DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

RECEIVED
FEB 9 2012
Division of Health Facilities

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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<br><br>For the standard Medicare/Medicaid recertification survey started on January 8, 2012 and completed on January 11, 2012 the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The sample included three (3) additional residents to verify specific concerns during the survey. | F 000 | F274:<br><br>In regard to failure to complete a comprehensive assessment within 14 days of a significant change: St. Luke's Home has and will continue to provide education to cross-train the Neighborhood Supervisors and the MDS Coordinator on each other's roles and responsibilities. St. Luke's Home has registered Neighborhood Supervisors to participate in an upcoming MDS 3.0 training provided by the North Dakota Department of Health. The interdisciplinary report guidelines will be updated by February 10, 2012, to include resident weight changes of greater than or less than 3#. Additionally, a noted increase or decrease in meal intakes will be added to the daily report sheets by February 10, 2012. St. Luke's Home will be implementing a weight category on February 10, 2012, into the daily nursing report sheets. The category includes the previous Resident's weight and the current Resident's weight. Neighborhood Supervisor's will review and monitor daily nursing report sheets and address any significant changes to the interdisciplinary care team during the tri-weekly interdisciplinary report. A newly created Resident Health Review Meeting will be initiated weekly starting February 13, 2012. At this meeting the interdisciplinary team will review the resident's health conditions and address and implement any significant changes | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on professional reference, record review, and staff interview, the facility failed to complete a comprehensive assessment of residents within 14 days for 1 of 1 sampled resident (Resident #9) who experienced a significant change (decline) in functional status. Failure to complete a comprehensive assessment in response to Resident #9's physical declines placed the | F 274 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andy Mejia on behalf of Karen Bowlden — TITLE: D.N.S. — (X6) DATE: 02/08/12

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 274 | Continued From page 1<br>resident at risk for continued decline and the lack of appropriate interventions to restore or maintain physical function.<br><br>Findings include:<br><br>The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, October 2011, page 2-20 through 2-23 states, "Significant Change in Status Assessment . . . is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. . . . Decline in two or more of the following: . . . Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency . . . Any decline in an ADL [Activity of Daily Living] physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment . . . Resident's incontinence pattern changes . . . Emergence of a new pressure ulcer at Stage II or higher or worsening in pressure ulcer status . . ."<br><br>Review of Resident #9's medical record occurred on all days of survey. Current diagnoses included Alzheimer's dementia, urinary incontinence, insomnia, transient cerebral ischemia, osteopenia, and a pelvic fracture on 12/08/11.<br><br>A quarterly Minimum Data Set (MDS), dated | F 274 | In addition, daily verbal nursing report was implemented in early January to enhance the hand off communication between licensed and non-licensed personnel. | 02/13/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 274 | Continued From page 2<br>06/22/11, identified Resident #9 as independent in the following Activities of Daily Living (ADLs): bed mobility, transfer, walking in room and in corridor, locomotion on and off the unit, and toilet use.<br><br>A quarterly MDS, dated 09/22/11, identified Resident #9 required extensive assistance of one person for the following ADLs: bed mobility, transfer, locomotion on and off the unit, and toilet use and the resident failed to walk in room or in corridor.<br><br>Resident #9's medical record lacked evidence facility staff considered completing a comprehensive assessment with the resident's significant change in function.<br><br>During an interview on 01/10/12 at 10:20 a.m., two supervisory nurses (#10 and #11) lacked awareness of a decline in Resident #9's ADLs from June to September and agreed facility staff should have completed a significant change MDS assessment. | F 274 | | |
| F 278 SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the | F 278 | F278<br>In regards to failure to complete MDS assessments which accurately reflected the resident's status identified on the MDS as having a toileting plan: On January 17, 2012, St. Luke's Home revised and individualized Resident's toileting plans to attain and maintain maximum bowel and bladder continence. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 278 | Continued From page 3<br>assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/27/2011.<br><br>Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI) (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 5 of 5 sampled residents (Resident #2, #3, #4, #8, and #9) identified on the MDS as having a toileting plan. Failure to accurately assess and code the MDS may affect the level of care provided by staff to the residents.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual, | F 278 | The Toileting Program Policy was revised on February 7, 2012, to include individualized toileting plans. Education on toileting plans, My Daily Living Needs, and proper documentation will be provided to the nursing personnel at the mandatory Skills Fair schedule for February 8, 9, and 10th. Bowel and Bladder Elimination Pattern evaluation forms will be reviewed on admission, quarterly, annually, and PRN by the MDS Coordinator and Neighborhood Supervisors to determine patterns of Resident continence and implement specific bowel and bladder toileting plans. Each month starting February 13, 2012, a sample of 10 Resident toileting plans will be reviewed by the Skin Care Coordinator, Staff Development Nurse, and/or designee. Results will be forward to monthly Quality Assurance Committee for review and follow up. | 02/13/2012 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 278 | Continued From page 4<br>page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . ." Page H-6 states, " . . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to:<br>* simply tracking continence status,<br>* changing pads or wet garments, and<br>* random assistance with toileting or hygiene . . . "<br>Page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of:<br>* an individualized care plan<br>* The Medicare Prospective Payment System<br>* Medicaid reimbursement programs<br>* quality monitoring activities . . .<br>* the data-driven survey and certification process<br>* the quality measures used for public reporting . . ."<br><br>- Review of Resident #2's medical record occurred on all days of survey and medical diagnoses included constipation and urge incontinence. Resident #2's "Urinary Continence Evaluation," dated 08/29/11 and 11/29/11, identified the resident with "stress incontinence [involuntary loss of urine with increase in intra-abdominal pressure, such as cough or laugh]." The evaluation identified the appropriate type of intervention for this resident as "habit training/scheduled voiding program."<br><br>Review of Resident #2's quarterly MDSs dated 08/29/11 and 11/29/11 identified the resident as | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 278 | Continued From page 5<br>frequently incontinent of urine and on a toileting plan.<br><br>Resident #2's "My Daily Living Needs" plan of care identified the toileting plan of "take to the bathroom before and after meals, every 2-3 hours at night and as I request. Tell me it's time to go to the bathroom during the daytime hours - if you ask I'll often say no, then try to go by myself later."<br><br>On 01/09/12 at 1:15 p.m., when asked if Resident #2 had used the bathroom, certified nursing assistant (CNA) (#7) stated, "she probably went at the time of her bath." At 4:55 p.m., an unidentified CNA just leaving the resident's room stated Resident #2 put her call light on to use the toilet.<br><br>During an interview on 01/09/12 at 1:55 p.m., an administrative staff nurse (#6) indicated that Resident #2 is on routine toileting, "she wheels herself into the bathroom and pulls the light." This contradicts the most recent MDS that indicates Resident #2 is currently on a urinary toileting program.<br><br>The lack of adequate assessment, establishment of an individualized toileting schedule based on the assessment, and the lack of implementation and monitoring of the plan failed to support the accuracy of Resident #2's above referenced MDS.<br><br>- Review of Resident #8's medical record occurred on all days of survey. The resident's MDSs, dated 06/21/11, 09/19/11, and 12/19/11, identified the use of a scheduled toileting plan | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 278 | Continued From page 6 | F 278 | | |

and frequent urinary incontinence. Resident #8's "Daily Living Needs" (CNA care plan), dated 06/27/11 and updated 01/04/12, identified a toileting plan as follows: "Help me to the commode before and after meals, every 2-3 hours at night and as I request. I may use the bedpan if I request."

