STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 For the standard Medicare/Medicaid recertification survey started on August 7, 2017 and completed on August 10, 2017, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for	F 156		9/20/17

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

Electronically Signed | 09/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 156	Continued From page 1 Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 156	Continued From page 2 [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office,	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 156	Continued From page 3 adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 156	Continued From page 4 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 156	Continued From page 5 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the email addresses of state advocacy groups including the State Ombudsman, State Survey Agency, Protection and Advocacy Network, and Medicaid Fraud/Abuse on 3 of 4 days of survey (August 7-9, 2017). Failure to provide this information has the potential to limit all residents and their	F 156	1.) The email addresses lacking on the posting were corrected immediately upon the surveyor reporting to administrative nurse # 1. The information was reported in the Resident Council meeting on 8/28/2017. 2.) All residents currently admitted to the facility have potential to be affected by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 156	Continued From page 6 families access to these agencies. Findings include: Observation on August 7-9, 2017 showed the names of advocacy groups displayed on a wall by the dining area. The facility failed to include/post email contact information for the State Ombudsman, State Survey Agency, Protection and Advocacy Network, and Medicaid Fraud/Abuse. During an interview on 08/09/17 at 5:00 p.m., an administrative nurse (#1) confirmed the display lacked the required information.	F 156	this deficient practice. 3.) The Social Service Director will have a listing of the requirements to be posted on the Social Service Board. Information list will be updated with each update in the CMS regulations. 4.) The Social Service Director will monitor the board weekly x 12 months to ensure required postings are current and visible. The information will be reviewed monthly at QA meetings.	
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide medically-related social services for 2 of 2 sampled residents (Resident #5 and #7) who exhibited distressed behaviors manifested by wandering, exit seeking and crying. Failure to assess the changes in the residents' mood and effectively and in a timely manner communicate these signs and symptoms to the medical provider subjected Resident #5 to a decline in psychological well being which placed the resident at risk for psychosocial harm. Findings include:	F 250	1.) Resident # 5 has had the care plan updated to show individualized and specific interventions for staff to attempt during behavioral episodes such as crying or elopement attempts. Staff education regarding behaviors and attempting interventions has been completed at the monthly staff meetings (Nurse Meeting held on 8/22/2017, CNA Meeting held on 8/29/2017) Education included interventions for resident # 5 and #7 as well as other non-pharmacological interventions and the importance of follow-up documentation. A binder with	9/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 250	Continued From page 7 Review of the facility policy titled "Goals and Objectives, Care Plans" occurred on 08/10/17. This undated policy, stated, ". . . 1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem . . . 5. Goals and objectives are reviewed and/or revised: a. When there has been a significant change in the resident's condition; b. When the desired outcome has not been achieved . . ." The facility failed to provide a policy/procedure for behavior management. - Throughout the day on 08/09/17, observations showed Resident #5 walking in the hallway carrying clothing and other items, and then leave the items on the floor in the hall way. On the afternoon of 08/09/17, observations showed the resident sobbing as staff member (#6) tried to console her through conversation. Review of Resident #5's medical record occurred on all days of survey. Diagnoses major depression, dementia, and anxiety disorder. An admission Minimum Data Set (MDS), dated 06/06/17, identified severely impaired cognition, and independent with ambulation. Resident #5's physician's orders showed the following: * 06/02/17 - Venlafaxine (an antidepressant) 75 milligrams (mg) daily, increased to 150 mg daily on 8/01/17 (2 months later) * 07/05/17 - Hydroxyzine (an antihistamine) 50 mg as needed (PRN) every 6 hours for anxiety and discontinued on 08/01/17 * 07/27/17 - Zyprexa (an antipsychotic) 5 mg	F 250	information on EVERY resident and possible interventions has been placed at each nurses station for all staff to refer to daily. Resident # 5 was seen by mental health nurse practitioner on 8/28/2017 with medication adjustments being made. Follow-up with FNP on 9/12/2017 and 9/15/2017 with continued medication changes. Resident # 7 already had specific interventions in place on the care plan (i.e. provide popcorn and NA beer) 2.) All residents admitted to this facility have the potential to be affected by this deficient practice. All resident admitted to the facility will have the binder with specific interventions in place- regardless of behavior potential. 3.) Resident #5 and #7 will have nursing documentation at least every 24 hours regarding behaviors exhibited and interventions attempted as well as efficacy of the interventions. Social Services Director or designee will monitor charting for trends of behaviors. 4.) Documentation will be reviewed weekly by social service director. Information will be brought forward to IDT meeting each Monday (weekly) x 12 months to determine if sig change or appointments needed. Resident # 5 and # 7 will be reviewed monthly during behavior committee, Nursing and CNA meetings x 12 months to evaluate for continued trends and intervention efficacy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 250	Continued From page 8 daily PRN for paranoia Resident #5's current care plan stated, ". . . DISCHARGE PLANNING: I have advanced dementia and I am unable to stay home unattended . . . Interventions: when I am weepy and sad, please just provide me support and reassurance. I am confused on why I am here. . . . Focus: I am at risk for elopement, I am not familiar with the Care Center, I miss my home and family . . . Interventions: I have a wander guard on my ankle. Identify my pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate, notify nurse, SS [social service] and provider. please check the wander guard every evening for proper function . . . Focus: I have depression. My mood fluctuates . . . Focus: Administer medications as ordered. Monitor/document for side effects and effectiveness. Encourage me to talk about my feelings. Listen to me with patience and compassion. Involve me in conversations with friends, family . . . and other residents. I love visiting. . . ." Review of Resident #5's Progress Notes between 06/02/17 and 08/07/17 identified staff documented the following mood and behaviors: * crying - 30 times * wandering - 9 times * exit seeking - 11 times included 2 elopements when the alarms sounded and staff responded immediately * packing clothes and items in the room - 17 times	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 250	Continued From page 9	F 250		

