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 _____	08/08/2024

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 08/05/24 and concluded on 08/08/24.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to ensure care and services were provided according to accepted standards of quality for 1 of 2 sampled residents (Resident #5) observed during stand-pivot transfers. Failure to ensure staff place call lights within the resident's reach placed residents at risk for falls and/or injury. Findings include: Review of the policy titled "Answering the Call Light" occurred on 08/08/24. This policy, revised October 2010, stated, ". . . When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. . . ." - During interviews on 08/05/24 at 1:36 p.m. and 08/06/24 at 9:15 a.m., Resident #7 voiced her concerns regarding staff's interaction with her roommate (Resident #5). She stated, "She	F 558	F558 Resident #5 care plan was reviewed and revised on 8/30/24 to include ensuring the call light is within reach when she is in her room. All residents requiring assistance with toileting/transfers could potentially be affected should the facility fail to ensure that call lights are within reach. Care plans will be reviewed and revised as needed on or before 9/10/24 to include call light within reach when resident is their room. Call light policy was reviewed and education provided regarding call light placement with professional nursing staff on 9/3/24 and CNA staff on 9/4/24.	9/12/24

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

Electronically Signed | 09/04/2024

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F 558	Continued From page 1 [Resident #5] asks to go to the bathroom often. They tell her, 'You just went.' So many times, the light is not within her reach. At night, she'll call out and I turn on my light. What if I am not here?" - Observation on 08/05/24 at 1:40 p.m., showed Resident #5 sitting in her wheelchair with the call light attached to the bed, out of the resident's reach. Resident #5 stated, "I have to go to the bathroom. I'm looking for my call light." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, osteoarthritis, and history of left femur fracture. The care plan identified, ". . . I need assist for locomotion of w/c [wheelchair] . . . I need assist with transfers, assist prn [as needed] . . . " During an interview on the afternoon of 08/08/24, an administrative nurse (#3) confirmed she expected staff to ensure call lights are within reach of the residents.	F 558	The Director of Nursing or designee will be responsible for auditing 5 random resident rooms for call light placement. 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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		9/12/24

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F 623	Continued From page 2 accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which	F 623		

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F 623	Continued From page 3 receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as	F 623		

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F 623	Continued From page 4 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident or the resident's representative a written notice of transfer for 1 of 3 residents (Resident #8) reviewed for hospital transfer. Failure to provide a written copy of the transfer notice does not allow the resident and/or their representative to make an informed decision regarding their rights. Finding include: Review of Resident #8's medical record occurred on all days of survey and identified Resident #8 transferred to a hospital on 02/22/24. The medical record lacked documentation the facility provided the resident and/or representative with a written notice of transfer. During an interview on 08/08/24 at 11:17 a.m., an administrative staff member (#3) stated she expected staff to provide a notice of transfer to the resident and/or representative any time the resident is hospitalized.	F 623	F623 Resident #8 had a one-time procedure that included an overnight observation stay on 2/22/24 in which there was not a notice of transfer or discharge completed. No corrective action for this resident can occur due to the time that has lapsed since the procedure. All residents requiring transfer, discharge, or scheduled to have a procedure requiring an overnight stay in the hospital have the potential to be affected by this deficient practice. Education provided to professional nursing staff on 9/3/24 regarding notice of discharge or transfer for hospitalization. The Social Service Designee will be responsible for auditing 3 random residents who have transferred from the facility, been discharged from the facility, or are having a scheduled procedure that will include an overnight observation stay for notice of transfer and discharge. 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	

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F 623	Continued From page 5	F 623	by the IDT through analysis and review of audit results. Social Service Designee will be responsible to report audit results to quality assurance quarterly.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		9/12/24