Resident #8's medical record included monitoring forms of her bowel and bladder habits during the week preceding each MDS assessment. The resident's toileting schedule lacked individualized times specific to her toileting needs, and she remained on the same toileting schedule since June 2011. Failure to monitor the resident's bladder habits on an on-going basis and re-evaluate/revise the toileting schedule according to patterns of incontinence does not allow for an individualized toileting plan.

- Review of Resident #9's medical record occurred on all days of survey. Current diagnoses included Alzheimer's dementia, urinary incontinence, chronic kidney disease, and a pelvic fracture diagnosed on 12/08/11.

Review of Resident #9's quarterly MDS dated 12/13/11, identified the resident as frequently incontinent and on a toileting program. An MDS narrative note, dated 12/19/11, stated, ". . . She cont [continues] to need ext[extensive]-total assist of 1-2 [with] all cares except indep [independent] [with] eating. . . . She cont to have freq [frequently] urinary incont [incontinent] . . . She is on a toileting program now since she's unable to take self to BR [bathroom]. . . .'

Resident #9's "My Daily Living Needs" plan of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 278 | Continued From page 7 | F 278 | | |

care, updated on 01/09/12, identified the toileting plan of "Assist me to the bathroom before and after meals.Every 2-3 hours at night and as I request," and alternative toileting plan stated bedpan as needed.

Observation on 01/09/12 at 9:20 a.m. showed a CNA (#19) changed Resident #9's brief wet with urine while the resident laid in bed.

Observation on 01/09/12 at 1:40 p.m. showed two CNAs (#19 and #20) assisted resident back to bed and changed a brief wet with urine.

The record lacked any evidence of assessment of Resident #9's routine voiding habits and no evidence of monitoring the implementation or resident's response to a scheduled toileting plan. The above interview indicated Resident #9's MDS inaccurately identified the resident as participating in a scheduled toileting plan.

- Review of Resident #3's medical record occurred on January 08-10, 2012. Medical diagnoses included dementia, and malignant neoplasm bladder. Resident #3's quarterly MDS dated 12/31/11, identified Resident #3 usually makes herself understood, sometimes understands others, memory problems, frequently incontinent of urine and occasionally incontinent of bowel, extensive assist for toilet use, and on a urinary and bowel toileting program.