A "Fax Communication to Provider" dated 07/05/17, stated, ". . . Resident has been emotionally distraught for past 3 days. Crying frequently, Wandering into other residents rooms, trying to get outside (has wanderguard). Trying to assist wheel-bound [sic] residents to standing position, and following staff members around asking 'What can I do?' Could we possibly get something to sedate her? . . . Hydroxyzine 50mg PO [my mouth] Q [every] 6 [hours] PRN anxiety [order received] . . ."

The record showed the medical providers saw Resident #5 on 06/20/17, and 07/14/17. During those visits the record lack information the facility staff informed the provider about the resident's distressed mood.

Review of four "Alternative Behavior Documentation Forms" for Resident #5, dated 06/02/17, 06/26/17 (2), and 07/21/17 described behavior of packing belongings. The current care plan failed to address this behavior, the effect on the resident, or any interventions to deescalate the situation.

- Review of Resident #7's medical record occurred on August 09-10, 2017. Diagnoses included dementia, Alzheimer's disease, and Parkinson. An admission MDS, dated 05/15/17, identified severely impaired cognition, wandering 1 to 3 days a week in dangerous places, intrudes on others, and independent with ambulation.

Resident #7's current care plan stated, ". . . DISCHARGE PLANNING: I plan on remaining in the Care Center, I will make this my home, I am unable to live alone, I have gotten lost while at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 250	Continued From page 10	F 250		

home . . . Focus: I am a risk for leaving building without supervision, I will wear a wander guard to alert staff . . . Interventions: Distract me from wandering by offering activities, food, conversation, television, book, NA [nonalcoholic] beer or wine, Wander alert per family request, When I am restless, please go for a walk outside with me . . . Communication: . . . engage in conversation that is familiar to me, sports, family, weather . . ."

Review of Resident #7's Progress Notes between 05/08/17 and 08/07/17 identified staff documented the following behaviors of exit seeking and wandering into others rooms 17 times included 4 elopements when the alarms sounded and staff responded immediately.

Review of three "Alternative Behavior Documentation Forms" for Resident #7, dated 06/15/17, 07/21/17, and 07/25/17, described behavior of wandering into other residents' rooms. A form dated, 07/03/17, stated, ". . . In the late afternoon (approx 1700) [approximately 5:00 p.m.] [Resident #7] was frantically pacing the north hallway . . . stopped at the door and tried to dissassemble [sic] the wanderguard box . . . Do you know how to take this off? . . ." The current care plan failed to address these behaviors or any interventions.