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F 625	Continued From page 6 by: Based on record review and staff interview, the facility failed to provide the resident or the resident's representative a written notice of bed hold for 1 of 3 residents (Resident #8) reviewed for hospital transfer. Failure to provide a written copy of the bed hold notice does not allow the resident and/or their representative to make an informed decision regarding their rights. Finding include: Review of Resident #8's medical record occurred on all days of survey and identified Resident #8 transferred to a hospital on 02/22/24. The medical record lacked documentation the facility provided the resident and/or representative with a written bed hold notice. During an interview on 08/08/24 at 11:17 a.m., an administrative staff member (#3) stated she expected staff to provide a bed hold notice to the resident and/or representative any time the resident is out of the facility overnight.	F 625	F625 Resident #8 had a one-time procedure that included an overnight observation stay on 2/22/24 in which there was not a written bed hold notice completed. No corrective action for this resident can occur due to the time that has lapsed since the procedure. All residents requiring transfer, discharge, therapeutic leave or scheduled to have a procedure requiring an overnight stay in the hospital have the potential to be affected by this deficient practice. Education provided to professional nursing staff on 9/3/24 regarding bed hold notice. The Social Service Designee will be responsible for auditing 3 random residents who have transferred from the facility, been discharged from the facility, or are having a scheduled procedure that will include an overnight observation stay for bed hold notice. 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. Social Service Designee will be	

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F 625	Continued From page 7	F 625	responsible to report audit results to quality assurance quarterly.	
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 observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plans to reflect the current status for 1 of 13	F 657	F657	9/12/24

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F 657	Continued From page 8 sampled residents (Resident #5) and 2 supplemental residents (Resident #7 and #30). Failure to review and revise the care plans limited staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Planning - Interdisciplinary Team" occurred on 08/08/24. This policy, revised December 2008, stated, ". . . The care plan is based on the resident's comprehensive assessment and is developed by the Care Planning/Interdisciplinary Team . . . The resident, the resident's family and/or the resident's legal representative/guardian are encouraged to participate in the development of and revisions to the resident's care plan. . . ." - Review of Resident #5's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 05/29/24, identified Resident #5 received a diuretic medication. The current physician's orders showed she received Lasix (a diuretic medication) daily. Resident #5's care plan failed to address the use of a diuretic medication. - Review of Resident #7's medical record occurred on all days of survey. The quarterly MDS, dated 07/18/24, identified Resident #7 received an anticoagulant medication. The current physician's orders showed she received Eliquis (an anticoagulant medication) daily. Resident #7's care plan failed to address the use	F 657	Resident #5□s care plan was reviewed and revised on 8/27/24 to include diuretic medication. Resident #7□s care plan was reviewed and revised on 8/27/24 to include anticoagulant medication. Resident #30□s care plan was reviewed and revised on 8/30/24 to include antidepressant medication. All residents receiving high risk medication could potentially be affected by this deficient practice. All residents requiring high risk medication care plans will be reviewed and revised as needed on or before 9/10/24 to include the listed medication(s). Education will be provided to all professional nursing staff on 9/3/24 on timely care plan review and revision to reflect resident current plan of care and status. Comprehensive care plan policy will be reviewed on 9/3/24. 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. IDT to meet weekly to review care plans, resident medication list will be printed and compared to the care plan to ensure all high-risk medications are care planned.	

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F 657	Continued From page 9 of an anticoagulant medication. - Review of Resident #30's medical record occurred on all days of survey. The quarterly MDS, dated 06/10/24, identified Resident #30 received an antidepressant medication. The current physician's orders showed she received Mirtazapine (an antidepressant medication) daily. Resident #30's care plan failed to address the use of an antidepressant medication.	F 657	The Director of Nursing or designee will be responsible for auditing 3 random resident□s comprehensive care plans for high risk medications, side effects and adverse reactions. 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice regarding physician's orders for 1 of 1 sampled resident (Resident #139) with a catheter. Failure to ensure physician's orders are clearly understood, correctly transcribed, and entered in a timely manner may result in a resident receiving an inappropriate medication, test, treatment, and/or other intervention. Findings include:	F 658	F658 Resident 139 catheter order reactivated on 8/8/24. All residents with indwelling foley catheters could potentially be affected by this deficient practice. Order policy reviewed and education provided to professional nursing staff	9/12/24