Review of Resident #3's current care plan stated "adls [activities of daily living] . . . I am incontinent of urine and BM [bowel movement] at times. . . See my daily living needs plan. . ." The resident's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 278 | Continued From page 8<br>"My Daily Living Needs" care plan stated, "Toileting Plan: Assist me to the bathroom before and after meals, at bedtime and every 2-3 hours at night and as I request." Resident #3 does not meet the definition of a urinary and bowel toileting program.<br><br>- Review of Resident #4's medical record occurred on January 08-10, 2012. Medical diagnoses included Alzheimers, incontinence, and dementia with behavioral disturbances. Resident #4's quarterly MDS, dated 12/05/11, identified Resident #4 frequently incontinent of urine, extensive assist for toilet use, and on a urinary toileting program.<br><br>Review of Resident #4's current care plan stated "adls [activities of daily living] . . . See My Daily Living Needs plan in my bathroom. . ." The resident's "My Daily Living Needs" care plan stated, "Toileting Plan: Help me to the bathroom before and after meals, every 2-3 hrs at Night and as needed."<br><br>During an interview on 01/10/12 at 1:50 p.m., a nursing supervisor (#6) stated Resident #3 and #4 "Are on routine toileting plans. We consider those toileting plans."<br><br>The MDSs for Resident #3 and #4 identified an individualized toileting plan, but care plans and an interview with a supervisory nurse identified the residents' on routine toileting plans. The resident's toileting schedule lacked individualized times specific to their toileting needs. Failure to monitor the resident's bladder habits on an on-going basis and re-evaluate/revise the toileting schedule according to patterns of incontinence | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 278 | Continued From page 9<br>does not allow for an individualized toileting plan to allow the residents to attain/maintain maximum bowel and bladder continence. | F 278 | | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>1. Based on record review, and review of facility policy and procedure, the facility failed to ensure 1 of 1 closed record resident (Resident #16) who experienced persistent chest pain received the appropriate care and services necessary to treat his medical condition. Failure to provide the necessary care and services delayed medical treatment and resulted in the resident being transferred to the hospital and being diagnosed with an acute myocardial infarction.<br><br>Findings include:<br><br>Review of the facility policy titled, "Change in a Resident's Condition or Status" occurred on 01/11/12. The policy, dated 04/07/09, stated, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative [sponsor] of changes in the resident's medical/mental condition. . ." | F 309 | F309<br><br>In regards to failure to provide the necessary care and services: Prior to the event, the Agency Representative was notified of the perceived lack of clinical skills to meet our standards. St. Luke's Home requested on October 26, 2011, that the Traveler LPN must not return to the facility. Nitroglycerin Standing Orders were reviewed and clarified with our Medical Director on January 18, 2012. The revised standing orders have been reviewed with the nurses at the monthly staff meeting held on February 6, 2012. St. Luke's Home will provide education for Nursing Personnel in regards to assessment skills, management, and follow-up of cardiac medical conditions by Monday, February 13, 2012. All Resident's that received Nitroglycerin will be added to the daily report sheets. In addition, an Acute Focus Care Plan will be implemented by the Charge Nurse upon administration of Nitroglycerin. Starting February 13, 2012, Neighborhood Supervisors will review the Acute Focus Care Plan and medical record for appropriate use and follow up of Nitroglycerin. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355083 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 10<br>The medical record of Resident #16, reviewed January 10-11, 2012, showed the facility admitted the resident on 10/25/11 from an acute care hospital stay with congestive heart failure, shortness of breath, and swelling of his ankles. The resident's admission diagnoses included chronic ischemic heart disease, atrial fibrillation, congestive heart failure, coronary artery disease, anxiety, hypoxemia, cerebrovascular accident, and other primary cardiomyopathies. The record indicated Resident #16 as his own responsible party, and a code level 2 [treating reversible conditions without chest compressions].<br><br>Resident #16's discharge instructions from the acute care hospital, dated 10/25/11, stated "Pertains to patients with shortness of breath, chronic obstructive pulmonary disease, or heart failure . . . When to call your Doctor: . . . Increased shortness of breath. Having to prop yourself up in bed with pillows to breathe. . . New or increased swelling in ankles, lower legs or belly . . . Chest pain."<br><br>Resident #16 physician's orders on admit included:<br>"Nitroglycerin 0.4 milligrams sublingual [under the tongue] as needed up to 3 doses 5 minutes apart, if after 3 doses still has pain call the MD [medical doctor] - notify the MD of nitro [nitroglycerin] use"<br>"Oxygen at 1 liter nasal canula to keep saturation > [greater than] 88% [percent] but < [less than] 96%"<br><br>Resident #16's nurses notes stated the following: *10/25/11 at 5:30 p.m., "Resident admitted to St. Lukes Home today at 1210 [12:10 p.m.]. Arrived | F 309 | Neighborhood Supervisors will address any discrepancies in a timely manner. The information in regards to Nitroglycerin use will be tabulated and forwarded to the Quality Assurance Committee monthly for review and follow up.<br>In regards to failure to try alternative treatment measures for pain or develop a comprehensive care plan related to pain management: St. Luke's Home Pain Management Policy was revised on February 7, 2012. St. Luke's Home PRN Medication Administration Policy was revised on February 3, 2012. Additional education was provided on the appropriate use of Acute Focus Care Plans on the February 6, 2012, at the nursing staff meeting. Acute Focus Care Plans will be implemented by the Charge Nurse for any Resident complaints of acute pain that a scheduled and PRN pain medication is given. Starting February 13, 2012, Neighborhood Supervisors will review Acute Focus Care Plans and the medical record for appropriate follow up and management of acute pain. Starting February 13, 2012, Neighborhood Supervisors will monitor the Pain Log Sheets monthly for appropriate use of scheduled and PRN pain medications and management of acute pain. Neighborhood Supervisors will forward data to the Quality Assurance Committee monthly for review and follow up. | 02/13/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 11<br>via ambulatory status. . . Code Status explained [with] family and res. [resident] and Code Level II was decided upon. . . BP [blood pressure] 90/50 sitting, 79/42 standing. . . O2 [oxygen] sats [saturation] 98% on RA [room air]. . .+1 edema [swelling] to bilat [bilateral] feet and ankles. . . No c/o [complaints] of pain at this time, although res. confirms that he sometimes has 'chest pain' that he takes nitro for. No c/o [complaints] SOB [shortness of breath] at this time . . . Res pleasant, cooperative and highly coherent."<br>*10/25/11 at 10:00 p.m., ". . . blood pressure 108/62, oxygen 95%. . . Res c/o SOB place O2 @ [at] 2L [liter], HOB [head of bed] elevated. c/o pain through chest muscles D/T [due to] [low] BP [blood pressure] no nitroglycerin given will monitor for [changes]." The facility failed to notify the physician promptly of the change in the resident's medical condition, and failed to follow the physician's orders for the administration of nitroglycerin and oxygen at 1 liter not 2 liters.