During an interview in the afternoon of 08/09/17, a social service staff member (#7) addressed Resident #5 and #7's behavior documentation. The staff member (#7) reported "I try to get staff to fill out an Alternative Behavior Documentation Form," which upon review details the behavior, interventions and outcomes. Record review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 250	Continued From page 11 identified this did not occur consistently in order to track and trend behaviors. The facility failed to adequately assess Resident #5 and #7's behaviors and moods, including monitoring for patterns/trends, causative factors, including time, place, persons involved, happenings prior to and at the time of the behavior, and implement appropriate individualized interventions to prevent the distressed behaviors from escalating. As a result, the facility failed to monitor the effectiveness of interventions and revise interventions as appropriate. Therefore, the lack of an individualized approach to assess and address the sign and symptoms affected the daily well-being of Resident #5 and #7.	F 250		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 314		9/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 314	Continued From page 12 by: Based on record review, policy review, and staff interview, the facility failed to provide the necessary care and services for 1 of 2 sampled residents (Resident #3) and 1 of 1 closed record (Resident #10) reviewed with a current/history of pressure ulcers. Failure to assess and monitor a resident's pressure ulcer as per the facility policy may result in deterioration of an existing pressure ulcer. Findings include: Review of the facility policy titled "Pressure Ulcers: Skin Assessment and Prevention" occurred on 08/10/17. This undated policy stated, "Purpose: . . .To accurately document observations and assessments of residents . . . Procedure: . . . 7. . . . The registered nurse should record the type of wound and the degree of tissue damage (i.e., for a pressure ulcer the stage). The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. . . . 14. The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound Flow Sheet. . . . should include at least the following: * Measurements - length, width, depth * Characteristics of the ulcer - including wound bed, undermining and tunneling, exudate, surrounding skin, etc. * Presence of pain * Current treatments Progress towards healing and any modifications to the plan of care/treatments should be assessed and evaluated by the registered nurse. . . ."	F 314	1.) Resident #3 has been evaluated and found to have frail skin, not a stage 1 pressure ulcer. 2.) All residents admitted to the facility have potential to be affected by this deficient practice. 3.) A contract has been signed with consulting company to provide training to all nursing staff regarding pressure ulcer staging and treatment. This training and the process changes our current model which will result in the problem not recurring. 4.) Monthly meetings with contracted company will occur to track residents with skin issues. Recommendations will be made for treatment through their wound care nurse with orders being written by in house providers. The Director of Nursing and/or the MDS nurse will observe the wounds weekly with a staff RN to ensure continuity of assessments. Results of weekly meetings will be reviewed at monthly QA meetings on a wound care tracking sheet. This will allow staff to track wounds and trends. Sheet will be updated weekly x 12 months with monthly (x 12 months) review at QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 314	Continued From page 13	F 314		

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included diarrhea, stage 1 pressure ulcers of right and left buttocks, miliaria rubra (heat rash with itching), and tinea cruris (fungal infection of warm, moist area such as groin and buttocks). Physician's orders included:
* 01/27/17, "Stage 1 Pressure to (L) [left] and (R) [right] buttocks. Apply calmoseptine TID [three times daily] and PRN [as needed]. Skin assessments to area Q [every] week and PRN until healed x [times] 3 weeks."
* 03/01/17, "Vaseline TID & PRN to open area (L) buttock & red area (R) buttock until healed."
* 07/10/17, "Calmoseptine to red area on buttocks TID until healed."

The current care plan stated, "I have two stage 1 pressure ulcer to my buttocks, I am not as mobile-I sit a lot in recliner and w/c [wheelchair]. . . . I have a Pressure relieving mattress on bed and pad in my recliner . . . provide me Weekly treatment with documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, notify provider of changes . . ."

During an interview on 08/09/17 at 5:05 p.m., an administrative nurse (#1) stated the facility lacked a consistent nurse to complete pressure ulcer assessments. The nurse (#1) stated the pressure ulcer assessment should include the dimensions of length, width, and depth measured weekly.