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F 658	Continued From page 10 Review of the facility policy titled "Orders (Verbal, Written, Telephone)" occurred on 08/08/24. This policy, revised December 2008, stated, ". . . Orders may only be received by licensed personnel (RN [registered nurse], LPN [licensed practicing nurse]) . . . faxed orders from primary care providers . . . will be reviewed and electronically signed by the ordering provider . . ." Observation on 08/05/24 at 1:25 p.m. showed Resident #139 with a catheter bag under her wheelchair. Review of Resident #139's medical record occurred on all days of survey and identified a return from the hospital on dated 07/30/24 at 2:39 p.m. The care plan stated, ". . . I have a foley catheter . . ." The current physician's orders failed to include an order for Resident #139's foley catheter. During an interview on 08/07/24 at 2:40 p.m., an administrative nurse (#3) confirmed staff failed to enter an order for Resident #139's catheter. She indicated staff missed transcribing the order when Resident #139 returned from the hospital.	F 658	regarding timing, accuracy and ensuring orders received for services provided on 9/3/24. The Director of Nursing or designee will be responsible for auditing 3 random resident□s physician orders for accuracy. 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 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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		9/12/24

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F 689	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to properly utilize assistive devices necessary to prevent accidents and/or injury for 1 of 2 sampled residents (Resident #14) observed during stand-pivot transfers. Failure to utilize a gait-belt during stand-pivot transfers placed residents at risk for falls and/or injury. Findings include: Review of the policy titled "Gait Belts" occurred on 08/08/24. This undated policy stated, ". . . A gait belt will be utilized with all residents who require assistance with transfers and ambulation. . . . To ensure safety from injury for both resident and nursing staff . . . Place the gait belt around the resident's waist and snug enough so it won't slip up . . . Snug the gait belt as the resident stands . . ." - Observation on 08/05/24 at 1:40 p.m., showed a certified nurse aide (CNA) (#7) placed a gait belt around Resident #5's waist, tightened the belt, locked the brakes on the wheelchair, and assisted her to stand by pulling upward on the back of her pants. Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, osteoarthritis, and history of left femur fracture. The care plan identified, ". . . I need assist with transfers . . ." - Observation on the afternoon of 08/06/24 showed two CNAs (#7 and #8) toileted Resident	F 689	F689 A gait belt was assigned to resident #14 room for use during transfers 8/11/24. A gait belt was assigned to resident #5□s room for use during transfers 8/11/24. All residents requiring assistance with transfers could be affected by this deficient practice. All rooms will have gait belts assigned to them for use when transferring residents on or before 9/6/24. Gait belt policy will be reviewed and education provided on proper use of gait belt was completed on 9/3/24 for professional nursing staff and 9/4/24 for CNAs. The Director of Nursing or designee will be responsible for auditing 4 random residents for proper use of gait belt during transfers. 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.	

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	355116	A. BUILDING _____ B. WING _____	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE LUTHERAN HOME	501 3RD AVE W LISBON, ND 58054

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F 689	Continued From page 12 #14. One of the CNAs (#8) placed a gait belt around Resident #14's waist, tightened the belt, locked the brakes on the wheelchair, and assisted her to stand by pulling upward on the back of her pants. Review of Resident #14's medical record occurred on all days of survey. Diagnoses included abnormalities of gait/mobility, disorders of bone density/structure, right hemiplegia following a cerebral infarction, and severe vascular dementia. The care plan identified, ". . . I need assist of 1 to transfer . . ." During an interview on the afternoon of 08/08/24, an administrative nurse (#3) confirmed she expected staff to utilize a gait belt when transferring residents.	F 689		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assess residents with a history of trauma and identify known triggers for 1 of 1 sampled resident (Resident #33) reviewed for Post-Traumatic Stress Disorder (PTSD). Failure to ensure staff assess residents with PTSD upon	F 699	F699 Resident #33□s trauma screening was completed on 9/6/24. Resident #33□s care plan was updated to include triggers	9/12/24

