wheelchair on or before 8/16/23. The Director of Nursing or designee will be responsible for auditing 6 random residents noted to use mechanical lifts and/or use wheelchairs for propelling for proper use and safety. Audits will occur weekly x3 weeks then monthly x2 months. Results of monitoring shall be reported at the facility quality assurance meeting with on-going frequency and duration to be determined by the IDT through analysis and review of audit	

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F 689	Continued From page 7 the resident to lift her feet. The resident stated, "I can't." The CNA (#3) then pushed the resident from her room down the hallway while both feet slid along the surface of the floor, making an audible noise. The CNA failed to place foot pedals on Resident #33's wheelchair. Observation on 07/31/23 at 8:30 a.m., showed an unidentified activity aide transferred Resident #30 by wheelchair to the dining room. The wheelchair lacked foot pedals for Resident #30's feet. During an interview on 08/01/19 at 5:53 p.m., an administrative nurse (#1) agreed Resident #17 should not be hanging in a semi-seated position while using the sit-to-stand lift and stated she expected staff to use foot pedals for residents who needed assistance when transported in a wheelchair.	F 689	results. Director of Nursing will be responsible to report audit results to quality assurance quarterly.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 1 of 7 residents (Resident #10) observed during medication administration. Three medication errors occurred during staff administration of 37 medications, resulting in an 8% error rate. Failure to properly prepare and administer medications may result in residents	F 759	F759 It is the practice of Parkside Lutheran Home to properly prepare and administer medications ensuring that our medication error rate is less than 5%. Resident #10's care plan was reviewed and revised on 8/14/23 to include the	8/25/23

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F 759	Continued From page 8 receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 08/01/23. This policy, dated March 2021, stated, ". . . iii. Twist open and remove outer cover from safety pen needle. iv. Screw the pen safety needle onto the insulin pen. h. Prime the insulin pen: . . . ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. . . ." Review of Resident #10's medical record occurred on 08/01/23. Physician's orders included Humalog insulin pen 10 units with meals. Observation of medication administration on 08/01/23 at 8:45 a.m., showed a nurse (#2) prepared a Humalog insulin pen for Resident #10. The nurse (#2) wiped the tip of the insulin pen with an alcohol swab, applied a needle, and without removing the needle cap dialed the pen to two units and held the pen horizontally to prime the pen. Observation of medication administration on 08/01/23 at 12:30 p.m. for Resident #10, showed a nurse (#2) prepared a Humalog insulin pen. The nurse (#2) wiped the tip of the insulin pen with an alcohol swab, applied a needle, and without removing the needle cap dialed the pen to two units to prime the pen. The nurse failed to prime the insulin pens without	F 759	diagnosis of Diabetes, insulin administration, blood glucose monitoring and diabetic nail care. All residents who have the diagnosis of diabetes could potentially be affected by this deficient practice. All care plans of residents having the diagnosis of diabetes will be reviewed and revised on or before 8/18/23 to include diabetes diagnosis, insulin, blood glucose monitoring and diabetic nail care. Insulin Pen policy will be reviewed with all professional nursing staff on 8/15/23. Education will be provided for all professional nursing staff on 8/15/23 regarding proper policy and procedure for using an insulin pen including priming technique. The Director of Nursing or designee will be responsible for auditing 3 random residents requiring insulin administration for proper preparing the insulin and administering to the resident. Audits will occur weekly x3 weeks then monthly x2 months. Results of monitoring shall be reported at the facility quality assurance meeting with on-going frequency and duration to be determined through analysis and review of audit results. Director of Nursing will be responsible to report audit results to quality assurance quarterly.	

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F 759	Continued From page 9 removing the needle cap on two observations and failed to hold the insulin pen vertically. During an interview on 08/01/23 at 5:45 p.m., an administrative staff member (#1) confirmed the nurse failed to prime the insulin pens correctly.	F 759		