<br>*10/25/11 at 10:30 p.m., "Res still c/o being uncomfortable with SOB faxed MD for PRN [as needed] Ativan order ro [related to] anxiety with SOB will monitor for [changes]."<br>*10/25/11 at 10:31 p.m., "Contacted on-call M.D. Telephone order: Ativan 0.5 mg [milligrams] po [by mouth] now for SOB may repeat q6h [every 6 hours] x [times] 2 if no relief. Ativan administered res states 'That's not gonna help' Told res. we could repeat dose in 6 hours if he had no relief. Res then asked if he could have an Alka-Seltzer and a Tylenol PM. Told res he may have Mylanta. Res states, 'If I drink that I will puke.' Then told res there was no order for him for Alka-Seltzer or Tylenol PM. Res stated 'Well then I don't want anything.' Will monitor for [changes] in SOB."<br>The facility contacted the physician for an | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 12<br>antianxiety medication, but failed to inform the physician of the resident's complaints of chest pain, SOB, and the need to administer oxygen to the resident.<br>*10/25/11 at 11:30 p.m., "Res req [requested] APAP [acetaminophen] for pain. 325 mg po 2 tabs given. Will monitor for [changes]." The MAR (medication administration record) stated, "Reason Given: res req c/o chest pain." The facility failed to follow the physician's orders and administer nitroglycerin for his continued complaints of chest pain.<br>*10/25/11 at 11:45 p.m., "BP 100/60. Res still c/o chest pain. Res states 'I should probably just go back to the hospital' Asked res why he wanted to go to the hospital Res states 'I have this chest pain and no one can figure out how to stop it.' Nitroglycerin 0.4 mg sl given." The facility failed to reassess the resident's chest pain in 5 minutes after the nitroglycerin was administered as ordered by the physician, and failed to contact the physician with the resident's complaint of chest pain.<br>*10/25/11 at 11:55 p.m., "Asked res if he was hurting anywhere. Res states, 'No, I'm not hurting anywhere, I think that tylenol really helped.' Asked res if he was experiencing chest pain. States 'NO I just got to sleep. How long will this medicine last?' Told res medicine should relieve pain for the duration of the night. Res states 'Don't bet on it. I took 3 Ambien once and it only lasted 3 hours.' Res seemed comfortable and relaxed [without] c/o chest pain. Will monitor for [changes]."<br>*10/26/11 at 12:01 a.m., "Res sleeping in bed [without] evidence of respiratory distress."<br>There was no evidence of further monitoring of Resident #16's condition, until the following | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 13<br>nurses note on:<br>*10/26/11 at 9:30 a.m., ". . . 2+ edema to feet/ankles, c/o pain to epigastric [upper middle part of the abdomen] area states gets this often esp [especially] if eating then going to bed. . ." The facility failed to notify the physician of the increase in edema as ordered in the discharge instructions from the acute care hospital, and failed to assess and treat the epigastric pain.<br>*10/26/11 at 12:15 p.m., "fax per Dr to clarify admit orders and for ativan BID [two times daily] and prn for anxiety."<br>There was no evidence of further monitoring of Resident #16's condition, until the following nurses note, more than 13 hours later, on:<br>*10/27/11 at 2:00 a.m., "Resident c/o indigestion 10 ml Maalox given."<br>*10/27/11 at 2:45 a.m., "Resident c/o being shaky 0.5 mg Ativan given po. Resident stated that he needed to go back to hospital. I asked why he thought he needed to go back to hospital, Res stated 'Because no one knows what is wrong with me' I ask [sic] resident to see if the Ativan would help. To give the medications time. Resident stated that he would see if the medication would help him sleep. If so then he would not have to go back to hospital. . .Res talked about how he didn't want to be alone. . ."<br>*10/27/11 at 3:30 a.m., "Resident c/o chest pain 0.4 mg nitrostat [nitroglycerin] given sl - will continue to monitor. . . B/P 100/60, O2 sats 97%. . ." The facility failed to reassess the resident's chest pain in 5 minutes after the nitroglycerin was administered as ordered by the physician.<br>*10/27/11 at 3:45 a.m., "Nurse placed nasal canula O2 @ 2L. Res sitting in recliner. Res stated chest pain relieved, but wants to remain in recliner." The facility failed to follow the physician | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 14<br>order for oxygen at 1liter as needed to keep oxygen saturation greater than 88% but less than 96%.<br>*10/27/11 at 5:15 a.m., "Resident awake, O2 @ 2L. Resident had very little sleep. Resting in recliner @ this time call light in place."<br>*10/27/11 at 7:50 a.m., "BP 88/56. . . Called to residents room. Resident lying on floor in front of bathroom door. Resident had walker laying upturned by side, only one shoe on, No apparent injury. . . Resident responded to touch and verbal stimuli. Neuro's [neurological] WNL [within normal limits] and moved all extremities. Hoyer used to place resident in bed. Neuros initiated. Fax prepared MD, family notified." The fax, dated 10/27/11,stated "Resident observed lying on floor in front of bathroom door. No apparent injury, No bumps or bruises to head. Resident responded to touch and verbal stimuli. Neuros WNL and moves all extremities. Will continue to monitor. Thanks." The facility failed to inform the physician of the resident's persistent complaints of chest pain, the administration of nitroglycerin, and the need for oxygen to be administered.<br>*10/27/11 at 9:30 a.m., "BP 77/53. . . Resident c/o chest pain and SOB, denies radiating pain. Resident is lethargic and weak. O2 per NC at 1L. Pain is helped when resident sits at 90 degree. Will continue to monitor." The facility failed to administer nitroglycerin as ordered by the physician, notify the physician of the resident's complaints of reoccurring chest pain, decrease in blood pressure, and the change in the resident's medical condition.<br>*10/27/11 at 10:30 a.m., "Assessed res [with] CN [charge nurse]. He appears to have [increased] CHF [congestive heart failure] s/s [signs and symptoms]. 2+ edema to feet. Hands are cool | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 15<br>and nail beds are clubbed & blue. Unable to obtain O2 saturation at this time. Call placed to MD with new orders received. Called daughter [name] as well and updated to [sic] fall earlier & current status. She agrees to res being sent to hospital. . ."<br>*10/27/11 at 10:45 "Ambulance here and transferred res to ER [emergency room]. . ."<br>*10/27/11 at 2:45 p.m., "Res. Admitted to ER [with] dx [diagnosis] of acute mi [myocardial infarction]."<br>*10/29/11 at 8:30 a.m., "ICU [intensive care unit] nurse from acute care hospital [name] called reported resident passed away."<br><br>The facility failed to provide adequate monitoring, intervention, and timely notification of the physician (per the physician's orders) which resulted in admittance to the ER (Emergency Room) with a diagnosis of acute myocardial infarction.<br><br>2. Based on observation, policy and procedure review, record review, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being for 1 of 2 sampled residents (Resident #9) with avoidable pain. Failure to address Resident #9's pain, evidenced during cares, resulted in the resident experiencing increased pain. Failure to try alternative treatment measures for pain or develop a comprehensive care plans related to pain management resulted in Resident #9 experiencing pain and may have resulted in the resident receiving unnecessary psychoactive medications for agitation. | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 16<br>Findings include:<br><br>Review of a facility policy titled "Pain Assessment and Management" occurred on 01/11/12. This policy, dated 02/01/11, stated, " . . . purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions . . . that address the underlying causes of pain. . . . pain management is a multidisciplinary care process that includes the following: a. Assessing potential for pain; b. Effectively recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management . . . conduct a pain assessment . . . whenever there is a significant change in condition and when there is onset of new pain or worsening of existing pain . . ."