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	12/11/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 5 of 12 sampled residents (Resident #2, #4, #5, #8, and #41). Failure to update care plans limited the 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 12/10/25. This policy, revised in December 2008, stated, . Each resident's comprehensive care plan is designed to: Incorporate identified problem areas; Incorporate risk factors . Reflect treatment goals . objectives . Aid in preventing or reducing declines in the resident's functional status . assessments of resident are ongoing, and care plans are revised as information about the resident and the resident's condition change. Review of the facility policy titled Smoking - Residents occurred on 12/11/25. This policy, revised April 2012, stated, . Any smoking-related privileges, restrictions, and concerns . shall be noted on the care plan . - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included atypical facial pain, low back pain, polyosteoarthritis, and generalized abdominal pain. The admission Minimum Data Set (MDS), dated [DATE], indicated moderate and frequent pain. Current physician's orders identified acetaminophen (a pain reliever) used for pain. Resident #2's care plan failed to include problems, goals, and interventions for pain management. During an interview on 12/11/2025 at 2:45 p.m., an administrative nurse (#1) confirmed staff failed to update resident #2 care plan. - Review of Resident #4's medical record occurred on all days of survey. Urinary tract infections (UTI) were identified on 12/16/24, 1/28/25, 7/8/25, 9/15/25, 10/20/25, and 11/28/25. Resident #4's care plan failed to include problems, goals, and interventions for chronic urinary tract infections. During an interview on 12/11/25 at 2:41 p.m., an administrative nurse (#1) confirmed staff failed to revise Resident #4's care plan. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included left hip pain and other chronic pain. The significant change MDS, dated [DATE], identified pain almost (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	constantly. Physician's orders included acetaminophen, Gabapentin (an anticonvulsant used to manage nerve pain), and Advil (a pain reliever) as needed for pain. A smoking assessment, dated 10/23/25, indicated Resident #5 as, safe to smoke without supervision. Resident has not been returning cigarettes to nurse each time she comes back from smoking like she has been told to. The progress notes, dated October 18-22, 2025, identified Resident #5 failed to obtain her cigarettes from the nurse and/or turn them in after each smoking episode. Staff explained this was a violation of their safe smoking privileges and a safety concern that may result in her smoking privileges being revoked. Resident #5's care plan failed to include problems, goals, and interventions addressing pain management and behaviors related to smoking. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included tobacco use. A smoking assessment, dated 12/21/24, stated, . He often times will not follow the policy/rules on where to smoke or returning his smoking materials to the nurse after he is done. Resident is safe to smoke but needs to be reminded of rules/policy around his smoking materials. Resident #8's care plan related to smoking failed to address behaviors related to smoking. - Review of Resident #41's medical record occurred on all days of survey. Diagnoses included ileostomy (a surgical created opening that allows stool and gas to exit). The care plan stated identified the presence of a colostomy (similar to an ileostomy). A progress note, dated 11/28/2025, stated, Res [Resident] returned to facility from medical stay at [name of hospital]. Res underwent ileostomy reversal . Resident #41's care plan failed to identify the ileostomy reversal. During an interview on 12/11/2025 at 2:45 p.m., an administrative nurse (#1) confirmed staff failed to update resident #41's care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure safe food practices and failed to maintain a clean and sanitary kitchen environment for 1 of 1 kitchen and 2 of 2 freezers on the Cozy Cottage Unit. Failure to properly store food items and maintain a clean and sanitary kitchen, food preparation, and storage areas has the potential for contamination of food and may result in a foodborne illness to residents, visitors, and staff. Findings Include: The 2022 Food and Drug Administration (FDA) Food Code, Chapter 3-16, Section 3-305.11 Food Storage, stated, . FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . Annex 3 Page 100, stated, . 3-305.12 Food Storage, Prohibited Areas. Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate . can be sources of microbial contamination for stored food. Chapter 4-6, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, stated, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. Review of the facility policy Food Storage occurred on 12/10/25. This policy, revised January 2004, stated, . Staff foods/fluids will not be stored in the kitchen refrigerator/freezer . Observation on 12/08/25 at 11:45 a.m. with a dietary manager (#3) showed an accumulation of food/dirt/grime debris in the following areas in the kitchen; * The entire kitchen floor, the tiled baseboards on the wall, the grate of the ice machine, the grate below the front door of the reach-in refrigerator and freezer, and on the large flour and sugar containers.* All kitchen walls contained splashes of food particles with areas of a sticky yellow substance.* The walk-in cooler showed food storage racks had surface material peeling, coated with a dirt/rust or grime substance, and employee food items stored alongside resident food items.