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F 699	Continued From page 13 admission, identify known triggers, and provide appropriate person-centered treatment/services may result in re-traumatization. Findings include: The facility failed to provide a copy of a policy addressing PTSD. Review of Resident #33's medical record occurred on all days of survey. A psychiatry note, dated 06/04/24, identified, "[Resident #33] . . . with a complex psychiatric history whose previous diagnoses include . . . PTSD . . ." The medical record failed to include an assessment addressing past traumas. The current care plan identified, ". . . I have diagnosis of . . . PTSD . . . Observe for s/sx [signs/symptoms] of depression and/or anxiety . . . document all mood symptoms and report to CN [charge nurse]. . . ." The care plan failed to identify known triggers and/or list interventions the facility put in place to prevent re-traumatization. During an interview on 08/07/24 at 1:20 p.m., an administrative nurse (#3) confirmed staff failed to assess residents with PTSD, identify their known triggers, and/or list interventions they put in place to prevent re-traumatization.	F 699	and interventions to prevent re-traumatization on 9/6/24. All residents who have a history of trauma could potentially be affected by this deficient practice. All current residents will be screened for trauma history on or before 9/10/24. New admissions will be screened upon admission. All trauma screenings will be reviewed quarterly, a new screening will be completed should a resident have a new identified traumatic or life changing event. Social Service Designee will complete ACHA Trauma informed Care training on or before 9/10/24. The facility policy of Trauma informed Care was reviewed and education was provided on said policy to Professional nursing staff on 9/3/24 and Certified staff on 9/4/24. The Director of Nursing or designee will be responsible for auditing 4 random residents for trauma screening, care plan identifiers of triggers and interventions to prevent re-traumatization if needed. 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	

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F 699	Continued From page 14	F 699	report audit results to quality assurance quarterly.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		9/12/24

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F 758	Continued From page 15 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure each resident's entire drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being for 1 of 5 sampled residents (Resident #14) reviewed for unnecessary medications. Failure to complete an Abnormal Involuntary Movement Scale (AIMS) screening for any resident receiving an antipsychotic medication may result in the resident experiencing an adverse reaction to the medication such as tardive dyskinesia [an involuntary movement disorder]. Findings include: Review of the facility's policy titled "AIMS Screening" occurred on 08/08/24. This policy, revised 04/23/02, stated, ". . . It is the policy of Parkside Lutheran Home to do an AIMS screening on all residents using a neruoleptic (Antipsychotic) and other specified medications. .	F 758	F758 Resident #16□s AIMS screening was completed on 8/30/24. All residents who are currently using antipsychotic medications could potentially be affected by this deficient practice. All residents using antipsychotic medications will be reviewed for current AIMS screening and a new screening will be completed if needed on or before 9/10/24. AIMS screening will be completed on all residents requiring such screenings at a minimum of every 6 months or with any medication change. Facility AIMS screening policy was reviewed and education provided on frequency of screening at professional nurses meeting on 9/3/24.	