<br><br>Review of Resident #9's medical record occurred on all days of survey. Current diagnoses included Alzheimer's dementia, insomnia, osteopenia, and pelvic fracture on 12/03/11. Scheduled medications and their indications of use included the following: 250 milligrams (mg) Depakote twice a day (BID) for dementia with behaviors, 650 mg Tylenol once a day for headache or knee pain, 0.5 mg Risperdal three times a day (TID) for dementia with behaviors, and a fentanyl patch for hip, leg, and back pain (started 01/10/12).<br><br>Resident #9's medication administration record (MAR) showed prn (as needed) Tylenol received on:<br>* 12/07/11 at 2:00 p.m.<br>* 12/11/11 at 5:00 a.m.<br>* 12/16/11 at 4:00 a.m.<br>* 12/27/11 at 11:45 a.m. | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 17<br>* 01/06/12 at 4:30 a.m.<br><br>Review of physician orders and medication administration records (MARs) showed the physician increased the dose of Depakote from 250 mg (milligrams) daily to twice a day (BID) on 12/09/11. The record showed 0.5 mg Risperdal BID initiated on 12/09/11 and increased on 12/14/11 to three times a day (TID) related to increasing behaviors.<br><br>Review of Resident #9's current quarterly Minimum Data Set (MDS), dated 12/13/11 (after the pelvic fracture), identified the resident with severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6, received scheduled pain medication, as needed pain medication, and non-medication interventions for pain. The resident's behavioral symptoms during the assessment period included physical and verbal behaviors 4 to 6 days a week. A MDS narrative note, dated 12/19/11, stated, ". . . with behaviors escalating her primary physician was notified . . . re-ordered the Risperdal . . . [arrow up] the Depakote . . . 12/14 behaviors continued et [and] her Dr [doctor] [arrow up] the Risperdal . . . takes Tylenol 650 mg . . . took prn [as needed] Tylenol [two times] . . . Little to no chg [change] [with] cares or behaviors in last 3 mo [months]. . ."<br><br>Resident #9's care plan, updated 12/27/11, identified " . . . Problem . . . I have had falls in the past. I have lower back pain . . . I fell 12/03/11 and fractured my pelvis . . . Approaches . . . See my daily living needs plan . . . Problem . . . I tend to have lower back discomfort and knee pain . . . I have some pain upon movement because of my | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 18<br>fractured pelvis . . . Approaches . . . If I am having pain offer me help to reposition, offer me a massage, see my medication sheets, treatment record and physician's orders. Move me slowly for repositioning and transfers. . . ."<br><br>Resident #9's Daily Living Needs, updated 01/04/12, stated, " . . .Transfers: . . . Comments: Move me slowly for transfers and repositioning - I have a fractured pelvis . . . Other notes: Report any pain or changes in my behavior to my charge nurse . . . "<br><br>Observations of Resident #9 included the following:<br>* 01/08/12 at 4:05 p.m.: two unidentified visitors in the Resident's room. One stated Resident #9 "isn't usually like this." When asked what she meant the visitor stated Resident #9 laid sleeping through their visit and not conversing with them.<br>* 01/09/12 at 9:20 a.m., A CNA (#19) provided morning cares with an administrative nurse member (#13) in the room. Resident #9 cried out "Hey!" when the CNA lifted her left leg to remove a pillow. When the CNA (#19) removed the resident's brief and performed perineal cares, Resident #9 cried out and tried to reach out and stop the CNA's hand. When the CNA (#19) placed a new brief, the Resident stated a profanity and grasped the CNA's arm and shirt. Resident #9 cried out "Ah!"as the CNA (#19) placed a pillow between her knees. When the administrative staff nurse (#13) asked the resident if she had pain, the resident replied "Shut up!"<br>* 01/09/12 at 9:40 a.m.: a CNA (#19) entered Resident #9's room with a breakfast tray. As the CNA raised the head of bed (HOB) Resident #9 | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 19<br>cried out, "Get out of here" and "Owe, Owe, Owe!" Resident #9 again cried out as the CNA (#19) repositioned her. Resident #9 slapped and grabbed the CNA's (#19) hands as the CNA attempted to give the resident a drink. At 10:05 a.m. a license practical nurse (#21) entered and offered a pain pill which the resident refused.<br>* 01/09/12 at 1:40 p.m., two CNAs (#19 and #20), with an administrative nurse member (#13) present in the room, transported Resident #9 back to bed using a full body lift. The resident screamed "No!" during the transfer and stated, "Yes" when asked if her back hurt. The two CNAs (#19 and #20) rolled Resident #9 to her left side and placed a pillow under her right side. Resident #9 stated, "Owe, Owe, Owe!" during movement. A licensed practical nurse (#21) entered room and offered a pain medication, but the resident didn't open her eyes or mouth.<br>* 01/09/12 at 2:55 p.m., Resident #9 laid in bed on her right side while an administrative nurse completed a pain evaluation. The Resident responded "yes" to having pain in her back, hip, legs and "yes" when asked if it hurt to move. The resident responded "yes" when asked if she would like something else for pain.<br><br>Resident #9's nurse's notes stated the following:<br>* 01/04/12 at 7:15 p.m., ". . . found resident sitting on floor by bed. Resident denies hitting head . . ."<br>* 01/05/12, "(late entry for 5:15 p.m.) . . . Resident observed on floor beside w/c [wheelchair]. . .Resident denies pain . . ."<br>* 01/06/12 12:15 a.m. "Res [resident] uncooperative early pm [with] assessment but once in bed did cooperate. When in w/c sat leaning over, would not sit straight up. Some c/o [complaints of] back pain when transferred to bed | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 20<br>. . . Inconsistent [with] c/o back pain . . ." and at 12:30 a.m., "Res uncooperative [with] taking fluids. Denies pain."<br>* 01/06/12 at 4:30 a.m., ". . . Res uncooperative and gets angry when asked about pain."<br>* 01/06/12 at 3:30 p.m., ". . . Resident very uncooperative during assessment. Continued to yell at CN [charge nurse] and resist assessment. Resident denies pain. . . .Refused to move lower legs for CN to assess strength. . . . refused to let CN perform ROM [range of motion] to legs but attempted to stand out of w/c [wheel chair] this afternoon. . ."<br>* 01/09/12 at 3:45 p.m., "While observing peri-cares at 1400 [2:00 p.m.], noted res. to be in what seems a great deal of pain [with] any movement. She yells out "ouch," hollering at staff and guarding [with] any movement. When pain assessment conducted, res. answered "yes" when asked if her legs, arms, back, and hips hurt. She also answered "yes" when asked if movement makes it worse. MD [medical doctor] faxed to ask for pain medication other than her current daily and PRN [as needed] Tylenol. . . ."<br>* 01/10/12 at 9:00 a.m., Resident #9 complaining of pain with movement and nurse practitioner wrote orders to transfer to clinic today.<br>* 01/10/12 at 2:10 p.m., Resident #9 returned from an appointment with new orders for a fentanyl patch and follow up bone scan scheduled on 01/12/12.<br><br>During an interview on 01/11/12 at 9:30 a.m., a CNA (#19) identified Resident #9 showed signs of pain on 01/09/11. The CNA failed to notify the charge nurse or offer alternative forms of pain relief, except repositioning. | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 309 | Continued From page 21<br>A pain evaluation for Resident #9, completed on 01/09/12 at 3:15 p.m., stated, " . . . Res. has shown increasing behaviors and yelling out, especially [with] movement which has increased following discharge from hospital . . ." This evaluation identified Resident #9 as having groaning, whimpering, grimacing, clenching of the jaw, resisting care, irritability, and guarding limb or other body part.<br><br>The MAR on 01/09/12 at 8:00 p.m. showed scheduled Tylenol not received by Resident #9 due to ". . .refused to open mouth to take po [by mouth] meds" and the medical record lacked evidence that the facility administered pain medication for 23 hours from the time the resident responded yes to having pain during her pain assessment until 01/10/12 at 2:10 p.m. when her physician ordered a fentanyl patch.<br><br>During an interview on 01/09/12 at 2:50 p.m. an administrative nurse (#13) stated she noticed today that Resident #9 had behaviors related to pain. This staff member reported Resident #9 had an increase behaviors when she was readmitted in December with her pelvic fracture and at that time her psychotropic medications were adjusted.<br><br>During an interview on 01/10/12 at 1:10 p.m., the administrative nurse (#13) agreed that Resident #9's current pain may be related with the falls on 01/04/12 and 01/05/12. | F 309 | | |