* The walk-in freezer showed the condenser line with thick ice and frost built up. Ice droplets formed in front of the ceiling fan and the ice particles, 2-inch-wide by 8-inch-long, dropped onto a package of food under the fan. Observation on 12/08/25 at 1:00 p.m. showed cold packs for resident use stored next to food items in the freezer on Cozy Cottage Unit. Observation of the kitchen on 12/10/25 at 12:34 p.m. with a dietary manager (#3) showed the following:* The base of a blender covered with food particles and a sticky substance.*Two beverage cup carts covered with dirt/debris.* A package of fried steak and a bag of cooked shrimp touched the ceiling in the walk-in freezer. During an interview on 12/10/25 at 12:34 p.m., the administrative dietary manager (#3) confirmed the kitchen needed thorough cleaning and understood the potential for food contamination.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, review of facility policy, and staff interviews, the facility failed to identify an incident of verbal abuse for 1 of 1 sampled resident (Resident #8) who was subjected to name calling and sworn at by a staff member. Failure to ensure residents were free from verbal abuse resulted in Resident #8's experiencing emotional distress and placed him and other vulnerable residents at risk of potential and/or continued verbal abuse.Findings include:Review of the facility policy Resident Abuse and Reporting occurred on 12/11/25. This policy, revised on 04/16/24, stated, . The resident has the right to be free from verbal . abuse . Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff . Verbal Abuse: Refers to any use of oral . language that includes disparaging and derogatory terms directed towards residents . regardless of their age, ability to comprehend, or disability. If abuse is witnessed . By the charge nurse or any member of the management team, the Administrator by means of this policy authorizes them to immediately suspend the employee which was seen abusing a resident.Review of Resident #8's medical record occurred on all days of survey. Diagnoses included anxiety, history of traumatic brain injury, major depressive disorder, and unspecified psychosis. The current care plan stated the following, . Observe for s/sx [signs/symptoms] of depression and/or anxiety (IE: . agitation . etc) document and report to CN [charge nurse] . Offer emotional support . I receive counseling through [name of clinic] every 2 wks [weeks] .A memo, dated 11/11/25 at 8:30 a.m., stated, . Writer heard hollering and banging coming from CC [Cozy Cottage Unit] DR [dining room], [Resident #8] and [certified nurse aide (CNA) (#2)] were having a loud disagreement. Alot of name calling and swearing going back and forth. Writer removed res [resident] from DR and CN visited with CNA. [Resident #8] was very upset with [CNA (#2)], he couldn't really explain how it started, but he wanted coffee.Another memo, dated 11/11/25, stated, During the meeting with [CNA (#2)], she stated that she was . waiting to serve breakfast to the residents . she glanced at her phone . and resident [#8] 'went off.' She was angry and started arguing back with him. She stated in hind sight [sic] she should have walked away from him and not engaged. She knows that it was wrong to have responded but he was calling her horrible names and using the 'N' [explicit content] word. I [Administrative Nurse (#1)] informed her that the correct action would have been to ensure that he was safe and walk away.The 24-hour reports showed CNA (#2) was assigned to care for Resident #8 on November 11th, 13th, December 4th, and 8th, 2025.During an interview on 12/10/25 at 4:00 p.m., an administrative nurse (#1) indicated she did not report the incident to the State due to the fact the resident and staff member were immediately separated. She later conceded that the CNA's behavior met the definition of verbal abuse.During an interview on 12/11/25 at 10:53 a.m., Resident #8 stated, I don't like that one girl [CNA (#2)].The facility failed to recognize a loud disagreement, name calling, and swearing as verbal abuse and protect Resident #2 during the investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, review of facility policy, and staff interviews, the facility failed to immediately report an incident of verbal abuse for 1 of 1 sampled resident (Resident #8) subjected to name calling and sworn at by a staff member. Failure to report the incident to the state survey agency (SSA) placed Resident #8 and other vulnerable residents at risk of potential and/or continued verbal abuse. Findings include:Review of the facility policy Resident Abuse and Reporting occurred on 12/11/25. This policy, revised on 04/16/24, stated, . Any staff . witnessing . any act . involving mistreatment . or abuse . must immediately notify the charge nurse. The charge nurse will immediately notify the Administrator, Social Services Designee and/or Director of Nursing. The ND Department of Health will also be notified of reports of allegations of abuse and that an investigation is pending. The facility will notify the ND Department of Health the results of the investigation with [sic] 5 working days. A memo, dated 11/11/25 at 8:30 a.m., stated, . Writer heard hollering and banging coming from CC [Cozy Cottage Unit] DR [dining room], [Resident #8] and [certified nurse aide (CNA) (#2)] were having a loud disagreement. Alot of name calling and swearing going back and forth. Writer removed res [resident] from DR and CN [charge nurse] visited with CNA. [Resident #8] was very upset with [CNA (#2)], he couldn't really explain how it started, but he wanted coffee. Another memo, dated 11/11/25, stated, During the meeting with [CNA (#2)], she stated that she was . waiting to serve breakfast to the residents . she glanced at her phone . and resident [#8] 'went off.' She was angry