- Review of Resident #10's medical record occurred on August 9-10, 2017. Diagnoses included a pressure ulcer to the left and right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 314	Continued From page 14 buttocks. The quarterly Minimum Data Set (MDS), dated 10/06/16, identified two stage 1 pressure ulcers. The current physician's orders stated skin assessment to bilateral buttocks every Wednesday until healed for three weeks and as needed until healed for three weeks. The resident expired on 01/28/17. The facility failed to comprehensively assess pressure ulcers, including: 1) measurement of length, width, and if worse than a stage 1 ulcer, also the depth 2) determine if an area of reddened skin is blanchable or not 3) document location of the ulcer with each assessment 4) complete a weekly assessment Failure to assess the residents' pressure ulcers comprehensively including dimensions, as per facility policy, and on a weekly basis limited the facility's ability to identify improvement/worsening of the ulcers and the need to implement alternative interventions.	F 314		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of manufacture guidelines, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 2 sampled	F 332	1.) Insulin dependent diabetic residents will have a discussion with the Director of Nursing to inform them of time change regarding insulin administration.	9/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 332	Continued From page 15 residents (Resident #4 and #12) observed receiving short acting insulin (NovoLog). Three errors occurred during staff administration of 29 medications, resulting in a ten percent error rate. Failure to ensure staff administered medications correctly may result in low blood sugar levels. Findings include: Review of the manufacturer insert received from the facility for NovoLog titled "NovoLog Insulin aspart injection", occurred on 08/09/17. The insert, dated February 2015, stated, ". . . Subcutaneous Injection . . . Because NovoLog has a more rapid onset and a shorter duration of activity . . . it should be injected immediately (within 5-10 minutes) before a meal. . . ." - Review of Resident #4's medical record occurred on all days of survey. Current physician orders included NovoLog 100 unit/ml (milliliter) subcutaneous with meals. An observation of medication pass on 08/08/17 at 11:05 a.m. showed a licensed practical nurse (LPN) (#2) administered 8 units of NovoLog to Resident #4. Resident #4 ate her first bite of food at 11:25 a.m. (20 minutes after administration). - Review of Resident #12's medical record occurred on all days of survey. Current physician orders included NovoLog 100 unit/ml subcutaneous with meals. An observation of medication pass on 08/08/17 at 11:15 a.m. showed a Registered Nurse (RN) (#3) administered 24 units of NovoLog to Resident #12. Resident #12 ate his first bite of	F 332	2.) All insulin dependent diabetic residents have the potential to be affected by this deficient practice. 3.) All nursing staff have been educated regarding the administration timeline of Novolog insulin in regards to the resident's first bite of food. Nurse meeting was held on 8/22/2017. 4.) The Director of Nursing or a designee will complete random audits of insulin dependent diabetic residents to ensure Novolog insulin is being administered no more than 10 minutes prior to a meal. Audits will be completed weekly x 4 weeks, then bi-weekly x 1 month, then monthly x 10 months. Audits will be reviewed at the monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 332	Continued From page 16 food at 11:35 a.m. (20 minutes after administration). An observation of medication pass on 08/09/17 at 5:02 p.m. showed a RN (#3) administered 24 units of NovoLog to Resident #12. Resident #12 ate his first bite of food at 5:42 p.m. (40 minutes after administration). During an interview on 08/09/17 at 8:49 a.m., a nurse manager (#1) confirmed the NovoLog manufacturer guidelines state inject NovoLog five to ten minutes before a meal.	F 332		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of	F 371		9/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 371	Continued From page 17 foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of the Food and Drug Administration (FDA) Food Code, review of documents provided by the facility, and staff interview, the facility failed to maintain sanitary conditions in 1 of 1 facility kitchen. Failure to maintain clean range hoods, floors, fans, garbage lids, and toasters, may result in unsanitary dietary conditions and contribute to foodborne illness outbreaks. Findings include: The FDA Food Code 2013, page 184-185, stated, ". . . Physical facilities shall be cleaned as often as necessary to keep them clean. . . . Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. . . ." Review of the facility policy titled "Preventive Maintenance" occurred on 08/09/17. This undated policy, stated, ". . . Vents above the oven are cleaned once per year by food and nutrition services staff. Hoods are cleaned twice per year by an outside contractor. . . ." Review of the facility policy titled "Floors" occurred on 08/09/17. This undated policy, stated, ". . . Floors shall be maintained in a clean, safe, and sanitary manner. . . . All floors shall be mopped/cleaned/vacuumed daily in accordance with our established procedures. . . ."	F 371	1.) St Luke's Care Center dietary staff have revised their cleaning schedule and verification process to ensure appropriate cleanliness of the kitchen area. This is a new process that will be sustained. All areas of concern have been cleaned to meet professional standards. 2.) All residents admitted to the facility have potential to be affected by this deficient practice. 3.) Wheels have been added to the tables to allow easier access to the floor for cleaning. Yearly (in June) the kitchen will under go a "deep cleaning" with extensive detailing. The kitchen will undergo a quarterly review to ensure proper cleanliness. Staff education completed 9/18/2017 at department meeting. 