| F 311 SS=D | 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. | F 311 | F311<br><br>In regards to failure to provide appropriate treatment and services to ensure safe positioning with locomotion: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 311 | Continued From page 22<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide appropriate treatment and services to ensure safe positioning with locomotion for 1 of 2 sampled residents (Resident #5) utilizing an electric wheelchair.<br><br>Findings include:<br><br>Record review for Resident #5 occurred on January 9-11, 2012. Medical diagnoses included paraplegia, neuropathy, anxiety, depression, and history of left tibia fracture. The most recent Minimum Data Set (MDS), dated 11/24/11, identified Resident #5 as cognitively intact, with no short or long term memory problems, total assistance with transfers, and extensive assistance with mobility. The medical record identified Resident #5 uses an electric wheelchair for locomotion and uses a self-releasing seatbelt in the wheelchair.<br><br>The medical record identified Resident #5 used a regular wheelchair for the months of August-November 2011 due to a fractured tibia. The medical record during this time identified Resident #5 experienced depression due to the inability to use his electric wheelchair. The facility re-assessed the resident for safety and returned the electric wheelchair to Resident #5 for locomotion on 11/29/11.<br><br>An interdisciplinary rehabilitation screening form, dated 12/07/11, stated "Referral . . . W/C [wheelchair] Mobility: wheelchair positioning . . . | F 311 | St. Luke's Home will be implementing a positioning monitor log on February 10, 2012. The Charge Nurse on duty will be responsible for monitoring and coordinating with unlicensed personnel the proper positioning of Resident #5. Starting February 10, 2012, the Charge Nurse on duty will complete the position monitor log every 2-3 hours daily for 4 weeks, then 3 times daily for 4 weeks, and then proceeding daily to ensure Resident safety. Education was provided to unlicensed personnel on proper positioning of Resident #5 on February 7, 2012. Additionally, education will be provided on February 8-10, 2012, on proper use of Stand-Up and Hoyer Lifts for Resident transfers and repositioning. On March 20, 2012, Prevent Inc. are scheduled to visit St. Luke's Home to reassess and provide re-education on our Safe Handling Program. Starting February 13, 2012, the Neighborhood Supervisor and/or designee will review the position monitor log for Resident #5 and forward the pertinent data to the Quality Assurance Committee monthly for review and follow up. | 02/13/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 311 | Continued From page 23<br>Comments: Pt. is leaning to the right in electric wheelchair due to improper positioning by staff. Staff needs to 1st [first] position the w/c cushion in the center or towards right side of chair. Staff needs to then Hoyer [transfer] him into w/c with straight pelvis. If pt. is placed in chair with pelvis tilt, the staff need to pull his pelvis towards the right to straighten it out. You may place small towel under right side of cushion only if needed."<br><br>An Occupational Therapy Progress Note, dated 12/16/11, stated ". . . Therapist is able to position pt. [patient] in chair so he is able to sit up straight and has wrote orders for staff to follow. When therapist observes pt. daily he is leaning severely to the right. Therapist has two concerns: 1. Pt. is not being placed in chair properly. 2. Pt. has poor trunk control/pelvic obliquity that he is unable to hold self up which may result in a fall out of chair. In order to qualify for an electric w/c, trunk control is essential for the patient's safety. The pt. would like to remain in electric wheelchair for his independence. . . ."<br><br>Observation of transfers identified the following:<br><br>* 01/08/12 2:30 p.m. A certified nursing assistant (CNA) (#5) along with an unidentified CNA transferred Resident #5 into his electric wheelchair. Observation showed the resident leaning to the right in the wheelchair and his trunk/pelvis not aligned in the center of the wheelchair. The CNAs did not reposition the resident or adjust his trunk/pelvis once in the wheelchair.<br><br>* 01/09/12 7:00 a.m. Two unidentified CNAs transferred Resident #5 into his electric | F 311 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 311 | Continued From page 24<br>wheelchair. The CNAs placed a small towel under the right side of his wheelchair cushion, but did not reposition him in his wheelchair. Observation showed the resident leaning to the right in the wheelchair.<br><br>Other random observations throughout the survey identified Resident #5 leaning to the right while in his electric wheelchair with his seatbelt fastened. During these observations, facility staff did not reposition Resident #5. On the morning of 01/11/12, Resident #5 demonstrated he could release and fasten his seatbelt independently.<br><br>During an interview on 01/10/12, a occupational therapist (#4) stated facility staff are expected to reposition Resident #5 and monitor his positioning throughout the day. This staff member stated she developed recommendations for staff to follow regarding how transfers and positioning for Resident #5 should be done. She further stated Resident #5 likes his electric wheelchair, enjoys the independence he receives from the electric wheelchair, and stated good positioning is a requirement for continued use of the electric wheelchair.<br><br>Failure of the facility staff to ensure proper positioning in his wheelchair according to the recommendations of the Occupational Therapist places Resident #5 at risk of losing his current level of independence through the use of his electric wheelchair. | F 311 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any | F 329 | F329<br><br>In regards to the failure to attempt gradual dose reductions (unless contraindicated): | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 329 | Continued From page 25<br>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure a drug regimen free from unnecessary medications for 1 of 3 residents (Resident #8) receiving a scheduled hypnotic and 1 of 6 sampled residents (Resident #9) receiving a scheduled antipsychotic. Failure to attempt gradual dose reductions (GDRs) (unless contraindicated) quarterly for hypnotic medications and failure to ensure antipsychotic medications were not increased without an adequate indication placed residents at risk of | F 329 | St. Luke's Home will implement a double check system starting February 13, 2012. The Consultant Pharmacist will be provided with a Medication Transaction Analysis Report. This report lists the start and end times of the medications of all Residents. The Consultant Pharmacist will review the report and compare to the Resident Medication Regimen Reviews monthly. The Consultant Pharmacist will forward the Medication Regimen Review notes along with Medication Transaction Analysis Reports to the Neighborhood Supervisor for comparison. Any discrepancies found will be brought to the Consultant Pharmacist to address in a timely manner. The Neighborhood Supervisors will tabulate data and forward to the Quality Assurance Committee monthly for review and follow up. | 02/13/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 329 | Continued From page 26<br>receiving unnecessary medications and experiencing adverse drug effects related to their use.