and started arguing back with him. She stated in hind sight [sic] she should have walked away from him and not engaged. She knows that it was wrong to have responded but he was calling her horrible names and using the 'N' [explicit content] word. I [Administrative Nurse (#1)] informed her that the correct action would have been to ensure that he was safe and walk away.During an interview on 12/10/25 at 4:00 p.m., an administrative nurse (#1) indicated she did not report the incident to the state.The facility failed to recognize a loud disagreement, name calling, and swearing as verbal abuse and report the allegation to the SSA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and review of facility policy, the facility failed to investigate an incident of verbal abuse for 1 of 1 sampled resident (Resident #8) who was subjected to name calling and sworn at by a staff member. Failure to thoroughly investigate the incident placed Resident #8 and other vulnerable residents at risk of potential and/or continued verbal abuse. Findings include:Review of the facility policy Resident Abuse and Reporting occurred on 12/11/25. This policy, revised on 04/16/24, stated, . All allegations must be thoroughly investigated by the designated department managers under the general direction of the Administrator. This may include, but is not limited to, interviewing all persons associated with the situation . The investigators will complete a written report and forward it to the Administrator or designee within 48 hours. A memo, dated 11/11/25 at 8:30 a.m., stated, . Writer heard hollering and banging coming from CC [Cozy Cottage Unit] DR [dining room], [Resident #8] and [certified nurse aide (CNA) (#2)] were having a loud disagreement. Alot of name calling and swearing going back and forth. Writer removed res [resident] from DR and CN [charge nurse] visited with CNA. [Resident #8] was very upset with [CNA (#2)], he couldn't really explain how it started, but he wanted coffee.Another memo, dated 11/11/25, stated, During the meeting with [CNA (#2)], she stated that she was . waiting to serve breakfast to the residents . she glanced at her phone . and resident [#8] 'went off.' She was angry and started arguing back with him. She stated in hind sight [sic] she should have walked away from him and not engaged. She knows that it was wrong to have responded but he was calling her horrible names and using the 'N' [explicit content] word. I [Administrative Nurse (#1)] informed her that the correct action would have been to ensure that he was safe and walk away.The facility failed to recognize a loud disagreement, name calling, and swearing as verbal abuse and failed to thoroughly investigate the incident, including interviewing other staff members and residents who were present in the dining room at the time of the incident.

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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. Based on observation, record review, policy review, and staff interview, the facility failed to provide medication in accordance with professional standards for 1 of 1 resident (Resident #31) with a percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted through the skin and abdominal wall directly into the stomach) observed during medication administration. Failure to accurately transcribe provider's orders may result in adverse health effects. Findings include:Review of the facility policy titled, Physician Orders/Transcribing for New and re-admitted Residents occurred on 12/11/25. This undated policy, stated, . Each medication order must have a route, dose, frequency and related diagnosis. The nurse who received the orders, checks that all of the above have been followed through . A second nurse will check all the orders written in the computer to the orders received from the MD [medical doctor] and queue that they are correct.Review of Resident #31's medical record occurred on all days of survey and identified a PEG placement. A physician order, dated 12/08/25, included Morphine concentrate (a pain medication), administer buccally (area inside the mouth between the cheek and the gums) or per peg tube for pain or dyspnea.Review of Resident #31's December 2025 medication administration record (MAR) occurred on 12/10/25. The order entered on the MAR, dated 12/08/25, identified the route of administration as buccal and failed to include via PEG tube. Observation on 12/10/25 at 1:30 p.m. showed a nurse (#7) administered morphine through Resident #31's PEG tube. This administration route did not match the transcribed order in the MAR. During an interview on 12/11/25 at 2:45 p.m., an administrative nurse (#1) confirmed staff failed to transcribe the order accurately in the MAR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services for 1 of 1 sampled resident (Resident #2) with a pressure ulcer. Failure to complete weekly assessments with measurements of pressure ulcers per facility policy, may result in new pressure ulcers, the deterioration of existing pressure ulcers, and delay healing.Findings include: Review of the facility policy titled Documentation of Wound Treatments occurred on 12/11/25. This undated policy, stated, . Wound assessments are documented upon admission, weekly, and as needed . The following elements are documented as part of a complete wound assessment: a. Type of wound . Stage of the wound . Measurements: height, width, depth . Description of wound characteristics . Weekly progress towards healing .Review of Resident #2's medical record occurred on all days of survey and identified a Stage 3 pressure ulcer to the right heel. Wound clinic assessments of Resident #2's right heel pressure injury showed the following:* 11/06/25 - 0.4 centimeter (cm) x 0.4 cm* 12/05/25 - 0.8 cm x 1 cm (29 days later) The medical record lacked weekly wound assessments of the right heel pressure ulcer with measurements. During interviews on 12/11/25 at 11:11 a.m. and 2:45 p.m., an administrative nurse (#1) confirmed Resident #2's medical record lacked weekly wound assessments and she expected staff to complete weekly wound assessments per wound treatment policy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, review of a professional reference, and staff interview, the facility failed to provide appropriate toileting for 1 of 2 sampled residents (Resident #31) who required staff assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and at risk for falls and/or injuries. Findings include:Review of the facility policy titled Incontinence occurred on 12/11/25. This undated policy, stated, . Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.Review of Resident #31's medical record occurred on all days of survey and included a diagnosis of cerebral infarction (stroke) and Alzheimer's disease. The Minimum Data Set (MDS), dated [DATE], identified substantial/maximal assistance with toileting, frequently incontinent of urine and occasionally incontinent of bowel. The care plan, dated 11/26/25, stated, . I need assistance with toileting.A nurse's note, dated 12/06/25 at 5:36 a.m., stated, . During toileting cares Resident urine has strong odor.Review of Resident 31's bladder elimination task record, dated November 27 through December 10, 2025, showed a toileting gap of three or more hours each day. November 27, 2025, showed an eight-hour toileting gap from 1:07 p.m. to 9:10 p.m., and December 2, 2025, showed an eight-hour toileting gap from 3:26 p.m. to 11:49 p.m.Observation on all days of survey identified a urine odor in Resident #31's room.Observation on 12/10/25 11:17 a.m. showed a certified nurse aide (CNA) (#2) assisted Resident #31 out of her and to the toilet. Resident #31's pants were visibly wet and smelled of urine and feces. The CNA (#2) removed the soiled pants and brief, completed perineal cares, applied a new incontinence brief and pants, and transferred Resident #31 to the recliner visibly wet from urine. The CNA (#2) failed to provide timely toileting assistance and failed to ensure a clean recliner.During interviews on 12/11/25 at 11:11 a.m. and 2:45 p.m., an administrative nurse (#1) stated she expected staff to assist residents with toileting needs every two to three hours and as needed unless they are independent with toileting, replace the wet recliner while the soiled recliner is cleaned, and at least a place a barrier between the resident and a wet recliner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 2 residents (Resident #2 and #31) in enhanced barrier precautions (EBP). Failure to practice infection control standards related to EBP and hand hygiene has the potential to spread infection throughout the facility. Findings include:Review of the facility policy titled Enhanced Barrier Precautions occurred on 12/11/25. This policy stated, . Initiation of Enhanced Barrier Precautions: . An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds . and/or indwelling medical devices . Implementation of Enhanced Barrier Precautions: . PPE (Personal Protective Equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact resident care activities include: . c. Transferring. d. Providing hygiene. f. Changing briefs or assisting with toileting. g. Device care or use: . feeding tubes . Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.Review of the facility policy titled Hand Hygiene occurred on 12/11/25. This policy, dated 10/2009, stated, . situations that require hand hygiene: . before and after resident contact . before and after handling peripheral vascular catheters and other invasive devices . before and after assisting a resident with toileting . after removing gloves . - Review of Resident #2's medical record occurred on all days of survey. The physician's orders, dated 10/01/25, stated, Advanced Barrier Precautions every shift .Observation on 12/08/25 at 2:01 p.m. showed two certified nurse aides (CNAs #5 and #6), performed hand hygiene, applied gloves, and without applying gowns, transferred Resident #2 from the wheelchair to the toilet using a mechanical lift, and assisted with toileting needs. The CNAs failed to apply gowns as per the EBP policy.- Review of Resident #31's medical records occurred on all days of survey. The physician's orders, dated 11/25/25, stated, Enhanced Barrier Precautions .Observation on 12/10/25 at 11:17 a.m. showed the CNA (#2) applied gloves, and without applying a gown assisted Resident #31 to the toilet. After completing perineal care, the CNA removed the soiled gloves and assisted the resident back to the recliner. Without performing hand hygiene, the CNA applied clean gloves, took garbage and dirty clothing bags down the hallway and placed them in appropriate bins. The CNA (#2) returned to room, removed the soiled gloves and performed hand hygiene. The CNA clipped the call light to the resident's sweatshirt sleeve, plugged the power cord back into the tube feeding device, and exited the room without performing hand hygiene. The CNA (#2) failed to wear a gown as per the EBP policy, failed to perform hand hygiene when removing soiled gloves and before applying clean glove, and before exiting the room.Observation on 12/10/25 at 1:20 p.m. showed a nurse (#7) entered Resident #31's room and administered medication through the percutaneous endoscopic gastrostomy (PEG) tube. The nurse failed to apply a gown as per EBP policy.During an interview on 12/11/25 at 2:45 p.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene, wear gowns and gloves for residents on enhanced barrier precautions during all close contact care and medication administration through a PEG tube.