4.) Dietary staff will complete a verification check list for each daily and weekly assignment. The dietary manager or designee will review these weekly to ensure completion of tasks. The areas of concern noted on the survey will undergo a quarterly audit to ensure cleanliness. The dietary manager will present a review of the check lists and quarterly audits at the monthly QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 371	Continued From page 18 Review of the facility policy titled "Sanitation - Cleaning Schedules" occurred on 08/09/17. This undated policy, stated, ". . . The Director of Food and Nutrition Services is responsible for monitoring staff to ensure that cleaning duties are completed to satisfaction and within the proper timelines. The cleaning schedule is available as a template and is to be used to assign and provide a printed schedule for the general and heavy duty cleaning of all equipment and kitchen areas. . . ." Review of the Range Hood service report titled "Automatic Fire Extinguishing Systems" occurred on 08/08/17. This service report, dated 04/18/17 stated, ". . . Hood grease build up light [not cleaned], filter grease build up light [not cleaned], duct grease build up light [not cleaned] . . ." Review of the dietary cleaning schedules for August 2017 identified the following: * Sweep and mop floors, under ovens, under dishwasher, and under counters daily * Clean juice machine daily * Wipe off garbage can lids daily * Wipe out big toaster/dump crumbs of small toaster weekly * Clean fans in dish room weekly. A tour of the facility's kitchen occurred on 08/08/17 at 2:05 p.m. and identified the following: * The range hoods above the stove showed grease buildup throughout and strands of dust buildup hanging from the sprinklers and light. * The dish drying area showed a fan with multiple strings of dust blowing in the direction of drying dishes.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 371	Continued From page 19 * The floor under the cooker/steamer showed a piece of bacon, multiple pieces of cereal, and dried chemical build up. * The floor under the microwave showed multiple pieces of cereal. * The floor under the dishwasher showed food residue, a fork, a cup, wrappers, and a bottle cap. * Behind the juice machine a used toothbrush laid on the floor. * Two garbage cans showed food debris on the containers and lids. * The cooking area showed three toasters with bread crumbs inside and the top outside of the toasters had a layer of residue. During an interview on 08/08/17 at 2:20 p.m. a dietary manager (#5) stated the used toothbrush is used to clean the juice beverage machine. During interviews on the afternoon of 08/08/17 a dietary manager (#4) confirmed the floors, the fan, garbage cans, and the toasters should be cleaned and the toothbrush for the juice machine should be thrown after each use. The dietary manager (#4) confirmed the range hood was last evaluated on 04/18/17, marked as being lightly dirty and stated she expected staff to clean the range hood after the 4/18/17 evaluation.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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:	F 441		9/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 441	Continued From page 20 (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 (facility assessment implementation is Phase 2); (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 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 441	Continued From page 21 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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, review of facility policy, professional reference review, and staff interview, the facility failed to follow infection control practices for 2 of 3 residents (Resident #12 and Resident A) observed during blood glucose monitoring. Failure to follow infection control practices related to cleaning blood glucose meters after blood sugar checks has the potential to spread infection to residents, staff, and visitors. Findings include: A Centers for Disease Control and Prevention publication titled "Frequently Asked Question (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration, "dated	F 441	1.) All diabetic residents in the facility have been designated with a personal blood glucose meter to further decrease the chance of infection transmission. 2.) All diabetic residents admitted to the facility have the potential to be affected by this deficient practice. 3.) All nursing and CMA II staff have been educated on the importance of proper infection control in regards to blood glucose meters. Meeting held on 8/22/2017 4.) The Director of Nursing or a designee will complete random audits to ensure blood glucose meters are being disinfected after each use. The audits will be completed weekly x 4 weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 441	Continued From page 22 03/08/11, stated, "Infectious agents, such as HBV [hepatitis B virus] can be transmitted through indirect contact transmission, even in the absence of visible blood . . . indirect contact transmission is defined as the transfer of an infectious agent (e.g., HBV) from one patient to another through a contaminated objective (e.g., blood glucose meter) . . ." Review of the facility policy titled "Infection Prevention and Control" occurred on 08/09/17. This undated policy, stated, ". . . Adherence to the practice of standard precautions is expected of all nursing staff. . . ." An observation of blood sugar monitoring on 08/08/17 at 11:15 a.m. showed a Licensed Practical Nurse (LPN) (#3) collected a blood fingertip sample from Resident #12 onto a test strip connected to a blood glucose meter. The nurse exited Resident #12's room with the blood glucose meter, disposed of the test strip, and failed to disinfect the blood glucose meter. Then the LPN (#3) used the same blood glucose meter and collected a blood fingertip sample from Resident A. The nurse exited Resident A's room with the blood glucose meter, disposed of the test strip, and failed to disinfect the blood glucose meter. During an interview on 08/08/17 at 11:20 a.m., the LPN (#3) stated she cleans the blood glucose meter at the beginning of each shift and when blood is visible on the blood glucose meter. An observation of blood sugar monitoring on 08/09/17 at 5:02 p.m. showed a LPN (#3) collected a blood fingertip sample from Resident	F 441	bi-weekly x 1 month, then monthly x 10 months. Audits will be reviewed monthly at the QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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 441	Continued From page 23 #12 onto a test strip connected to a blood glucose meter. The nurse exited Resident #12's room with the blood glucose meter, disposed of the test strip, and failed to disinfect the blood glucose meter. During an interview on 08/09/17 at 8:49 a.m., an administrative nurse (#1) confirmed blood glucose meters should be disinfected after each use.	F 441		