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F 758	Continued From page 16 . AIMS screening . . . shall be the testing tool used to assess the absence or presence of tardive dyskinesia . . . While resident continues med [medication], testing shall be done every 6 months. . . ." Review of Resident #14's medical record occurred on all days of survey. The current physician's orders revealed Resident #14 received the antipsychotic medication Abilify daily for major depression and psychosis. The care plan stated, ". . . Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects . . . adverse reactions of PSYCHOTROPIC medications . . . tardive dyskinesia . . ." An AIMS, dated 07/07/23, identified no abnormal facial, trunk, or extremity movements at the time of the assessment. The medical record failed to include a January 2024 and July 2024 re-assessment. During an interview on the afternoon of 08/08/24, an administrative nurse (#3) confirmed she expected staff to reassess any resident receiving an antipsychotic medication every six months.	F 758	The Director of Nursing or designee will be responsible for auditing 2 random resident charts for AIMS screening completed every 6 months or with a medication change. 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 880 SS=E	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.	F 880		9/12/24

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F 880	Continued From page 17 §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 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	F 880		

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F 880	Continued From page 18 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 by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 5 of 13 sampled residents (Resident #11, #14, #25, #90, and #139) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions, urinary catheters, and hand hygiene has the potential to spread infection throughout the facility. Findings include: ENHANCED BARRIER PRECAUTIONS Review of the facility's policy titled "Enhanced Barrier Precautions" occurred on 08/08/24. This	F 880	F880 Resident #11□s record was reviewed and enhanced barrier precautions was deemed necessary on 8/9/24. PPE placed outside of resident room so it is readily available on 8/9/2 for use when providing high-contact care activities. Resident #90 no longer resides in the facility. Resident #139□s record was reviewed and enhanced barrier precautions was deemed necessary on 8/9/24. PPE placed outside of resident room so it is	

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F 880	Continued From page 19 undated policy stated, ". . . 'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and gloves [sic] use during high contact resident care activities. . . . An order for enhanced barrier precautions will be obtained for residents with any of the following . . . Wounds . . . chronic venous stasis ulcers . . . and/or indwelling medical devices . . . feeding tubes . . . catheters . . . even if the resident is not known to be infected or colonized with a MDRO . . . Make gowns and gloves available immediately near or outside of the resident's room. . . . PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities . . . High-contact resident care activities include . . . Device care or use . . . feeding tubes . . . urinary catheters . . . Wound care: any skin opening requiring a dressing . . ." - Review of Resident #11's medical record occurred all days of survey. The medical record identified the following physician's orders for stasis ulcer dressing changes: * 03/28/24, "Left Lower ankle wound one time a day for leg wound Wash w [with]/soap, water, and washcloth; Promogran [type of wound treatment] in wound; cover w/gauze pad and hold with rolled gauze." * 03/28/24, "Right Lower Leg Wounds-daily one time a day for Wounds r/t [related to] Cellulitis of Rt LE [right lower extremity] Change daily; wash w/soap & H2O [water], protective oint [ointment] to lower leg, promogran to wounds--roll between fingers & poke into wounds w/Q tip; cover w/gauze & [and] tubigrip [a multi-purpose, elastic	F 880	readily available on 8/9/2 for use when providing high-contact care activities. Care plan reviewed and updated to include proper catheter care on 9/3/24. All residents who are identified as having wounds and/or indwelling medical devices could potentially be affected by this deficient practice. All residents meeting the above criteria were identified as of 8/9/24 and proper PPE placed for use in resident□s rooms. Enhanced barrier policy reviewed and education provided when PPE is required at the professional nurses meeting on 9/3/24 and the CNA meeting on 9/4/24. Catheter Care policy reviewed and education provided on proper steps of catheter care at the CNA meeting on 9/4/24. Hand hygiene policy reviewed and education provided on proper hand hygiene at the CNA meeting on 9/4/24. The Infection Preventionist or designee will be responsible for auditing 2 random residents for proper enhanced barrier precautions in place. 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.	

