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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 27221 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 [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.

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.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 13101 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 .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 13101 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13101 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 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 [DATE], 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 [DATE], 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 of an anticoagulant medication. - Review of Resident #30's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], 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. 27221

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 27221 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: 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 27221 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 #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.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 27221 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 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.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 27221 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. 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 13101 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 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 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]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 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. 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 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* 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 wheelchair, and without performing hand hygiene, placed the call light within reach. The CNA failed to sanitize her hands after providing toileting cares and prior to performing other tasks. 27221 47896