<br><br>Findings include:<br><br>The Nursing 2011 Drug Handbook, 31st Edition, Lippincott, Williams, and Wilkins, page 787-788, stated, ". . . Sedative-hypnotics . . . Ambien . . . Indications & Dosages . . . Short-term management of insomnia . . . Adverse Reactions . . . headache, depression, dizziness, lethargy . . . Nursing Considerations . . . Use drug only for short-term management of insomnia, usually 7 to 10 days. . . ."<br><br>- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included senile dementia, unspecified insomnia, depression, and a history of falls. Current medications included Ambien (a hypnotic) 5 mg at bedtime. Review of Resident #8's medical record identified the last GDR attempt for Ambien occurred in April 2010. Resident #8 remained on the current dose of Ambien (5 mg) since that time.<br><br>Resident #8's physician's progress notes from January 2011 through January 11, 2012 showed the physician failed to identify continued indications for the use of Ambien or contraindications for a GDR.<br><br>During an interview on the morning of 01/11/12, a supervisory nursing staff member (#1) confirmed the lack of (or contraindications for) a GDR attempt of Ambien since April 2010. | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 329 | Continued From page 27<br><br>- Refer to F 309.<br><br>Review of Resident #9's "Pain Flow Sheet" indicated the resident received 650 mg of Tylenol on 12/07/11 at 2:00 p.m. for leg pain and on 12/27/11 at 11:45 a.m. for back pain. Review of Resident #9's nurses notes identified on 12/08/11 at 10:30 a.m., the resident experienced pain in right pelvic area with movement. The medical record lacked evidence of an assessment of pain or administration of pain medication for pain on the morning of 12/08/11.<br><br>Resident #9's physician orders and medication administration record (MAR) showed the physician ordered Risperdal (an antipsychotic) 0.5 mg twice a day on 12/09/11 and increased the dose to 0.5 mg three times a day on 12/14/11.<br><br>Observations of Resident #9 on 01/08/12 and 01/09/12 showed Resident #9 experienced pain during movement as observed by the Resident grabbing at staff and stating "Owe, Owe, Owe."<br><br>During an interview on 01/10/12 at 1:10 p.m., an administrative nurse (#13) agreed that Resident #9's behaviors may be in relation to pain.<br><br>The facility failed to consider pain as reason for behaviors prior to implementing and increasing the dose of Risperdal. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. | F 428 | F428<br><br>In regards to the failure of the Consultant Pharmacist to recommend and report drug regimen irregularities: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 428 | Continued From page 28<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility's consultant pharmacist failed to recognize and report drug regimen irregularities for 1 of 3 sampled residents (Resident #8) receiving a scheduled hypnotic. Failure to review residents' medication regimens and report irregularities places residents at risk of receiving unnecessary medications and experiencing adverse drug effects related to their use.<br><br>Findings include:<br><br>- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included senile dementia, unspecified insomnia, depression, and a history of falls. Current medications included Ambien (a hypnotic) 5 mg at bedtime, with the last gradual dose reduction (GDR) attempt occurring in April 2010.<br><br>The facility's consultant pharmacist reviewed Resident #8's medications monthly. Resident #8's record lacked evidence to indicate the pharmacist recommended a GDR of Ambien within the past year.<br><br>During an interview on the afternoon of 01/10/12, | F 428 | St. Luke's Home will implement a double check system starting February 13, 2012. The Consultant Pharmacist will be provided with a Medication Transaction Analysis Report. This report lists the start and end times of the medications of all Residents. The Consultant Pharmacist will review the report and compare to the Resident Medication Regimen Reviews monthly. The Consultant Pharmacist will forward the Medication Regimen Review notes along with Medication Transaction Analysis Reports to the Neighborhood Supervisor for comparison. Any discrepancies found will be brought to the Consultant Pharmacist to address in a timely manner. The Neighborhood Supervisors will tabulate data and forward to the Quality Assurance Committee monthly for review and follow up. | 02/13/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 428 | Continued From page 29<br>a licensed pharmacist (#3) and a supervisory nursing staff member (#1) confirmed the lack of pharmacy recommendations for a GDR attempt throughout 2011. | F 428 | F441<br><br>In regards to the failure to follow accepted standards of practice regarding infection control: St. Luke's Home provided education to unlicensed nursing personnel regarding hand hygiene, and infection control on February 7, 2012. Education on Peri-Care, hand hygiene, personal protective equipment, and other infection control measures will be reinforced at the C.N.A. Skills Fair on February 8-10, 2012. St. Luke's Home will continue to provide education on Peri-Care, hand hygiene, personal protective equipment, and other infection control measures at the monthly unlicensed nursing personnel meetings. St. Luke's Home will continue to monitor Post-Toilet Hand Hygiene 3 times weekly and provide on the spot education when needed. The data will continue to be tabulated and reported to the Quality Assurance Committee monthly for review and follow up. St. Luke's Home will continue to monitor the dining areas 3 times weekly for proper feeding techniques, hand hygiene, and other infection control measures. Education will continue to be provided on the spot as needed. | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility 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.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 30<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED 01/27/11 and A REVISIT SURVEY COMPLETED ON 03/24/11.<br><br>Based on observation, record review, facility policy and procedure, and staff interview, the facility failed to follow accepted standards of practice regarding infection control for 4 of 8 residents (Resident #2, #6, #7, and #9) during personal cares and 1 supplemental resident (Resident #18) assisted during meal time. Failure to follow infection control practices has the potential to spread infections within the facility and places residents, staff and visitors at risk.<br><br>Findings include:<br><br>Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 01/11/12. This policy, revised January 2012, stated, ". . . Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . . . Before and after assisting a resident with toileting (hand washing with soap and water) . . . After handling soiled or used linens, dressings, bedpans, catheters and urinals . . . Hand hygiene is always the final step after removing and disposing of personal protective equipment . . . The use of gloves does | F 441 | F441<br><br>In regards to the failure to follow accepted standards of practice regarding infection control: St. Luke's Home provided education to unlicensed nursing personnel regarding hand hygiene, and infection control on February 7, 2012. Education on Peri-Care, hand hygiene, personal protective equipment, and other infection control measures will be reinforced at the C.N.A. Skills Fair on February 8-10, 2012. St. Luke's Home will continue to provide education on Peri-Care, hand hygiene, personal protective equipment, and other infection control measures at the monthly unlicensed nursing personnel meetings. St. Luke's Home will continue to monitor Post-Toilet Hand Hygiene 3 times weekly and provide on the spot education when needed. The data will continue to be tabulated and reported to the Quality Assurance Committee monthly for review and follow up. St. Luke's Home will continue to monitor the dining areas 3 times weekly for proper feeding techniques, hand hygiene, and other infection control measures. Education will continue to be provided on the spot as needed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 30<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED 01/27/11 and A REVISIT SURVEY COMPLETED ON 03/24/11.<br><br>Based on observation, record review, facility policy and procedure, and staff interview, the facility failed to follow accepted standards of practice regarding infection control for 4 of 8 residents (Resident #2, #6, #7, and #9) during personal cares and 1 supplemental resident (Resident #18) assisted during meal time. Failure to follow infection control practices has the potential to spread infections within the facility and places residents, staff and visitors at risk.<br><br>Findings include:<br><br>Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 01/11/12. This policy, revised January 2012, stated, ". . . Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . . . Before and after assisting a resident with toileting (hand washing with soap and water) . . . After handling soiled or used linens, dressings, bedpans, catheters and urinals . . . Hand hygiene is always the final step after removing and disposing of personal protective equipment. . . . The use of gloves does | F 441 | The data will continue to be tabulated and forwarded to the Quality Assurance Committee monthly for review and follow up.<br>St. Luke's Home will continue to monitor Peri-Care on 10 Residents per unit monthly and all Residents on UTI protocol. Education will be provided on the spot as needed. The data will continue to be tabulated and reported to the Quality Assurance Committee monthly for review. St. Luke's Home will implement contact precaution monitors on 10 Residents with contact precautions on February 13, 2012. Education will be provided on the spot as needed. The data will be tabulated and forwarded to the Quality Assurance Committee monthly for review and follow up. | 02/13/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 31<br>not replace handwashing/hand hygiene. . . ."<br><br>Review of the facility policy titled "Standard Precautions" occurred on 01/11/12. This policy, revised January 2012, stated, ". . . 4. Gowns. a. Wear a gown (clean, non-sterile) to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, . . ."<br><br>Review of the facility policy titled "Isolation-Categories of Transmission-Based Precautions" occurred on 01/11/12. This policy, revised January 2012, stated, ". . . Contact Precautions. In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident . . . Example of infections requiring Contact Precautions include . . . multi-drug resistant organisms (e.g. MRSA . . . d. Gown . . . wear a gown . . . for all interactions that may involve contact with a resident or potentially contaminated items in the resident's environment. . . ."<br><br>- During an observation at 7:40 a.m. on 01/09/2012, a certified nursing assistant (CNA) (#7), donned gloves and assisted Resident #2 with morning cares. After performing perineal cares the CNA failed to remove her gloves and perform hand hygrine, before assisting Resident #2 with dressing, using the stand lift, providing care of the resident's glasses, and combing her hair.<br><br>Review of the facility policy titled "Nutrition and | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 32<br>Food Services Infection Control and Employee Hygiene and Sanitary Practices" occurred on 01/11/12. This policy, dated 10/06/11, stated, ". . . Contact between food and bare (ungloved) hands are [sic] prohibited. . . ."<br><br>- During the breakfast meal on 01/09/2012 at 9:00 a.m. an observation of meal assistance showed the CNA (#7) feeding Resident #18 a piece of toast with bare hand contact. The CNA fed the resident cereal with a spoon and then set the spoon down and picked up the toast with jelly and fed the resident. During this observation the CNA failed to wear gloves or use a manner of assistance where she would not touch the resident's toast.<br><br>- Observation during the initial tour of the facility on the afternoon 01/08/12 identified the following:<br><br>* Room 123- an empty, uncovered urinal stored on the floor in the bathroom next to the toilet.<br><br>* Room 129- an empty, uncovered urinal stored on the bedside table next to a glass of water and a supplement.<br><br>During an interview on the morning of 01/11/12, an admininstrative nursing staff member (#1) stated urinals should be stored in a plastic bag, off the floor, and away from food items.<br><br>- During an initial tour of the facility on the afternoon of 01/08/12, an administrative nursing staff member (#13) identified Resident #6 on contact precautions for Methicillin-Resistant Staphylococcus Aureus (MRSA) present in her urine. | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 33<br><br>Record review for Resident #6 occurred on January 9-11, 2012. Medical diagnoses included MRSA present in her urine and the presence of a Foley catheter.<br><br>Observation of catheter cares occurred on 01/08/12 at 4:00 p.m. A CNA (#5) applied gloves and emptied Resident #6's catheter into a graduated container. The CNA (#5) emptied the urine from the cylinder into the toilet, rinsed the inside of the container using a sprayer located on the back of the toilet, and stored the container on the back of the toilet. The CNA did not apply a gown or a face shield prior to emptying the catheter or rinsing the container per facility policy.<br><br>During an interview on 01/09/12 at 3:00 p.m., a charge nurse (#12) confirmed contact precautions for Resident #6 and this required staff to apply a gown when performing catheter cares.<br><br>During an interview on 01/10/12 at 7:20 a.m. (8:20 a.m. CST), an administrative nurse (#13) stated staff needed to apply a gown and gloves when performing catheter cares for Resident #6 due to contact precautions for MRSA present in her urine.<br><br>- Observation of personal cares occurred with Resident #7 on 01/08/12 at 2:34 p.m. The resident voided and stooled in a bed pan, and a CNA (#2) provided perineal care. The CNA then set the bed pan aside and removed her gloves. Without performing hand hygiene, the CNA donned a new pair of gloves and applied moisture barrier cream to the resident's coccyx and | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355063 | A. BUILDING _____ B. WING _____ | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKES HOME | 242 10TH ST W DICKINSON, ND 58601 |

| (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 34<br>buttocks. Using the same gloves, the CNA then applied the cream between the resident's abdominal folds.<br><br>During an interview on the morning of 01/11/12, a supervisory nursing staff member (#1) confirmed he expects CNAs to perform hand hygiene after completing perineal care and before performing other tasks.<br><br>- Observation on 01/09/12 at 9:20 a.m. showed a CNA (#19) place a urine soaked brief on Resident #9's bed. After performing peri-cares and prior to removing her gloves, the CNA obtained A&D ointment (a skin barrier cream), squeezed the tube of ointment with her gloved hands, applied the cream in the perineal area, and placed the A&D ointment tube on the bedside table. After donning new gloves, the CNA placed the A&D ointment on the ledge of the sink, performed hand hygiene, and placed the A&D ointment from the sink ledge into cupboard for storage. | F 441 | | |