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F 880	Continued From page 20 tubular bandage] size F single layer from toes to knees for compression; may wear at noc [night] if comfortable." * 07/24/24, "Flush R [right] Hip wound with saline jet twice daily as needed. Poke & gently pack 14 inch idofor [sic] packing strip into deep tunneling (2.5cm) into wound with end of qtip [sic]. do not over stuff. Cover with gauze and tape as desired. two times a day for R groin wound." Observation on all days of survey showed Resident #11 with dressings to both lower extremities. The facility failed to place Resident #11 on EBP and failed to make PPE readily available to staff. During an interview on 08/08/24 at 10:40 a.m., a nurse (#6) reported gloves are commonly used when changing Resident #11's dressings. She further stated staff will wear a gown, gloves, mask, and eye protection if the facility suspects something [due to reddened skin or drainage]. - Review of Resident #90's medical record occurred all days of survey. The medical record indicated Resident #90 had an indwelling medical device - a feeding tube. Observation on 08/07/24 at 11:42 a.m. showed a nurse (#6) donned gloves and then flushed Resident #90's feeding tube. The facility failed to place Resident #90 on EBP and failed to make PPE readily available to staff. - Review of Resident #139's medical record occurred all days of survey. The medical record indicated Resident #139 had an indwelling medical device - a urinary catheter.	F 880	The infection preventionist or designee will be responsible for auditing 4 random CNAs for proper catheter care. 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. The infection preventionist or designee will be responsible for auditing 4 random CNAs for proper hand hygiene. 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. Infection Preventionist will be responsible to report audit results to quality assurance quarterly.	

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F 880	Continued From page 21 Observation on 08/06/24 at 10:57 a.m. showed a certified nurse aide (CNA) (#9) donned gloves and performed Resident #139's catheter cares. The facility failed to place Resident #139 on EBP and failed to make PPE readily available to staff. During an interview on 08/08/24 at 11:17 a.m., an administrative nurse (#3) confirmed residents with an indwelling medical device need to be placed on EBP. CATHETER CARES/HAND HYGIENE Review of the facility's policy titled "Catheter Care, Urinary" occurred on 08/08/24. This policy, revised October 2010, stated, ". . . Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. . . . Be sure the catheter tubing and drainage bag are kept off the floor. . . ." Review of the facility's policy titled "Hand Hygiene" occurred on 08/08/24. This undated policy 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 assisting a resident with toileting . . . After handling soiled equipment . . . After removing gloves . . ." Observations showed the following: * 08/05/24 at 1:25 p.m., two CNAs (#7 and #10) donned gloves and laid Resident #139's urinary drainage bag on the floor while they placed the sling around the resident and attached it to the full body lift. The CNAs failed to keep the urinary	F 880		

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F 880	Continued From page 22 drainage bag off the floor. * 08/06/24 at 10:57 a.m., a CNA (#9) donned gloves, drained Resident #139's urinary drainage bag, sanitized the drainage port, reconnected the tubing to the bag, and removed his gloves. Without performing hand hygiene, the CNA (#9) donned gloves and attempted to place the urinary drainage bag into a privacy bag. When the drainage bag got caught under the wheelchair, the CNA (#9) disconnected the drainage tube from the bag, dropped the end of the tube on the floor, picked it up, and reconnected it to the bag without sanitizing the end. Without performing hand hygiene, the CNA (#9) donned gloves, disconnected, sanitized, and reconnected the end of the tube to the bag, removed his gloves, and washed his hands prior to exiting the room. The CNA failed to keep the catheter bag and tubing off the floor, failed to sanitize the end of the tube prior to reconnecting it to the bag, and failed to sanitize his hands after handling soiled equipment. * On the afternoon of 08/06/24, two CNAs (#7 and #8) donned gloves and transferred Resident #14 into the bathroom. After the resident voided, one of the CNAs (#8) performed peri-cares, removed her gloves, transferred the resident into the wheelchair and then into bed, covered her with a blanket, placed the call light within reach, and exited the room without performing hand hygiene. The CNA (#8) failed to sanitize her hands after providing toileting cares and prior to exiting the room. * 08/06/24 at 4:20 p.m., two CNAs (#7 and #8) donned gloves and transferred Resident #25 into the bathroom. After the resident voided, one of the CNAs (#8) performed peri-cares, removed her gloves, transferred the resident into the	F 880		